HEALTHY MEDIA LITERACY: BRIDGING CRITICAL MEDIA LITERACY AND HEALTH LITERACY TO PROMOTE POSITIVE BODY IMAGE AND HEALTH

by

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ABSTRACT

In light of rampant body shame, disordered eating, physical inactivity, and widespread misunderstanding of what constitutes a healthy body, it is crucial to identify mechanisms by which women can resist distorted health discourse and redefine health for themselves outside of appearance-oriented ideals. Through following a group of 42 women ages 18-35 as they engaged in a health and media literacy curriculum developed for this study, and by using critical feminist methods to analyze participants' responses to open-ended surveys before, during, and 2 weeks after completing the curriculum, this study seeks to identify effective means for resisting appearance-focused health ideals. Through the development of a practical and accessible healthy media literacy curriculum and analysis of participants' self-reported beliefs and behaviors throughout the process, this project contributes praxis-oriented research to assist scholars, health educators, and individual women in cultivating and promoting resistance to distorted health discourse. The findings of this study also suggest that women who engage with a healthy media curriculum can develop and cultivate strategies to resist distorted health discourse by writing body image narratives that bear witness to their own lived experiences.

TABLE OF CONTENTS

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CHAPTER 1

INTRODUCTION: FEMALE BODY IMAGE AND PHYSICAL HEALTH

Women's health and fitness are consistently and pervasively misrepresented in mass media, framed most often in terms of thinness and sex appeal rather than wellness or achievement (Eskes, Duncan, & Miller, 1998; Markula, 2001). A wealth of research exists on the representation of women's bodies in media throughout the past few decades, with perhaps the most consistent finding being the promotion of a thin ideal, as thinness is consistently emphasized and rewarded for women, with thin bodies being greatly overrepresented and praised while average weight or overweight bodies are underrepresented and marginalized (Eggermont et al., 2005; Fouts & Burggraf, 1999; Harrison & Fredrickson, 2003; Harrison & Gentles, 2006; Hendriks, 2002; Pompper & Koenig, 2004).

Accepted definitions and indications of physical health have remained relatively stable throughout the past several decades, with the same basic vital signs and measures of efficient bodily function used by medical professionals since the early 20th century. These include blood pressure, extremely low or high body fat percentage, presence of disease, cardiovascular fitness, and other factors. However, dominant discourse and

public perceptions regarding female health and fitness have shifted dramatically toward a focus on thinness over the past century, and most noticeably the past 25 years, as evidenced by mass media's almost exclusive textual and visual depiction of healthy bodies as extremely thin, toned, and free of any unsightly "blemishes" like cellulite (Krcmar, Giles, & Helme, 2008; Spitzer, 1999). Perhaps the most prominent purveyor of health information over the past century, women's magazines have played a major role in depicting and defining health and ideal body weight for women. Women's magazines are shown to be the No. 1 source for health information for women outside the doctor's office and adolescent girls report media as their main source for health information (Barnett, 2006).

Along with demonstrating the prevalence of the thin ideal, the past 15 years have brought a wealth of research on the influence of thin-ideal media on viewers' body perceptions. Many of these studies offer consistent evidence that exposure to thin-ideal media is associated with body image disturbance in adolescent and adult females, including body dissatisfaction, distortions in body image, internalization of the thin ideal, drive for thinness, increased investment in appearance, and increased endorsement of disordered eating behaviors (American Psychological Association, 2007; Grabe, Ward, & Hyde, 2008; Harrison, 2008; Harrison & Fredrickson, 2003). Body image is defined as a person's evaluative perceptions of her or his body, particularly its appearance, and body image disturbance is conceptualized as either demonstrably inaccurate perceptions of the body's size or proportions, or dissatisfaction with one or more of the body's observable features (Harrison, 2008).

Though women of color are greatly underrepresented in mainstream media and are often depicted in negative and stereotypical ways (Pugh Yi & Dearfield, 2012), that does not mean they are immune to thin ideals. Botta (2000) found that for both Black and White girls, exposure to TV beauty ideals was associated with a stronger drive for thinness and greater body dissatisfaction. Roberts et al. (2004) echoed these findings, declaring that Black girls may be particularly vulnerable to internalizing media messages that emphasize beauty and appearance. Borzekowski, Robinson, and Killen (2000) found that the number of hours watching music videos increased the appearance and weight concerns of teen girls, with those findings being strongest among the Black girls tested. In studies where Latina teenage girls report greater body satisfaction compared to White girls, they still report comparable or higher rates of disordered eating (Barry & Grilo, 2002; Crago, Shisslak, & Estes, 1996; Granillo, Jones-Rodriguez, & Carvajal, 2005; White & Grilo, 2005). Greater acculturation into mainstream U.S. culture has been associated with preference for much thinner body types among Mexican American women. Studies have found second-generation Mexican Americans had the highest levels of disordered eating among first- through fifth-generation Mexican Americans. In other words, Latinas who are daughters of first-generation Americans were most likely to have an eating disorder, potentially as a result of trying to fit in with U.S. ideals, which may differ starkly from ideas about bodies found in their parents' native cultures (Goodman, 2002). Furthermore, Latina adolescents describe an ideal body type that looks extremely similar to the White norm and they report the desire to lose weight at similar rates to their White peers (Neumark-Sztainer et al., 2002; Poran, 2002; Rosen & Gross, 1987). Generally, television watching is related to lower self-esteem and higher levels of

disordered eating for girls and women of all races and ethnicities (Harrison & Gentles, 2006; Tiggemann, 2006).

As representations of women's bodies across all media have focused so intensely on thinness over the last 30 years, rates of eating disorders have skyrocketed – tripling for college-age women from the late 1980s to 1993 and rising since then to 4% of U.S. women suffering with bulimia. Approximately 10 million women are diagnosable as anorexic or bulimic, with at least 25 million more struggling with a binge eating disorder (NEDA, 2010). Perhaps more alarming is the 119% increase from 1999-2006 in the number of children under 12 hospitalized due to an eating disorder, the vast majority of whom were girls (Rosen, 2010). Though the Department of Health reports that no exact cause of eating disorders has yet been found, they do admit some characteristics have been linked to their development, such as low self-esteem, fear of becoming fat, and being in an environment where weight and thinness are emphasized (Rosen, 2010) – all of which are shown to be related to media exposure of idealized bodies, which is all but inescapable.

While scholarly research has consistently linked these serious women's health issues to media's pervasive and unrealistic beauty ideals, this connection needs to be viewed as not only a problem with perceptions of beauty, but with dangerously distorted perceptions of health. Though extensive empirical evidence can tell us that current beauty ideals of extreme thinness and tall, shapely perfection have little to no correlation with actual indicators of physical health and wellness, we still see convincing evidence demonstrating that people believe this ideology to be true.

Numerous studies demonstrate that the vast majority of girls and women now perceive underweight bodies and extremely low body weights as being ideally healthy (Kantrowitz & Wingert, 2007; Rosen, 2010), and even underweight and average-weight females are striving for weight loss using dangerous and unhealthy means (Eskes, Duncan, & Miller, 1998; Grabe, Ward, & Hyde, 2008; Posavac, 1998). According to studies done in the last 5 years, 66% of adolescent girls wish they were thinner, though only 16 are actually overweight, and 35% of 6- to 12-year-old girls have been on at least one diet (Rosen, 2010). The relentless quest for thinness is especially dangerous for all people, but especially for young people, since research shows that unhealthful dieting behavior in youth increases the risk for the development of anorexia and bulimia as well as obesity in adolescence and beyond, even for individuals who were considered to be at a healthy weight when they started dieting (Harrison, 2008; Neumark-Sztainer, Wall, Guo, Story, Haines, & Eisenberg, 2006).

Profit-driven media are not the only source of the promotion of thin ideals, or a focus on appearance rather than actual health. Critical scholars also consider other health messages and sources to be appropriate targets of analysis, including government reports, height/weight tables like the BMI, health measurement scales and charts, health agency initiatives, etc. Gerbensky-Kerber (2011) argued that an analysis of BMI and obesity-related discourses offers an opportunity to answer Ford and Yep's (2003) call for health communication scholarship that "opens up space for the discourse of suspicion and to analyze how power privileges some groups and marginalizes others" (p. 355). This promotion of critical analysis of physical health definitions from media and health agencies takes up Gerbensky-Kerber's call to "scrutinize efforts to improve wellness and

fitness for the ways in which they address or reflect gendered assumptions about bodies (or body image), and what the unintended consequences of labeling practices could be" (2011, p. 363).

Asking people to consider the disparities between the way health is represented and real people's lived experiences – using both scholarship and reflection on personal experience – helps to shed light on distorted health discourse. In terms of health measurements, the BMI, which is the national standard for judging healthy weight, is proven to be highly inaccurate for non-White races and ethnicities since it is based on a U.S. Caucasian standard. In particular, in some Asian populations, a specific BMI reflects a higher percentage of body fat than in White or European populations (James, 2002). Some Pacific populations and African Americans in general also have a lower percentage of body fat at a given BMI than do White or European populations (Stevens, 2002). Even the World Health Organization has acknowledged the extensive evidence that "the associations between BMI, percentage of body fat, and body fat distribution differ across populations" (WHO, 2004). Still, the Centers for Disease Control (CDC) continues to endorse and promote the use of BMI for all individuals to self-diagnose their health status.

Further demonstrating the variable nature of what constitutes health for individuals, the BMI is inaccurate for adolescents, including anyone under the age of 20. Unfortunately, it is still widely used to diagnose weight (and thus health) status among children and teens, despite experts warning of the unstable, developing nature of adolescent bodies. In light of this, and considering the prepubescent thin body ideals perpetuated so pervasively by mass media (and also circulated within social media),

scholars cite a crucial need to provide girls in early adolescence with information regarding the physical changes that occur with the onset of puberty, which pushes them further from the cultural ideal (Choate, 2007; Neumark-Sztainer, 2007). “Girls can learn of the normative nature of their weight gains and begin to challenge the inconsistencies between the thin ideal and their maturing bodies” (Choate, 2007, p. 320).

This critical look into a generally taken-for-granted measure of health is revealing of the ways distorted health discourse is circulated and upheld, despite extensive evidence that it is not accurate or effective (Czerniawski, 2007). In direct contradiction to this focus on thinness in media and public perception of health, a rich body of research shows that health and fitness often has very little correlation to body weight or an individual’s BMI. This is evidenced by a meta-analysis of medical studies since the 1970s that concluded overweight and active people may be healthier than those who are thin and sedentary (Heimpel, 2009; Macias Aguayo et al., 2005). In the wake of high rates of obesity and related chronic diseases, health educators and medical experts have begun a push toward a “health at any size” movement that encourages people to switch their focus away from weight loss and toward healthy behaviors that can increase physical and emotional health at any weight (Calvert Finn, 2001; King, 2009; Macias Aguayo et al., 2005).

Physical activity is shown to lead to body satisfaction when girls and women develop an appreciation of what their bodies can do, rather than how they appear to others (Choate, 2007). When girls exercise to improve their overall fitness (versus working out to burn calories), they are more likely to possess positive body image (Song, 2011). It is important to note that in encouraging this focus on physical activity rather

than size measurements, warning should be given that women also need assistance in setting realistic expectations for the effects of exercise in changing body shape, losing weight, or other aspects of their lives, since distorted health discourse perpetuates ideas of easy weight loss and corresponding changes in one's happiness, attractiveness, etc. (Choate, 2007; King et al., 2009; Pompper & Koenig, 2004).

Still, studies show that even when people *know* what they need to do to be healthy, and how that differs from prevalent distorted health messages, that knowledge only turns into healthful habits through the mediator of self-efficacy (Oman & King, 1998; Rimal, 2000). An important concept in Bandura's (1977) social cognitive theory, self-efficacy is confidence in one's ability to achieve a goal or complete a task. In the example of physical activity, people have to believe they can exercise – in the right ways, consistently, effectively, without hurting themselves, embarrassing themselves, or whatever else might hold them back – in order to do it and stick with it (Song, 2011). That makes self-efficacy a hugely vital goal for anyone who cares about improving their own health or others'.

An interesting experimental study on eating disorder prevention by Neumark-Sztainer et al. (2000) measured adolescent girls' "self-efficacy to impact weight-related social norms among peers" before and after a media literacy intervention. They found the self-efficacy measure to be significantly improved in both short- and long-term testing. A major objective of the study was to "increase the girls' understanding that they do not need to be passive recipients of potentially harmful social norms, but rather that they have the ability to advocate for change" (p. 1471), and this strongly resonates with the goals of my work. Rimal (2000) echoed several other studies in the past several years that

have shown health knowledge gets translated into healthful habits through the mediation of perceived self-efficacy**.** Health self-efficacy to not only achieve health for oneself, but also to promote understanding of health and healthy behaviors among one's friends and family, is a crucial component of the fight against widespread body hatred and unhealthy behaviors among women.

Social Cognitive Theory also provides insight into the ways misconceptions about health are circulated and shared among media, peers, medical professionals, and other sources: "Much social learning occurs either designedly or unintentionally from models in one's immediate environment," Bandura (1977) emphasized (p. 271). "However, a vast amount of information about human values, styles of thinking, and behavior patterns is gained from the extensive modeling in the symbolic environment of the mass media" (Bandura, 1977, p. 271). This symbolic environment increasingly includes social media like Twitter or Facebook, where more than half of the U.S. population over age 12 has an account (Webster, 2011). Discussion of social media influence on body satisfaction is growing due to the ever-present ability to share images and media texts, especially those that scrutinize women's bodies or represent idealized, Photoshopped bodies. Reports cite constant self-comparisons and increasing body anxiety among females who are heavy social media users (Enayati, 2012).

CHAPTER 2

LITERATURE REVIEW

Overview of Media Literacy and Health Literacy

In light of rampant body shame, disordered eating, physical inactivity, and widespread misunderstanding of what constitutes a healthy body, it is crucial to develop strategies to help people critically recognize and reject harmful messages about women's bodies and health and then work to cultivate and promote true health and fitness in their own lives and circles of influence. Two areas of research and pedagogy that can be effectively applied to this subject are media literacy and health literacy. Through an analytical review, I will ground these two bodies of research in the literature and then situate media literacy and health literacy within the realm of body image and physical health. Due to its wide-spanning roots, applications, and measurements, I begin this review with an overview of media literacy's evolution and applications and follow that with a look into its theoretical grounding and implications. Following this discussion of media literacy, I will offer a literature review of health literacy and discuss its relationship to media literacy.

Finally, I will justify, define, and situate my proposal for a combination of health literacy and media literacy to be used in the cultivation and promotion of women's

positive body image and physical health. Due to the pervasive misrepresentation of health in media and widespread health and body image problems, scholars have called for the development of media literacy curricula and health interventions that specifically address women's physical health and body image (Harrison, 2008; Van den Berg & Neumark-Sztainer, 2007). This project aims to fill this gap in the literature by contributing such a curriculum, as well as theoretically grounded mechanisms for resistance to distorted health ideals.

Media Literacy: Evolution and Applications

Just as traditional literacy teaches students to critically analyze literature, the concept of media literacy expands the notion of literacy to include mass communication, popular culture, and new technologies. With a foundation in critical theory and pedagogy, media literacy deepens the potential of literacy education to critically analyze relationships between media and audiences, information, and power (Kellner, 2007). Critical media literacy is generally concerned with helping people "experience the pleasures of popular culture while simultaneously uncovering the practices that work to silence or disempower them as readers, viewers, and learners" (Alvermann & Hagood, 2000, p. 194). Through this critical lens, media literacy encourages and allows people to analyze how society functions, maintains power structures, and develops and perpetuates traditional narratives through mediated messages.

Media literacy is based on the foundational premise that media and popular culture hold power to shape beliefs and influence behaviors, even acting as a powerful, mass-produced form of "public pedagogy," as described by Henry Giroux (2004).

Conceptualizing popular culture and dominant discourse as even more powerful than a "public pedagogy," Frankfurt School critical theorist Theodor Adorno (1991) described such standardized, commodified messages as the products of the "culture industries," which work as a tool of the dominant culture to subjugate the masses through unconscious means; the more that people are passive consumers of it and do not consciously think about its influence, the more they might fall prey to its unconscious messages. Many who write about critical media literacy and the importance of teaching people to read the world are basing their thought on the pioneering work of Adorno (Tisdell, 2007). Thus, critical literacy represents a form of everyday defense against the culture industries, informed by critical knowledge of that industry and by recognition of the interests at stake, especially insofar as these differ from the interests of the ordinary public (Adorno & Horkheimer, 1972).

As media literacy evolved in the U.S. from a focus on technical skills and competency, educators – often influenced by Paolo Freire (1971) – adopted an "empowerment" philosophy centered on informed inquiry to develop a more critical form of media literacy (Thoman & Jolls, 2005). This approach emphasizes Freire's notion of "critical consciousness" (Nutbeam, 2000, p. 264). In essence, it seeks to help students learn to read the world as well as the word (Freire, 1971) – in this case, how the world of the media and popular culture can both resist and reinforce the interests of the dominant culture (Kline et al., 2006).

This reflected the tradition of British cultural studies, which provided a strong empowerment-focused foundation and impetus for media literacy in the U.K., prompted by Hoggart's (1959) advocacy for critical cultural studies that promised democratizing

potential from cultural ideology. British media studies advocate Len Masterman (1985) consolidated these ideas into a formal critical pedagogy that taught "ideological deconstruction to protect younger students from commercial manipulation" (Kline et al., 2006, p. 134). His critical media education curriculum aimed to promote empowerment among students through demystifying popular texts, especially news and advertising, by using literary, ideological, and semiotic analysis to encourage reflective questioning against the forms and contents of print and electronic media (Kline et al., 2006). Critical pedagogue Ira Shor (1992) defines critical pedagogy as "Habits of thought, reading, writing, and speaking which go beneath surface meaning, first impressions, dominant myths, official pronouncements, traditional clichés, received wisdom, and mere opinions, to understand the deep meaning, root causes, social context, ideology, and personal consequences of any action, event, object, process, organization, experience, text, subject matter, policy, mass media, or discourse" (p. 129).

Ongoing debate exists within educational circles regarding what exactly constitutes effective media pedagogy and critical media literacy, with groups citing different agendas and programs that advocate varying approaches and foundational beliefs. Kellner (1998) described a traditionalist "protectionist" approach, which "would attempt to 'inoculate' young people against the effects of media addiction and manipulation by cultivating a taste for book literacy, high culture, and the values of truth, beauty, and justice, and by denigrating all forms of media and computer culture" (Kellner, 1998, p. 113). Kellner cites Neil Postman, author of the popular books *Amusing Ourselves to Death* (1985) and *Technopoly* (1992) as exemplifying this protectionist approach. Postman warns of a decline in the ability of mass media to share serious ideas,

saying TV images have replaced the written word, which demeans and undermines political discourse and by turning real, complex issues into superficial images, while privileging entertainment over ideas and thoughts (1985). Media educator Faith Rogow notes that much of early educational practice, typically influenced by media effects research, resulted in teaching that focused on the potential or presumed "dangers" of media (Thoman & Jolls, 2005). She concludes that, pedagogically, the approach is fatally flawed, and students often become cynical instead of intellectually skeptical because a negative approach does not provide them with any sense of agency.

Anderson (1983) calls this protectionist approach "impact mediation," which is often organized around problem areas like violence, nutrition and body image, and stereotyping. Many public health officials and scholars have identified media exposure as a risk factor and media literacy as a protective factor (Hobbs, 1998). Despite evidence supporting the efficacy of media literacy to mediate the harmful influences of media, a media literacy curriculum focused too much on protecting people can lead to an instructor-focused classroom, with the teacher imparting "facts" about media manipulation and students listening quietly. Scholars warn that "such an approach to teaching and learning may cause students to parrot the correct interpretations – the ones the teacher has sanctioned – and, in doing so, media literacy education may lose its authenticity and its relevance to students' lives" (Hobbs, 1998, p. 19).

The teaching of media literacy has generally focused on school curriculum or classroom interventions and focused on adolescents and college students. Popular conceptions of media literacy tend to focus on three steps, as discussed in the Kline et al. (2006) "cultural judo approach." In this interactive critical media literacy approach, Kline

et al. (2006) augmented classroom lessons with creative activities focused on making the moments of critical learning more accessible in three phases: reflection, which focuses on students' examination of the risks associated with their own media use and preferences; deconstruction, which is based on exercises to expose the critical concepts that children use in understanding both the benefits and risks of media (junk food, couch potatoes, addiction); and reconstruction, which is based on creative engagement in strategies for changing lifestyles through designing and articulating alternatives.

Through the Center for Media Literacy (CML), Thoman's (2005) media literacy philosophy centers on informed inquiry in a four-step process similar to that of Kline et al. (2006): Awareness, Analysis, Reflection, and Action. Later, the CML turned this model into "Five Core Concepts and Questions" that continue to inform media literacy education (Thoman & Jolls, 2005) for people of varying ages and abilities:

- All media messages are constructed. Who created this message?
- Media messages are constructed using creative language with its own rules. What creative techniques are used to attract my attention?
- Different people experience the same media message differently. How might people understand this message differently from me?
- Media have embedded values and points of view. What lifestyles, values, and points of view are represented in or omitted from this message?
- Most media messages are constructed to gain profit and/or power. Why is this message being sent?

As Kellner and Share (2007) describe, "For most students in the U.S., critical media literacy is not an option because it is not available; it is not even on the radar." As many scholars have observed (Hobbs, 1998; Tisdell, 2007), the U.S. has lagged far

behind Australia, the United Kingdom, and Canada in developing approaches to critical media literacy. While media literacy education is propagated by several national organizations (Media Education Foundation, Alliance for Media Literate America, and Action Coalition for Media Education, etc.), and teacher associations such as the National Council of Teachers of English and the National Council for the Social Studies, and recommended as an effective health promotion strategy by The American Academy of Pediatrics, the Office of National Drug Control Policy, and Centers for Disease Control and Prevention (Bergsma & Carney, 2008), media literacy is not required in public school curricula and is not financially supported (Kellner & Share, 2005; Rosen, 2010).

Evaluative studies of media education research addressing the admittedly complex tasks of assessing the learning outcomes of media literacy programs have found important benefits from media literacy interventions (Emery & McCabe, 2003; Hobbs, 1998; Scharrer, 2003). Moreover, an encouraging body of evidence shows media literacy programs have been shown to increase children's critical understanding of advertising (Feshbach, Feshbach, & Cohen, 1982; Robert et al., 1980), change attitudes toward media violence (Voojis & van der Voort, 1993), and help students make informed and responsible lifestyle choices about risky products such as cigarettes and alcohol (Austin & Johnson, 1997; Bradford, 2001; Verkaik & Gathercoal, 2001).

Media literacy scholarship and initiatives have almost solely focused on young people, with few studies considering adults and their interactions with media (Tisdell, 2007). In the area of media and cultural studies, a number of research pieces focus on how adults construct their identities in light of popular culture (e.g., Hall, 2001; Radway, 1984; Richards, 2005). "Given the natural connection between adult education and

critical media literacy, it is curious that discussions about teaching people to read the world of media and popular culture are so limited" (Tisdell, 2007, p. 6).

Media Literacy: Theoretical Frameworks and Implications

Research on media literacy is widely varied in its use of theory, and often includes no mention of theoretical guidance. Hobbs (1998) reminded scholars that it is "critical to develop theory and research that predicts, documents, measures, and evaluates the complex processes of learning and teaching about the media" (p. 28). In reviewing the scholarship around critical media literacy, Alvermann and Hagood (2000) found that authors' definitions of critical media literacy depend on their theoretical perspectives and on the disciplines that inform their work. They summarized four threads that run through some of the current theoretical influences and thinking about critical media literacy: 1) a focus on pleasure, which emphasizes people's ability to reflect on the pleasures associated with being either creators or consumers of media; 2) a focus on the ways media reproduces or resists dominant culture; 3) an emphasis on how individuals and groups construct meaning differently depending on their interests and positionality (gender, race, class, sexual orientation, age, etc.) and the social and historical context; and 4) a perspective that highlights how media produces gendered and other group-based identities through power relations that people can either use or resist (Tisdell, 2007, summarizing Alvermann & Hagood, 2000). Educators often use a combination of these perspectives to help people develop critical media literacy skills that students can use to make active, conscious choices to resist or draw on cultural messages in the construction of their identities (Buckingham, 2003).

In delineating the varying worldviews and beliefs that underlie culture and communication research, Burrell and Morgan (1988) highlighted four distinct paradigms: Interpretivist and Functionalist, which represent scholarship of regulation, and Critical Humanist and Critical Structuralist, which represent scholarship of radical change. In attempting to synthesize these useful theoretical frameworks with the range of critical media literacy perspectives, Alvermann and Hagood's (2000) four conceptions of critical media literacy scholarship comfortably align with Burrell and Morgan's (1988) four theoretical paradigms based on the authors' descriptions of media literacy scholars' theoretical underpinnings. Though Alvermann and Hagood (2000) did not reference these theoretical paradigms, media literacy research can benefit from calling on existing theoretical foundations to better justify, predict, and explain the purpose and potential of media literacy (Hobbs, 1998).

Burrell and Morgan's (1988) functionalist paradigm, which has foundations in the work of social theorists such as Comte, Spencer, and Durkheim, and is identified by various labels, including positivist (Kim, 1988) and objective (Gudykunst & Nishida, 1989), may be said to encompass Alvermann and Hagood's (2000) third thread, which emphasizes the ways individuals and groups construct meanings differently. This thread fits within the functionalist paradigm in that such scholars often seek to describe and predict human behavior and often view culture as being defined a priori by group membership (Martin & Nakayama, 1999). Much like functionalists, Alvermann and Hagood's (2000) description of these standpoint-focused scholars' meaning construction reflects functionalists' view of the relationship between culture and communication as causal and deterministic, meaning group membership and the related cultural patterns can

theoretically predict behavior. Alternatively, this thread of critical media literacy can also be interpreted in a more postmodern sense, in that individuals can be seen as taking up cultural texts differently, depending on their interests and positioning in various social and historical contexts (Alvermann & Hagood, 2000). This postmodern lens might align more closely with Burrell and Morgan's (1988) critical humanist paradigm, which will be examined substantively in this chapter.

Burrell and Morgan's (1988) interpretivist paradigm might encompass Alvermann and Hagood's (2000) pleasure-focused thread, since interpretivist scholars' ultimate goal is often to understand, rather than predict, human communication behavior. This thread fits within the functionalist paradigm in that the pleasure-focused lens of research emphasizes the uses and gratifications of media consumption and creation, which reflects functionalists' view of the reciprocal nature of culture and communication. Interpretivism emphasizes the "knowing mind as an active contributor to the constitution of knowledge" (Mumby, 1997, p. 6) – an emphasis that aligns with pleasure-focused scholars' emphasis on people's ability to reflect on the pleasures associated with consuming and creating media (Martin & Nakayama, 1999). Culture and communication research in this paradigm has also been labeled as interpretive (Ting-Toomey, 1984), humanistic (Kim, 1988), and subjective (Gudykunst & Nishida, 1989). Livingstone (2008) emphasized that "audiences diverge in their interpretations, generating different – sometimes playful, sometimes critical, always contextually meaningful – readings of the same media text in practice" (p. 58), which represents interpretivist media literacy research.

Alvermann and Hagood's (2000) second thread in critical media literacy scholarship focuses on the ways media reproduce or resist dominant culture, which can

be seen as synthesizing well with Burrell and Morgan's (1988) critical structuralist paradigm. This paradigm is largely based on the structuralist emphasis of Western Marxists like Gramsci (1971), which emphasizes the significant structural and material conditions that "guide and constrain the possibilities of cultural contact, intercultural communication and cultural change" (Martin & Nakayama, 1999, p. 9). Accordingly, scholars in this critical media literacy thread are generally concerned with how society and politics are structured to work to one's advantage or disadvantage (Kellner & Share, 2005) and how issues of ideology, bodies, power, and gender produce various cultural artifacts (Alvermann & Hagood, 2000; McRobbie, 1997). This thread's focus on media reproduction of or resistance to dominant culture grew out of cultural studies and reflects critical structuralists' focus on examining economic aspects of industries that produce cultural products and analyze how some industries are able to dominate the cultural sphere with their products (Fejes, 1986; Meehan, 1993) – thus focusing on popular culture texts and positioning culture as a site of struggle, as reflected in the aforementioned media literacy thread and corresponding theoretical paradigm (Alvermann & Hagood, 2000; Burrell & Morgan, 1988).

Finally, to offer media literacy a firm theoretical framework, Burrell and Morgan's (1988) critical humanist paradigm can be synthesized with Alvermann and Hagood's (2000) thread emphasizing ways media produce identities through power relations that can be used or resisted. Described as stemming from a feminist pedagogical perspective, this critical media literacy thread focuses on how popular culture texts function to produce certain relations of power and gendered identities that students may learn to use or resist as part of their everyday school experiences (Alvermann & Hagood,

2000; Finders, 1997). With the critical humanist research goal of locating oppression and strategies for resisting oppression, this paradigm encompasses Alvermann and Hagood's (2000) critical media literacy thread in multiple ways. Departing from a critical structuralist paradigm that advocates change from an objectivist and deterministic standpoint – with all possibilities for change and resistance resting on the structural relations imposed by the dominant structure (in this case, media) – critical humanists recognize oppression perpetuated by media texts and also seek to locate resistive strategies due to a foundational "belief in the possibility of changing uneven, differential ways of constructing and understanding other cultures" (Martin & Nakayama, 1999, p. 9).

This feminist-based media literacy thread highlights how media produces gendered and other group-based identities that people can either use or resist (Alvermann & Hagood, 2000), which closely mirrors the critical humanist goal of "articulating ways humans can transcend and reconfigure the larger social frameworks that construct identities" (Martin & Nakayama, 1999, p. 8). These similar perspectives are founded upon works of Althusser (1971), Gramsci (1971), and Frankfurt School theorists like Horkheimer and Adorno (1988), Martin and Nakayama (1999), and Alvermann and Hagood (2000).

As previously mentioned in the discussion of the interpretivist paradigm, there is some overlap between interpretivists and critical humanists, as both see culture as socially constructed and recognize the voluntaristic nature of human behavior (Burrell & Morgan, 1988). However, critical humanist researchers conceive of this voluntarism and human consciousness as "dominated by ideological superstructures and material

conditions that drive a wedge between them and a more liberated consciousness" (Martin & Nakayama, 1999, p. 8). Differing from interpretivists, critical humanists see culture, then, as not just a variable, nor as benignly socially constructed, but as a site of struggle where various communication meanings are contested (Fiske, 1987). In this sense, Alvermann and Hagood's (2000) second thread emphasizing the ways individuals and groups construct meanings differently may also be said to fit within the critical humanist paradigm if individuals are actively resisting or taking up cultural texts differently, due to their interests and social and historical contexts. This possibility for interpretive resistance is reflected in critical humanist analyses that explore how media and other messages are presented and interpreted (and resisted) in conflicting ways, such as Flores's (1994) analyses of Chicano/a images represented in media or Peck's (1994) analysis of discourses represented in race relations on *Oprah* (Martin & Nakayama, 1999).

As a challenge to traditional theories of media power, Livingstone (2008) discussed a turn in critical media literacy and audience studies that coincides with the overlap between interpretivist and critical humanist paradigms.

> The analysis of 'active' and interpretative audiences, plural, counterposed the creativity of a locally resistant viewer against the hitherto confident claims of media imperialism. It undermined forever the unimpeachable authority of the analyst's identification of the singular, underlying meaning of any media text by demonstrating that polysemy operated not only in principle but also in practice. (Livingstone, 2008, p. 51)

This focus on tactics of appropriation resonates with the work of other feminist media scholars like Judith Butler (1993), who emphasize the radical constructionist notion of reading transgressively and resistance through privileging multiple meanings and interpretations. Other feminist scholars like Susan Bordo (1993) depart from this

radical postmodernist line of thought by focusing on the material consequences of media texts and performances, which serves to recentralize the power of media in influencing people's lived experiences and behaviors.

Regardless of theoretical underpinnings and methodological preferences, media literacy scholars seem to have come to an agreement that a pedagogy of critical inquiry must be at the center of media literacy education, which entails the asking of questions about media texts (Hobbs, 1998; Thoman & Jolls, 2005). "The cultivation of an open, questioning, reflective, and critical stance towards symbolic texts should be the center pole of the media literacy umbrella, as it is the concept most likely to ensure its survival" (Hobbs, 1998, p. 27).

With notions of media literacy that were largely developed in the 1980s, 1990s, and early 2000s, the question of how current conceptions of media literacy account for and relate to new media, including social media, is a relevant and important one. Scholarly discussion of media literacy in the context of the changing media landscape over the past two decades has generally tended to revolve around utopian and dystopian perspectives (Jackson, 2008). Through a utopian lens, the Internet provides people with new opportunities for creating and learning while also facilitating the development of necessary technological and communicative skills. Electronic media are viewed as tools of empowerment that ultimately liberate all people from real-world social inequalities (Jackson, 2008, p. 383). Conversely, the dystopian perspective argues that the Internet has negative effects on users – and especially on young people, who are exposed to inaccurate and potentially harmful content and situations. Furthermore, time online is

viewed as time away from family, friends, and other more useful and healthy pursuits like reading books, doing schoolwork, and being physically active (Jackson, 2008).

Media literacy perspectives stem from both of these camps in terms of their treatment of "new media," from a protectionist frame of immunizing people from the harms of technology to a "preparationist progressive" frame that aims to prepare and empower students to interpret and use media effectively (Hobbs, 1998). Kellner (1998) articulated the bipolar sentiments of scholars this way: "I am rather bemused by the extent to whether they reveal either a *technophilic* discourse that presents new technologies as our salvation, as a solution to all our problems, or a *technophobic* discourse that sees technology as our damnation, demonizing it as the major source of all our problems" (p. 120).

One way media literacy scholars have addressed this question of "new media" is to focus on the fact that media literacy encompasses both consuming and producing media, which leads to the reframing of questions based more on participation and production (Livingstone, 2008). Noting the common ground between critical audience studies and critical media literacy due to the reciprocal relationship between media and users, Livingstone (2008) discussed the reframing of questions based on audiences to questions based on literacy. An emphasis on new conceptions of literacy – "cyberliteracy, digital literacy, computer literacy, media literacy, Internet literacy, network literacy, and so on" (p. 55) – has begun to hold sway in areas that audience studies once dominated. This new discourse allows scholars to examine ways people engage with media and communication technologies, often through critical analysis of how these enable, direct, or impede particular interpretations by users (Snyder, Angus, & Sutherland-Smith, 2004).

Considering both the consumption and production aspects of literacy, the potential for audience activity and interactivity with media texts has expanded demonstrably with interactive media – especially social networking – yet little substantial media literacy research exists that focuses on the ways people use or interpret social media messages. Scholars have not explicitly addressed or analyzed interactive social media in a media literacy context, despite the fact that more than half of all Americans age 12 and up have a Facebook account (Webster, 2011). Though audience studies long argued on behalf of the "active" television audience in the last century, the critical potential of those audiences has been dwarfed by the possibilities today: "Recent digital technologies have radically enhanced these kinds of interactivity by explicitly emphasizing the user's response and active assistance in the formation of the media text itself and by developing particular tools to facilitate this" (Fornas, Klein, Ladendorf, Sunden, & Svenigsson, 2002, p. 23). The utopian promise of the democratizing potential of social media is based on this thinking, but many media literacy scholars continue to be skeptical of such emancipatory claims.

Livingstone (2008) asserted, "Yet, even as we [pay] as much attention to the literacies of creative production ("writing") as to those of reception (or "reading"), we should note that the widespread significance of everyday creative practices remains more claimed than proven" (p. 56). She warned of the tendency to overcelebrate people's creative potential in engaging with Web 2.0 and other digital opportunities, just as print literacy was seen as a route to emancipation through expression, learning, creativity, and civic participation. She cited the necessity of looking critically at the regulation of print literacy, with its history of moral and commercial restrictions and exclusions, which can

shed light on the sometimes overstated potential of media literacy to emancipate and empower (Livingstone, 2008).

Unfortunately, few, if any, scholars are undertaking research regarding media literacy in a social media context to lend support to either the dystopian or utopian perspectives. "A central empirical question, as yet relatively unexplored in the literature, underlies this debate: To what extent do the skills of media literacy transfer from one genre or symbolic form to another?" (Hobbs, 1998, p. 21). Researchers seem to work under the assumption that media literacy's basic tenets apply across media genres, texts, and technologies, as this question is most frequently left unaddressed. Livingstone (2008) calls for further research into this realm, saying,

> So, this mutuality between text and reader is central to understanding the interpretation of both old (or mass) and new (or interactive) media. Only thus can we understand how viewers interpret, diverge from, conform to or re-create meanings in the process of engaging with media, and so such an analysis suggests some fascinating directions for researching people's engagement with new media also, thereby revealing what is increasingly termed their media literacy. (p. 55)

Health Literacy: Evolution and Applications

The concept of health literacy stands in stark contrast to the theoretical grounding and critical scholarship of media literacy. Unlike media literacy, which has decades of scholarship behind it, health literacy is a relatively new construct in health promotion scholarship, and has rarely been situated in theory, methods, or curriculum (Nutbeam, 2000). The concept is rarely used outside of its strictest, surface definition of a person's ability to read and understand health materials, demonstrated by research objectives to "determine the ability of patients to complete successfully basic reading and numeracy tasks required to function adequately in the health care setting" (Williams et al., 1995). In

scholarship, health literacy is generally used to describe the relationship between patient literacy levels and their ability to comply with prescribed therapeutic regimens (Nutbeam, 2000).

Many scholars have simply equated health literacy with general literacy regarding reading, vocabulary, and pronunciation (Williams et al., 1995). When expanded beyond the sense of basic reading literacy, health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Ghaddar et al., 2012; Glassman, 2012). In forming this definition, these authors have cited an Institute of Medicine publication titled "Health Literacy: A Prescription to End Confusion" **(**Nielsen-Bohlman, Panzer, & Kindig, 2004), which is revealing of the murky waters that have surrounded this concept.

Most research has either sought to measure individuals' health literacy or uses the assumption or evidence of "low health literacy" in a population as justification for proposing alternative ways to help experts communicate health information (Ghaddar et al., 2012; Stableford & Mettger, 2007; Williams et al., 1995). Though not explicitly grounded in any theoretical framework, the most frequent operationalization of health literacy in scholarship utilizes a positivist framework for viewing expert-given health messages as truth, with those experts requiring one accurate interpretation of their messages by patients and consumers in order to bring about positive health outcomes and signify that person's health literacy. Nutbeam (2000) says the perpetual use of this "fundamental but somewhat narrow definition of health literacy misses much of the deeper meaning and purpose of literacy for people" (p. 264).

Commonly used means for measuring health literacy clearly represent this positivist framework and the narrow definition of health literacy. The New Vital Sign (Weiss, Mays, & Martz, 2005) instrument uses an ice cream nutrition label and six health literacy and numeracy assessment questions. Researchers base scoring of a person's health literacy level on "the number of questions answered correctly per the instrument scoring instructions and key" (Ghaddar et al., 2012, p. 30). The Test of Functional Health Literacy in Adults measures a person's ability to perform reading and computational skills by presenting prose passages and numerical information (e.g., prescription bottle labels and appointment slips) and asking 17 questions that were scored as either correct or incorrect (Williams et al., 1995).

In attempting to address health literacy on the Internet, researchers use the eHealth Literacy Scale (Norman & Skinner, 2006), which is an 8-item scale designed "to measure consumers' combined knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems." This scale uses a self-report survey to measure skills and competencies, with respondents indicating their level of agreement on a 5-point scale of agreement to disagreement. "The summation of responses indicates their level of eHealth literacy," Ghaddar et al. claim (2012, p. 30). Though scholars have investigated Internet health information-seeking and Internet use proficiency, little health literacy research has investigated social media and how people navigate health information in an interactive media environment.

Interest in promoting health literacy is widespread, especially considering the American Medical Association's statement that poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and

race" (American Medical Association, 1999). Improving consumer health literacy is an objective of the U.S. Department of Health and Human Services' report *Healthy People 2010* due to its role in the improvement of health care quality and reduction of costs, which require individuals to take an active role in making informed health care decisions (Glassman, 2012).

Health Literacy: Theoretical Frameworks and Implications

The promotion of health literacy and seeking to increase those competencies remains the underlying goal of most research in this area, but few scholars have invoked theory or developed curricula or methods to teach health literacy. Nutbeam (2000) emphasizes that the field of health education was considerably strengthened by the development of more sophisticated, theory-informed interventions during the 1980s, which were successful in disease prevention. By focusing on the social context of behavioral decisions, and helping people develop personal and social skills required to make positive health and behavior choices, this type of program was successful in preventing disease, teenage substance misuse, and other health concerns (2000, p. 264).

Considering the efficacy of theory-driven research and interventions in health education, Nutbeam (2000) calls for a more critical conception of health literacy. He emphasizes that health literacy should be considered an outcome of successful health promotion and seeks to expand the field to recognize the full implications of literacy. As an alternative to traditional health literacy, he defines "critical health literacy" as the development of "more advanced cognitive skills which can be applied to critically analyze information, and to use this information to exert greater control over life events

and situations" (Nutbeam, 2000, p. 264). The World Health Organization's definition of health literacy also reflects this critical focus: "By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment" (Nutbeam, 2000, p. 264). In terms of the method of education and communication, a critical definition provides a challenge to communicate in ways that invite interaction, participation, and critical analysis.

However, that critical foundation for researching and promoting health literacy is rarely used. "Disappointingly, the potential of education as a tool for social change, and for political action, has been somewhat lost in contemporary health promotion" (Nutbeam, 2000, p. 264). Critical scholar Heather Zoller echoed that statement, saying a resistance-oriented framework is not common in health-oriented fields. "Any examination of the role of people's agency in resisting and transforming dominant power relations is relatively rare in health communication" (Zoller, 2005, p. 351).

Healthy Media Literacy: Bridging Health Literacy and Media Literacy

Due to the pervasive misrepresentation of health in media and widespread health and body image problems, scholars have called for the development of media literacy curricula and health interventions that specifically address women's physical health and body image (Harrison, 2008; Van den Berg & Neumark-Sztainer, 2007). This call to action can be viewed as a call to bridge media literacy and health literacy – a pairing of the theoretical and pedagogical foundation of media literacy with the health information focus of health literacy. Research has confirmed media literacy can be used to teach girls and women to become more critical consumers of mediated images of "ideal beauty"

(Bissel, 2006; Grabe, Hyde & Ward, 2008; Irving & Berel, 2001; Posavac et al., 1998), which is useful in preventing disordered eating and body dissatisfaction. Even minimal exposure to a critical deconstruction of media images has been shown to impact students' affective behavior, as demonstrated in a study by Chambers and Alexander (2002), which shows that a simple media literacy presentation can help students develop a better understanding of the effects of media images on thoughts and behavior.

Accordingly, the results of Irving and Berel's (2001) study suggest that a short media literacy intervention can be effective in helping women to be more skeptical about media representations. "Given that critical thinking skills may be the initial step in protecting women and girls from the detrimental effects of media," Irving and Berel concluded that "this result is promising" (p. 110). In light of this evidence for the potential benefits of media literacy, Jamieson, Jordan, and Romer (2008) noted that media literacy approaches have not focused on building healthy lifestyles and emphasized the need for scholars to develop media literacy approaches focused on nutrition and healthy decision-making.

Well-documented links exist between exposure to mediated thin ideals and body dissatisfaction, as well as links among body dissatisfaction, disordered eating, sedentary lifestyles, and low self-efficacy to achieve health (Song et al., 2011; Van den Berg et al., 2007). Despite this substantial evidence, I have not found any other scholars who have combined critical media literacy with health literacy (or a health education intervention) in order to address these issues among women. This is a startling gap in the literature, considering the wealth of research on these subjects and the existing evidence to

demonstrate the efficacy of media literacy to strengthen people's resistance to unrealistic and destructive messages in media (Van den Berg & Neumark-Sztainer, 2000).

Healthy Media Literacy: Application and Overview

To combat body shame, disordered eating, and distorted health discourse regarding what constitutes a healthy body, I propose the development a theoretically grounded, research-based conception of media literacy that focuses specifically on female bodies and health. I have termed this curriculum "Healthy Media Literacy." By grounding this curriculum in the intersection of media literacy and health literacy and bridging the two with a critical focus on female bodies and health, I aim to justify my conception of the Healthy Media Literacy (HML) curriculum as a pedagogical tool to teach women how to: 1) recognize distorted health discourse and reject or retain health messages through critical questioning and deconstruction; 2) redefine health outside of appearance-focused ideals; and 3) resist distorted health ideals personally and publicly.

To introduce and explain my proposed curriculum, I will first define and situate my conception of Healthy Media Literacy in the relevant literature, accounting for theoretical foundations and methodological implications of the curriculum's 3-step process. By integrating the relevant, research-supported aspects of critical media literacy and health literacy into one comprehensive curriculum (which can alternatively be viewed as a multipart intervention), I aim to promote empowerment from distorted health ideals, as well as to improve body image and positive health choices.

Based on existing evidence in support of similar programs and frameworks for promoting positive physical, spiritual, and mental health, Healthy Media Literacy has the

potential to help people achieve these possibilities through its focus on cultivating personal, cognitive, and social skills that determine the ability of people to gain access to, understand, and use information to promote and maintain good health. The aforementioned objectives reflect traditional objectives of media literacy pedagogy as well as outcomes of Nutbeam's (2000) model of health literacy. My formulation of HML is inherently critical in that it relies on and fosters the ability to break down and analyze media messages, practices, processes, and influence (Scharrer, 2003) with regard to discourses surrounding body image and physical health.

Though grounded in media literacy literature that has largely been applied to school curriculum, HML is not specifically designed for schools or a student age group, though it could be easily tailored for such in the future. It is not my intention to have it administered on a mandatory basis in a school setting, but rather for participants to engage with the curriculum on a voluntary basis, individually, online. In alternative contexts not utilized in this study, this curriculum could be undertaken in a wide variety of individual or group settings: at home on personal computers, through counseling, religious meetings, club or team gatherings, or with family or friends.

Rather than an enforced and one-sided curriculum, I see this project as an innately critical and interactive form of health activism that can be shared on a grassroots level in a wide variety of forms, but is particularly well suited for a multipart intervention in the form of an image and text-based intervention distributed via the Web. Bissel (2006) found media literacy – specifically by way of a visual presentation – to be an important factor in helping young women better understand the social effects of mass media. Research also suggests Web-based intervention programs like HML can be of value in

combating negative effects of media. “In particular, it could be used to provide psychological interventions designed to prevent, treat, and help guard against relapses associated with body dissatisfaction and disordered eating” (Luce, Winzelberg, Zabinski, & Osborne, 2003 as cited in Harrison, 2008, p. 189), which reflects HML’s objectives. Harrison (2008) cited a longitudinal study that measured the efficacy of Web-delivered educational interventions designed to reduce body dissatisfaction and disordered eating symptoms, which succeeded in significantly reducing those attributes and behaviors over the course of four months (Celio et al., 2000).

Healthy Media Literacy: Theoretical and Methodological Implications

I define the outcome of Healthy Media Literacy as the skills to gain access to, understand, analyze, and use information to promote and maintain positive body image and good health. As will be described in Chapter 3, my approach to the Healthy Media Literacy curriculum reflects Alvermann and Hagood’s (2000) media literacy thread emphasizing the ways media produce identities through power relations that can be used or resisted, which I previously discussed as aligning with Burrell and Morgan’s (1988) critical humanist paradigm. Stemming from feminist pedagogy, this approach to Healthy Media Literacy focuses on how dominant discourse about health (represented by mass media and social media texts and public perceptions of health) functions to produce certain relations of power and gendered identities that people may learn to use or resist (Alvermann & Hagood, 2000).

This project aligns most clearly with a critical humanist paradigm in that it views opportunities for resistance as independent from the structural relations imposed by the

dominant structure – in this case, media and health discourse (Burrell & Morgan, 1988). This project seeks to help people recognize oppression perpetuated by media and health discourse and then work to locate resistive strategies within, and despite, the dominant structure that imposes such oppression. This project is founded on a foundational "belief in the possibility of changing uneven, differential ways of constructing and understanding" health discourse (Martin & Nakayama, 1999, p. 9). It is not feasible to remove or change the dominant structure of mass media and the distorted health discourse it promotes, but that does not mean the people within the dominant structure have no power. Through media literacy, health literacy, and a variety of resistance strategies discussed further in this chapter, women can recognize harmful messages, redefine health in accurate ways, and resist distorted health discourse personally and publicly.

Utilizing critical theory and a methodology of ideological criticism, discussed in depth in Chapter 3, this HML program relies on a foundational belief that the rampant misunderstanding of what defines health can be attributed to a dominant beauty ideology that equates health and fitness with mediated ideals characterized most prominently by thinness (Eskes, Duncan, & Miller, 1998; Markula, 2001). Multiple analyses reveal evidence that the constant reinforcement of thinness as the defining indicator of female fitness has reached ideological force in today's society (Eskes et al., 1998; Urbanska, 1994), demonstrated by current discourse, or the languages and practices that construct and represent our view of women's bodies and health. Just as Foucault's (1977) focus on the relationship of discourse, knowledge, and power led him to Marxism, with its emphasis on the class positions and interests concealed within particular forms of

knowledge (Hall, 1997, p. 75), my critical framework relies upon the idea that there is power to destabilize this ideology by acknowledging the economic interests at stake in maintaining the ubiquity of profit-driven beauty ideals in dominant health perceptions.

Marx argued that commonly held ideas reflect the economic basis of society, which means the "ruling ideas" are those of "the ruling class that governs a capitalist economy, and correspond to its dominant interests" (Hall, 1997, p. 75). In the case of beauty ideology, the "ruling ideas" are represented by discourse that equates health and fitness with physical appearance, and the "ruling class" is represented by those who profit from the ideology remaining unchallenged and invisible. In other words, the power-holders are those who purport to offer solutions or strategies to help women achieve (unattainable) ideals. Specifically, these include the flourishing industries behind beauty products, diets, weight loss, cosmetic surgery, and women's media sources such as *Shape* and *Self*, which claim to hold the keys to health and fitness, while framing it all in terms of appearance. Critical media and health literacy offer empowering skills to actively recognize such oppression and consciously resist it (Kellner & Share, 2007).

Critical scholars argue that human consciousness is "dominated by ideological superstructures and material conditions that drive a wedge between them and a more liberated consciousness" (Martin & Nakayama, 1999, p. 8). To promote the achievement of that "more liberated consciousness," this project utilizes a focus on critical literacy for both media and health to promote awareness of harmful health ideals, reflexivity, and resistance. This critical view of culture differs from that of interpretivist or functionalist scholars, in that culture is viewed as "not just a variable, nor as benignly socially constructed, but as a site of struggle where various communication meanings are

contested" (Fiske, 1987). The cultural discourse regarding women's bodies and physical health is the site of struggle from which I theorize resistance in terms of a critical humanist paradigm.

With so many power holders with serious capitalist interests at stake in maintaining the force of beauty ideology in women's beliefs about their bodies, it is unlikely that the dominant discourse regarding women's health will change anytime soon. That precludes my reliance on a structuralist framework. Rather, my theorizing on resistance stems from a critical humanist and feminist perspective, which maintains that dismantling and revealing beauty ideology is possible for those who recognize its existence and its harmful influence on perceptions of women's health. With consciousness of those power structures and material conditions that are exerting harm, my work reflects a critical humanist foundational belief in "the possibility of changing uneven, differential ways of constructing and understanding" cultural discourse (Martin & Nakayama, 1999, p. 9).

Collective Disidentification

Critical feminist scholars have a long history of offering strategies for dismantling and revealing ideologies related to women's oppression – especially in terms of their bodies. In her seminal book *Bodies That Matter: On the Discursive Limits of Sex*, Judith Butler (1993) identified "collective disidentification," or multiple people or groups uniting to stand against a particular ideology, as a strategy to dismantle oppression. "Collective disidentification can encourage reconceptualization of which bodies matter and which are yet to evolve as critical matters of concern" (p. 4). Bordo (1993) also

invoked the idea of collective disidentification in the introduction to "Unbearable Weight" when she discussed the power of simply sharing a moment of shock and rage with a room full of young girls as she showed them examples of Photoshopping to reveal the unreality of media images – starting with the infamous 1989 *TV Guide* cover featuring Oprah's head pasted onto a young, thin, White actress's body. This experience is reflective of an opportunity for empowerment, which is gained as "individuals develop a shared conception of how they are systematically exploited to benefit another group" (Radford-Hill, 1986, p. 159).

Upon engaging with a group of college-age women to openly discuss body image, Rubin et al. (2004) found, "Most group members felt they were alone in their difficulty challenging mainstream beauty ideals" (p. 36). Rubin et al. (2004) suggested that feminist scholars or leaders "can help by sharing their own strategies and struggles in resisting normalized beauty ideals, and by validating young feminists' struggles and celebrating their courage to name and challenge their oppression" (p. 36). Solidarity, unity, understanding, and empathy can arise from these circumstances in the form of collective disidentification as more and more women begin to view themselves as the authorities on their own bodies, on their own health, and their own lived experiences with what it means to be healthy or to strive for fitness.

Zoller (2005) said the development of collective identity may be a powerful influence in the appeals health activists employ, and it is an important resistive aspect of the Healthy Media Literacy program. This potential for networking and increasing participation in and skills associated with Healthy Media Literacy can contribute to grassroots actions calling for or enacting substantial change in the ways health is

communicated and represented. “Health education could also raise awareness of the social, economic and environmental determinants of health, and be directed toward the promotion of individual and collective actions which may lead to modification of these determinants” (Nutbeam, 2000, p. 267).

The rifts that exist between women’s own bodies and mediated representations of women’s health ideals have the potential to serve as a unifying bond to promote collective disidentification with harmful body ideals. D’Enbeau and Buzzanell’s (2010) critical feminist analysis of the difference between women’s lived realities and mediated representations of motherhood and caregiving is a prime example of the power of such tensions. Through the use of journaling, personal narrative, observation, and critical analysis of mass media, D’Enbeau and Buzzanell (2010) eloquently analyzed the commodification of “baby bumps” and “post-baby bodies” that stand in direct opposition to what mothering does to actual bodies.

They urged mothers to resist falling prey to the pressure to airbrush their bodies and experiences out of existence, and instead embrace their real postbaby bodies and hard-won battles as caregivers in order to reveal the tensions between profit-driven messages and reality. “The tension – between embodied media representations and ordinary embodied realities – offers an opportunity of resistance. As we tell, write and share our stories of embodied caregiving, we counteract the commodification of the bump through everyday talk, experience and understanding” (D’Enbeau & Buzzanell, 2010, p. 37). From this theorizing, lived experiences told from the perspective of real, lived-in bodies can encourage collective disidentification with cultural myths about women’s healthy bodies. Furthermore, this critical framework posits that awareness of,

and empowerment from, distorted health ideals can be cultivated through the resistive act of embracing and revealing body and health realities. This is reflective of Bordo's call to recentralize the body in feminist scholarship in order to privilege "the authority of our own experiences" (1993, p. 238).

Testimonio

One of the ways D'Enbeau and Buzzanell (2010) shared their stories of embodiment was through personal narrative, including personal journaling, as their form of "ongoing sensemaking about embodied caregiving and motherhood" (p. 32). Similarly, those opportunities for shared experiences of unity and collective disidentification can be cultivated by the Chicana feminist strategy of "*testimonio*" (Beverley, 1999; Brabeck, 2003), or giving voice to oppression through personal narrative.

Also thought of as "speaking truth to power" (Beverley, 1999), this inherently political and value-driven theoretical construct emerged from Critical Race Theory and has generally been used to document the experiences of oppressed groups and denounce injustices (Huber, 2009). Though no universal definition of *testimonio* exists, scholars have identified several elements that should be considered. First, Brabeck (2003) says one of *testimonio*'s distinctive features is that it challenges traditional assumptions about what constitutes knowledge. The Latina Feminist Group (2001) describes *testimonio* as a way to create knowledge and theory through personal experiences.

This is reflective of Wood and Cox's (1993) call for critical theory that is more reflective of material reality: "The issue is not whether theory or lived experience should be the focus of research, but rather how these two may join in a productive conversation

that, like any good conversation, produces something richer than either party alone could" (p. 280). In line with broadening traditional perspectives on epistemology, the idea of theorizing from and about lived experience is also reflective of embodiment theory, which challenges the mind-body distinction and "views the body as both a legitimate source of knowledge and a product of culture that is as open to analysis as any other culturally inscribed phenomenon" (Fonow & Cook, 2005, p. 2012).

The solidarity that can result from the sharing of *testimonios* represents another key feature of this construct: an insistence on the collective identity of the narrator in speaking about her experience as a member of a collective group (Brabeck, 2003). "The speaker in *testimonio* gains credibility not through being an exceptional member of a community but through being a part indistinguishable from the whole" (p. 53). Delgado (1999) argues for the importance of viewing *testimonio* as a collectivist form of discourse. The author of a *testimonio* does not speak as a representative of a group; rather, they invite identification with their experience by performing "an act of identity-formation which is simultaneously personal and collective" (Yudice, 1991, p. 15). By representing more than just one person's isolated experience, another collectivist attribute of *testimonio* is its ability to help create alliances and a sense of solidarity among readers who sympathize with the community represented by it (Avant-Mier & Hasian, 2008).

One of the major factors that contribute to body satisfaction is social support (Choate, 2007). Aligning oneself with a group is a crucial aspect of feminist scholar Cynthia Dillard's (2000) strategies for resisting dominant ideologies, and this echoes ideas of collective disidentification as well. As Dillard explained, "defining oneself in relation to one's cultural and social community also defines one's participation within

that community, both one's connection and affiliation as well as one's responsibility" (p. 673). Collective identity is both invoked and expected by *testimonio*, and Frye (1996) suggests, "We might acquire friendlier voices by listening in friendly and responsible ways to the voices of more other women – a listening that I have already suggested is central to the success of the collective project of pattern perception and meaning-making" (p. 45).

It was this aspect of "listening in friendly and responsible ways to the voices of more other women" that drew me to implement *testimonio* as an important aspect of this study. To avoid perpetuating a one-sided researcher/subject dynamic that appears so often in academic research, I wanted to utilize a distinctly feminist strategy of listening and opening up a space for active participation in this research that was not solely directed and defined by my narrow questions.

Scholars warn that in forming their own ways of knowing and making meaning through *testimonio*, women must be critical. Granting themselves authority as perceivers does not necessarily mean women can immediately recognize and reject the ideologies they have internalized and reinternalized throughout their media-filled lives. Chicana feminist scholar Cherrie Moraga (1983) offered a variety of self-reflexive questions as a key to encouraging critical self-reflection and encouraging women to situate themselves within a web of unrecognized hegemony that too often dictates their own self-perceptions of health and judgments of others' bodies and health: "How have I internalized my own oppression? How have I oppressed?" (p. 30) Similarly, Dillard (2000) offered a call for critical self-reflexivity as a tool for progressing in feminist thinking and privileging experience as a legitimate epistemology: "Self-conscious, determined examination and

struggle is often required in order to reject distorted and oppressive perceptions of women in general and African-American women particularly, and to value human thought and action from self-defined standpoints" (Dillard, 2000, p. 671).

Feminist theory encourages particular attention to be paid to gender in considering oppressive perceptions about groups, and this is particularly relevant to health ideals regarding women's bodies, which are most often depicted, described, and evaluated from an outsider's perspective in cultural discourse. It is often hard for women to separate their own perceptions of their bodies and health status from an objectified, outsider's view. As Fredrickson and Roberts (1997) described it, objectified media portrayals play an important role in socializing girls and women to perceive their own bodies from the perspective of another's gaze (Fredrickson & Roberts, 1997). This self-objectification is manifested as "the tendency to perceive one's body according to externally perceivable traits (i.e., how it appears) instead of internal traits (i.e., what it can do)" (p. 218).

Critical Whiteness studies remind us of the fact that issues of embodiment and marginalization cannot be considered in a vacuum, and that Whiteness as "neutral" or "normal" is a problematic stance (Frankenberg, 1993; Kolchin, 2002). As a White researcher, therefore, I am sensitive to the danger of wrongly appropriating the theoretical construct of *testimonio*, which derives from Critical Race Theory. I am a White scholar, and I recognize that this method was developed by and for women of color to shed light on systems of racial power. However, I see *testimonio* as highly relevant and appropriate for this project. Race is an innately significant aspect of media literacy, health literacy, and individual body image, and thus is a necessary area of attention for the Healthy

Media Literacy curriculum and research. Women of all races and ethnicities are marginalized and oppressed by distorted health ideals that exert powerful influence on women's self-perceptions and behaviors. Indeed, women are often depicted and objectified in ways that vary by race or ethnicity within media and health discourse, which will be acknowledged and discussed throughout the HML curriculum.

As a White scholar adapting and applying *testimonio* to my own scholarship, I understand the necessity of assessing my own privilege and bias, and this need to assess privilege was highlighted before participants had the opportunity to write their own *testimonios* in the HML program. As Tierney (2000) warns, the use of *testimonio* can become vulnerable to appropriation of anyone telling a story of struggle or conflict, including those in more privileged positions in society. "However, we must remember the original purpose of *testimonio* – to center the knowledge and experiences of the oppressed. Thus, when adapted in educational research and pedagogical practice, it is important to recognize *testimonio* as a tool for the oppressed, and not the oppressor" (Huber, 2003, p. 648). By aligning my work with a critical feminist stance on the side of the oppressed, I see *testimonio* as an appropriate theoretical construct for promoting understanding of, and resistance to, distorted health ideals that are exerting significant harm on women at all intersections of experience, regardless of the race or ethnicity each participant embodies. Using *testimonio* in the HML curriculum can help recenter race as an important construct to consider in media and health literacy, individual experiences with body image, and the mechanisms by which individuals resist harmful body-related messages.

Conclusion

As discussed in this chapter, two areas of research and pedagogy that can be effectively applied to this subject of understanding and improving female body image and health are media literacy and health literacy. Through an analytical review, I have grounded these two bodies of research in the literature and situated media literacy and health literacy within the context of body image and physical health, with further grounding in feminist notions of resistance. As noted above, scholars have called for the development of media literacy curricula and health interventions that specifically address women's physical health and body image (Harrison, 2008; Van den Berg & Neumark-Sztainer, 2007). This project, further outlined in Chapter 3, aims to fill a gap in the literature by contributing a media literacy curriculum with a health intervention, as well as theoretically grounded mechanisms for resistance to distorted health ideals. To amplify the empowering potential of such a curriculum and privilege the voices of study participants, I have also included a discussion of feminist theories of resistance, with particular attention paid to collective disidentification and *testimonio* as tools for revealing and dismantling harmful beauty ideology that distorts women's health discourse.

Rather than simply fulfilling a need that exists in the literature, this study represents an opportunity to utilize new approaches and perspectives that can contribute to the promotion of positive body image and healthy behaviors on a wide scale. By engaging with women through a free and accessible health and media literacy curriculum and gathering responses in their own words, this project can shed light on strategies

women already use to lead healthy lives and feel positively about their bodies, as well as strategies they and others can learn and implement as a result of this study.

CHAPTER 3

METHODOLOGY

In response to scholars' calls for media literacy curricula that addresses women's physical health and body image (Harrison, 2008; Van den Berg & Neumark-Sztainer, 2007), I have justified, defined, and situated a proposal for a combination of health literacy and media literacy to be used in the cultivation and promotion of women's positive body image and physical health. This approach, which I have termed Healthy Media Literacy, seeks to promote and cultivate positive body image and health behaviors. Utilizing this curriculum, the study outlined in this chapter also seeks to fill another gap in the literature by contributing theoretically grounded mechanisms for resistance to distorted health ideals. This is consistent with Zoller's (2005) observation that "any examination of the role of people's agency in resisting and transforming dominant power relations is relatively rare in health communication" (p. 351).

My critical foundation for HML entails an emphasis on the power relations concealed within the ideology of beauty, which power relations are critical in creating and upholding dominant myths about female health being defined in terms of appearance and thinness. HML seeks to reveal and contribute to the dismantling of those power structures through providing a health literacy intervention that focuses on cultivating self-

efficacy within women to recognize and reject those harmful norms and make healthy changes in their own lives while positively influencing others.

Calling for a critical stance in health communication scholarship, Zoller (2005) said "existing work may be faulted for inattention to concrete methods of resistance and social change" (p. 351). This study, in conjunction with the Healthy Media Literacy curriculum, relies on the identification and promotion of mechanisms by which women can resist distorted health messages and redefine health for themselves outside of appearance-focused terms. Through critical analysis of participants' responses to open-ended questions and their self-reported health beliefs and behaviors, this study focuses on the identification and cultivation of such concrete methods of resistance. This project is founded on the belief that it is imperative to identify strategies to help people critically recognize and reject harmful messages about women's bodies and health, which will allow women to cultivate and promote true health and fitness in their own lives and circles of influence.

In order to identify effective means for resistance to appearance-focused health ideals, I followed a group of 42 women ages 18-35 as they engaged in the Healthy Media Literacy (HML) curriculum developed for this study and used critical feminist methods to analyze participants' responses to open-ended surveys before, during, and 2 weeks after completing the curriculum. This chapter provides an overview of this study's design and research questions, a discussion of the critical methodology implemented in the data analysis and curriculum design, and my own critical self-reflection.

Research Questions

Having reviewed the literature and identified the existing needs for research, I present two guiding questions. To investigate women's resistance to appearance-focused health ideals, this dissertation will pursue the following research questions:

RQ 1: What are the mechanisms by which women redefine health for themselves outside of appearance-oriented ideals and resist distorted health discourse in media and elsewhere?

RQ 2: How are these mechanisms acquired and/or developed?

Study Design

I will now discuss the study design and methodology I used to address these research questions. I recruited 42 women ages 18-35 in northern Utah by asking for anonymous participation in an online body image research study using social media and community networking, which I advertised by highlighting the potential to improve health and contribute to research that may help other women. I initially had planned to recruit 25 women, but decided to accept all willing and qualified participants due to the possibility of attrition over a 5-week study, which resulted in 42 participants at the study's commencement. Though a broad age range of girls and women are affected by negative body image, I limited participants for this study to only women 18 to 35, which is within the range of "viable reproductive ages" for women (Fredrickson & Roberts, 1997). Women of this age group are particularly susceptible to negative body image due to life events that may change a woman's body or lifestyle, such as going to college, pregnancy, child rearing, or starting a career; or that place great emphasis on appearance,

such as dating and marriage. Women of this age group are also able to actively make health and lifestyle decisions for themselves, as opposed to younger women or girls who, for example, may rely on parents to make food-buying decisions. I accepted 42 participants in order to have a large enough number of responses to yield compelling findings collectively, but also to ensure that I could carefully analyze each participant's responses to each of the three questionnaires over the 5-week study period – both individually and comparatively over time. Each of the 42 participants also had the opportunity to write and submit a *testimonio*, which represented a potentially significant collection of writings available for analysis.

To minimize homogeneity among participants, I distributed fliers throughout the University of Utah campus, as well as coffee shops, libraries, and similar locations in the Salt Lake Valley. I also contacted a variety of associates who work with diverse cultural groups, who distributed the flier online and in person. Participants volunteered for the study by contacting me (through a generic e-mail address without my name attached) and qualified to participate (by fitting gender, age, and location requirements). Questionnaires were conducted online through submission forms accessible via a WordPress-hosted website designed and used solely for this study. Submissions were paired and kept anonymous by replacing names with individual codes. Acknowledging the possibility of attrition among participants, I offered a practical incentive for all women who completed the entire HML program in the form of a drawing for a $50 Visa gift card.

The study was conducted over a 5-week time period, with participation beginning at filling out the pre-intervention questionnaire before beginning Step 1: Recognize, and ending approximately 2 weeks after completing Step 3: Resist. Participants were able to

complete the 3-step program at their own pace within a 5-week time period, but they were not allowed to complete more than 1 step per week. During this process, participants were asked to complete a questionnaire 3 times: before beginning Step 1: Recognize (Questionnaire 1, found in Appendix A), after completing Step 2: Redefine (Questionnaire 2, found in Appendix B), and approximately 2 weeks after completing the final Step 3, Resist (Questionnaire 3, found in Appendix C). Participants submitted responses in the form of an online questionnaire with unlimited space, which allowed them to respond in as many or as few words as they chose. The open-ended questionnaires were designed to promote self-reflexivity and critical reflection on the material discussed in the curriculum at three separate times. Participants recorded and submitted their responses electronically through the website.

The three questionnaires were designed to help better understand the ways women think about health and the ways that relates to their personal body image, or the way they perceive their own bodies. By broadly asking about their definitions of health and the ways they measure it, and then asking them to place themselves into that definition, I aimed to open up a discussion of what factors have contributed to their own self-perceptions of health and body image. I chose open-ended questions that started out broad and became narrow, with more of a focus on the participant's own individual health, to stimulate sharing of specific beliefs and experiences regarding bodies and health perceptions. I approached these questionnaires with the understanding that many women's beliefs about healthy bodies are informed by for-profit, appearance-focused media, and that interrogating those beliefs can reveal the ways those ideologies are internalized and accepted as normal.

The three questionnaires varied. Questionnaire 1, preceding Step 1, focused broadly on body image, health perceptions, health behaviors, and media usage. Questionnaire 2, following Step 2, focused more specifically on distorted health discourse and the potential for redefining health in more empowering ways. It reiterated information presented in the HML curriculum regarding the BMI and appearance-based measures of health and fitness, and asked participants to respond specifically to that information. Questionnaire 3, completed in Week 5, reiterated the broad questions of the first questionnaire and ended with an open-ended focus on resistance. Utilizing resistance strategies to combat the influence of distorted health ideals is a continuous task upon becoming more health and media literate. In this final step, participants were asked to consider what strategies they already used or might implement in their own lives to promote positive body image. (Questionnaires 1-3 appear in Appendices A-C.)

Answering structured but open-ended questions at the specified times provided insight into participants' initial beliefs and behaviors regarding health and body image during the first week, as well as participants' responses to a health information intervention in the second week. This also provided insight into any changes in beliefs or behaviors following their engagement with the curriculum in the fifth week. With reflexivity perpetually in mind, I made my best effort at understanding each woman's intended messages and interpretations of health based on her own beliefs and experiences. Allowing my critical feminist perspective to guide my analysis, I organized and explored the participant responses using codes to represent themes or trends in the data (see Appendix D). Coding permits data to be "segregated, grouped, regrouped and relinked in order to consolidate meaning and explanation" (Grbich, 2007, p. 21).

I used coding to classify, categorize, and make meaning of participant responses. These reflected notions of beauty ideology, appearance-focused or objectified views of health, internal- or ability-focused views of health, evidence of self-efficacy to achieve health, barriers to healthy choices, interpersonal experiences that inform self-concepts and body perceptions, disruptions to beliefs about health or one's own body image, strategies for recognizing or rejecting appearance-focused notions of health, strategies for redefining health in empowering ways, and other codes revealed through the analysis. Throughout the coding process, I developed a list of relevant codes that I continuously added to and revised for pertinence and clarity. This open-ended coding process allowed me to consider and evaluate both anticipated and unanticipated themes and findings in participants' responses. Once these codes were developed and revised, I clustered them to draw broader conclusions about the influence of beauty ideology on health perceptions and behaviors, as well as means for resisting such ideology and redefining health in meaningful ways. In particular, I analyzed themes in the codes in relation to how the women felt about their bodies, which proved to be a meaningful avenue for analysis.

With a critical feminist framework and a focus on ideological criticism as a lens through which to view the written responses, I used participants' own words to shed light on opportunities for change and resistance to beauty ideology and distorted health ideals. In doing so, I strived to weave together narrative evidence of beauty ideology and resistance to distorted health perceptions, citing both personal accounts from individual participants and broad findings in the data. (See Appendix D for an example of data coding.)

Critical Methods in Data Analysis

Using the compiled data, I performed a close textual analysis using a critical feminist lens to identify prominent themes that were revealed in each set of questionnaires and then identified changes in participants' survey responses that could shed light on resistive strategies or changing ideas of what constitutes health. I undertook this analysis with the foundational belief that distorted health ideals have reached ideological status in U.S. culture. I identify such a large and diverse population as the ideologically influenced group due to the nature of the force that is largely responsible for circulating and reinforcing such beliefs: mass media.

Despite varying cultures and groups that make up one larger U.S. population, I intentionally group them all under one larger umbrella of media influence, since mass media are widely available across almost all socioeconomic statuses, races, ethnicities, and geographical locations. This shared set of messages, images, and values can be broadly construed as constituting U.S. residents' beliefs about women's bodies and health, which are continuously recirculated and reinforced through dominant discourse in social media and public discussion of health. Through close textual analysis that utilized a lens of feminist ideological critique, I analyzed participants' questionnaire submissions for evidence of ideological influence on health ideals and body perceptions.

To investigate my research questions and identify resistive strategies that can be used to combat distorted health perceptions, I employed a critical feminist methodology. With roots stemming from the Enlightenment Project and Marxist theory, critical theory and methodologies have a long and contested history. Critical research represents what has been termed a "discourse of suspicion" (Mumby, 1997 p. 9), in that it is inherently

skeptical and analytical of forms of power, authority, social structures, and the naturalness of social order, including scientific knowledge, which I implement through a critique of Body Mass Index (BMI) and other popular health measurements. Marxist thinkers specifically indicted capitalism and the industrialization of society for the ways they had manipulated potentially beneficial aspects of technology to benefit ruling classes (those in power of the markets) to create systems of domination and alienation. Scholars of the Frankfurt School (Adorno, 1988; Horkheimer, 1988) took on a form of neo-Marxism that embraced the Marxist idea that people cannot resist power they cannot see or recognize. The Frankfurt School first identified critical theory based on the idea that people who can only see their choices will remain unknowingly oppressed, but people who can see the powers that limit their choices are able to resist. This critical aspect of my methodology is woven throughout my Healthy Media Literacy curriculum, but is especially visible in Step 1: Recognize and Step 2: Redefine, which relies on shedding light on media power structures that heavily influence portrayal of women's bodies and health discourse.

The second generation of this school of thought was developed by Habermas (1984), who believed the main problem of communication – and the main force of oppression – was the ways ideological beliefs precluded the possibility for people to engage in discursive reflection. Authentic communication could only be achieved in the presence of genuine dialogical conversation (or dialogue with questioning of all knowledge claims) and critical self-reflection, which he theorized would naturally result in rationality, or valid knowledge claims. Though full and final transcendence from ideological thinking would never be fully possible, Habermas (1984) said discursive

reflection was progressively emancipating. This discursive reflection entailed an emphasis on routinely and consistently interrogating biases, taken-for-granted beliefs, and displays of power or social order. This aspect of my critical methodology is manifested throughout the HML curriculum in the form of self-reflexive questioning that precedes Step 1, concludes Step 2, and concludes Step 3. Furthermore, I have implemented my own discursive reflection in consistently questioning my own assumptions, privileges, and biases as I analyzed and reported on participants' submissions.

From a focus on power structures and emancipation, critical theory and its methodologies split into what could be seen as two categories: critical structuralist and critical humanist (Martin & Nakayama, 1999; Morgan & Burrell, 1988). Critical structuralist lines of theorizing about oppression focused on a Marxist view of the material realities and structures that created meaning and order for people in a given society, which resulted in structures of domination and alienation. This critical perspective views all potential for change in a society resting on those structures, believing that without a radical change in those material realities and processes that produce social order in class-divided societies, there could be no hope for resistance. Alternatively, the critical humanist view relies on a foundational belief in the potential of humans to overcome and resist power structures and systems that oppress them.

There are varying views on what represents possible responses to ideology, and critical researchers are responsible to identify and situate their own response in order to effectively outline a path to resistance for – and with the assistance of – those who are oppressed. This study relies on the development of a path to resistance in the form of

effective strategies, the identification of successful units of the HML curriculum that promote healthy behaviors, and other possibilities for resistance. Shelby (2003) said an effective ideological critique must be diagnostic, in that it should both reveal the oppressive forces and highlight strategies for resistance so those who are in its grip can better envision alternatives. Langsdorf (1997) echoed Foucault (1977) in saying despite the environment of social forces that prevent ideologies from being seen – let alone subverted – oppressed people *can* and *do* carry out alternatives to the status quo. This idea in the potential of people to resist oppression is reflective of critical humanism, which is where I align my research.

Shelby (2003) offers a meta-analysis of these perspectives of ideological criticism that are useful in delineating my own theoretical standpoint. He breaks down scholars' responses to what can happen once ideology has been identified and illuminated into two categories: idealist and materialist, which can be further divided into two categories of functionalist and processualist analyses. An idealist believes if people would simply think more rationally and critically, and be more reflective, they would recognize ideological beliefs and be able to resist them. Marxists reject this idea out of a structuralist view that privileges an emphasis on material life and real social structures that impede empowerment. A functionalist materialist aims her focus on analyzing and interrogating a class-divided society's power structures and reproductive orders, since they support and reinforce ideology by their very nature. A processualist might recognize the influence of power structures, but also recognize the agency of people in overcoming and resisting oppression through discursive reflection, dialogic communication and collective action. "The point of ideology-critique is not merely to expel social illusions but to empower

those in their grip to change the oppressive conditions that make ideologies necessary" (Shelby, 2003, p. 188). My methodological stance aligns most closely with this Marxist materialist-processualist view of resistance, but with some distinctly feminist considerations and modifications.

The addition of feminist thought to critical modernism amplifies the power of ideological criticism substantially. Feminist scholars have been critical of Marxist approaches for their ignorance of gender in the production and constitution of social order that fundamentally marginalizes women. They have also been critical of Enlightenment-oriented thinking for its masculinized definition of "rationality" and what constitutes valid knowledge claims. By recentralizing gender as a major focus of critical analysis, feminism adds a necessary and fruitful dimension by which to understand ideology and capacities for resistance to oppression. This rethinking of the Enlightenment Project by feminists contributes a more holistic view of what constitutes knowledge and how one can come to validate any type of knowing.

By incorporating a clear feminist focus in to my critical modernist methodology of ideological criticism, I am able to recenter gender as a constitutive aspect of social order within distorted health ideals, and also shift a focus to lived experience as a legitimate way of knowing. I claim a distinctly critical humanist focus on the potential for women to recognize and resist distorted health ideals in my HML program and continued research and activism. Shedding light on ideology through health and media literacy, sharing personal experiences with body image and health, writing *testimonios*, and recentralizing lived experience are all promising means to show the discrepancy between mediated cultural ideals of bodies and real life healthy bodies. My analysis of study

participants' questionnaires was driven by the critical feminist knowledge that those strategies have power to promote resistance to distorted health ideals through collective action.

It is not enlightenment and awareness of ideologies alone that produce freedom – it is awareness coupled with collective action to resist that produces freedom and has potential to change power structures and social relationships of domination and alienation. Feminist theory privileges the importance of social and familial support, including collective identity and collective disidentification with harmful norms, as promising means for resistance and resilience. This methodological stance, situated firmly in critical modernism, humanism and feminism, represents a promising marriage of theoretical tools to shed light on ideology while also identifying and promoting resistance strategies to cultivate alternatives to the health-harming status quo. This critical project combining media literacy and health literacy seeks to reveal beauty ideology's influence on health perceptions and illuminate strategies to resist such forces.

Critical Self-Reflection

The critical theory staples of discursive reflection and self-reflexivity are embedded in my Healthy Media Literacy program. This critical focus encourages women participating in the study to continuously interrogate their own perceptions of health, their behaviors, and their plans, as well as the mediated and cultural messages they are exposed to regarding health. The necessity of critically assessing one's own privilege is of particular interest to me, both as a critical scholar suspicious of power and bias and also as a White scholar seeking to adapt and apply the Chicana feminist tool of *testimonio*

to my own research. In aligning with the critical feminist staple of making privilege, positionality, and biases explicit, bell hooks' (1990) words may resonate with feminist scholars or women seeking to articulate their own voices:

> I have been working to change the way I speak and write, to incorporate in the manner of telling a sense of place, of not just who I am in the present but where I am coming from, the multiple voices within me. I have confronted silence, inarticulateness. When I say, then, that these words emerge from suffering, I refer to that personal struggle to name that location from which I come to voice – that space of my theorizing. (1990, p. 146)

I am driven to openly acknowledge the space of my own theorizing, which draws from both academic and spiritual ways of knowing. My perpetual interest in body image, women's health, and media literacy springs from a well of personal experience in adolescence that was defined by pain, crippling self-consciousness, and preoccupation with appearance. The driving force behind my focus on resistance is the tremendous empowerment I have experienced through increasing my spiritual and academic knowledge regarding media influence, distorted health ideals, and women's potential to overcome and resist such forces. I am a 28-year-old, White, female, middle-class, educated, feminist member of The Church of Jesus Christ of Latter-day Saints (a "Mormon"), and I feel a strong intellectual and spiritual conviction about the power of critical feminism and media literacy to guide women on the path to body satisfaction, health, and empowerment. This force guides my research and activism within and beyond the realm of academia.

My church teaches some unique doctrine relating to women, including the existence of not only a Heavenly Father, but a Heavenly Mother – God's equal partner. In turn, I was taught that along with a righteous husband or wife, we can all achieve our Heavenly Mother and Father's status as gods. Unlike all other Christian religions, my

church teaches that Eve made the difficult but correct choice by partaking of the forbidden fruit in the Garden of Eden, thus enabling herself and Adam to have children, which brought the souls of all humankind to Earth to gain mortal bodies and exercise their own agency to return to God through following his son, Jesus Christ. Because of such teachings and the influence of a strong, loving, hard-working, encouraging mother in my life, I always had some sense of my own power and potential as a female. That feeling of empowerment has grown as I learned about feminism in my undergraduate years and felt an undeniable urge to reconcile the perceived differences between my religion and my newfound feminism. That now-comfortable relationship between Mormonism and feminism has grown into an energizing force in my life that drives my religious worship, academic research, and activism.

Just as my religion taught me that human bodies are gifts made in the image of God and that the soul is made up of both the mortal body and immortal spirit of a person, I believe there is power in teaching girls and women that they are more than just bodies to be looked at. Media and cultural discourse so often teaches girls and women that we are defined by the appearance of our bodies and minimizes us to a collection of parts in need of constant judgment, fixing, and fixation. I fight that dehumanizing, limiting view by teaching girls and women to recognize when and how objectification happens, redefine their ideas of health in empowering and achievable ways, and actively resist the messages and behaviors that reduce them to mere bodies to be judged and analyzed.

I claim the use of a critical humanist methodology while recognizing it is a praxis-oriented, mobilizing extension of critical theory that is oriented toward social justice, advocacy, and activism on behalf of those who are disempowered. It makes no claims to

objectivity or necessary distance between researcher and those being researched, and neither do I. As a young woman who has struggled with body dissatisfaction and self-objectification, and who experienced the damaging effects of holding appearance ideals above actual health and fitness, I acknowledge a personal, vested interest in the promotion of positive body image and physical fitness over thin ideals. I align my work with Gadamer's (1979) notion of praxis, which casts an ethical responsibility toward activism on the researcher who uncovers and understands oppressive power structures. Through this critical lens, it is not enough to merely shed light on ideologies that privilege some and marginalize others – a scholar must leave his or her comfortable space in the academy to join the world of the activist, which is done through working directly with the disempowered community to develop opportunities and strategies for resistance. In this case, the disempowered community consists of any women who struggle with negative body image and distorted health ideals perpetuated by dominant forces of sexism, patriarchy, and profit-driven media. I have been invested in the cause of promoting positive body image at the level of both scholar and activist for several years, and see it as my responsibility. I undertook this study with social change as my impetus and motivation.

CHAPTER 4

STUDY IMPLEMENTATION

Upon receiving approval from the Institutional Review Board to conduct this study and recruiting 42 willing and qualified participants, as outlined previously, I commenced the study by sending participants an instructional e-mail with the consent form and Questionnaire #1 (also referred to as Q1 for convenience), and asked that they respond with their answers via e-mail within 1 week. Upon receiving each returned questionnaire (which signified their consent to participate), I sent each participant a link to the private Healthy Media Literacy (HML) curriculum website, with instructions to complete the first unit within a 1-week time period and signify their completion by submitting their e-mail address through a fillable field at the end of the unit online. The only demographic information I gathered from participants was if they were female, if they fit within the 18-35 age requirement, and if they lived in northern Utah. I did not request other personal information because it was not considered crucial to my research questions and I wanted participants to maintain a sense of privacy so they felt comfortable sharing information with me that can often be embarrassing, deeply personal, or that might not have ever been shared before.

Participants were aware that the study they were participating in was being conducted by a PhD candidate with interest in better understanding and promoting

women's health. They were not given my name or other identifying information at the beginning of the study. I also felt it was necessary to maintain my own anonymity so participants felt comfortable sharing with an approachable but professional anonymous researcher, rather than someone she might know through church, the gym, mutual friends, or a nonprofit that I codirect, which has gained prominence in Utah. I made sure all recruiting for the study was done separately from any connection with the nonprofit, the Beauty Redefined Foundation, since much of the research presented in the curriculum is already available online through our website and our social networking profiles, and I felt this would compromise my findings relating to changes in attitudes or behaviors throughout the study process.

All 42 women submitted full responses to Questionnaire #1 via e-mail to commence their participation in Week 1 of the study. See Appendix A for the full list of questions. Their answers to the 11 open-ended questions served as a baseline or foundation from which to detect any substantial individual changes in reported beliefs or attitudes about body image or health and changes in reported health behaviors. Simultaneously, the collective responses to Questionnaire #1 served to provide a broad context for what kinds of beliefs and attitudes this particular group of women held regarding body image and health. Aside from 1 question asking participants to describe their typical media usage, all questions were designed to prompt critical reflection regarding their perceptions of their own bodies and their own health, as well as what it means to be healthy and where they learned those ideas.

In the following sections, I will discuss the implementation of each unit in the Healthy Media Literacy curriculum, including the content and objectives of each unit and corresponding questionnaires.

The Three-Step Process

The three steps of the Healthy Media Literacy curriculum (Recognize, Redefine, and Resist) are founded upon critical theory and centered in the promise of pedagogical inquiry, empowerment, and resistance through a focus on revealing and dismantling pervasive beauty ideology that distorts discourse about women's health. These steps closely reflect the processes laid out by Thoman and Jolls (2005) and Choate (2007) for promoting critical media literacy, with particular attention to messages regarding physical health.

Step 1: Recognize

The initial "recognize" process in Health Media Literacy revolves around recognizing the influence of media and distorted ideals on public and personal perceptions of female bodies and physical health. This step is based on existing critical analysis of media and health discourse through ideological deconstruction that emphasizes the socially constructed nature of such messages. My critical feminist approach to ideological deconstruction in HML is not focused solely on mass media messages regarding female bodies and health, but also entails an updated integration of social media influences – including social networking discussion of female bodies and health on Facebook, Pinterest, blogs, and other forms of interactive media. While much

media literacy research focuses exclusively on mass media as the most prominent purveyor of shared information, the HML curriculum also teaches participants to look critically at social media messages as relevant discourse on women's bodies and health. Participants are also encouraged to use social networking interactions to promote media and health literacy as a means for resistance. HML also considers other health messages outside of popular media to be appropriate targets of analysis, including government reports, height/weight tables like the body mass index (BMI), health measurement scales and charts, and health agency initiatives.

This initial "recognize" step in the Healthy Media Literacy program entails a critical look at the ways women's bodies have been portrayed in mass media, including the thin ideal, the role of digital manipulation, "whitewashing" of women of color both digitally and physically over time, and what influence these portrayals of women's bodies are shown to have on girls and women. This first section of the curriculum can be viewed as a form of informational intervention that revolves around the profit-driven nature of most media, particularly how media depend on advertising and thus cater to advertisers within their content using the ideals described above. As so many industries rely on creating anxieties in audiences by defining flaws and problems (particularly in terms of female appearance) and then selling the products and services to fix those flaws (Kilbourne, 1999), it is necessary to cultivate a critical awareness of the pervasive influence of advertising on all for-profit media content (Choate, 2007). This section of the curriculum incorporates a textual and visual discussion of digital manipulation, or Photoshopping, in the ways images of women's bodies are represented in mass and social media (See Appendix E). This aspect of media literacy has proven to be an attention-

grabbing audience favorite (Ridolfi & Vander Wal, 2008), but also very effective at destabilizing beauty ideals by helping women to attribute extreme thinness and other idealized attributes to external factors, rather than attainable realities (Reaves, Hitchon, Park, & Woon, 2004).

Along with shedding light on the unrealistic nature of depictions of women's bodies in media, Step 1 of HML also helps to reveal the objectifying nature of so much media representation of women. Women of all races and ethnicities are often depicted, described, and evaluated from an outsider's perspective – often referred to as the "male gaze," which serves to privilege a male perspective while marginalizing women (Mulvey, 1975). The male gaze is demonstrated in media when women are positioned as objects for male enjoyment, through the look of the camera, the spectators, the narrative viewpoint, dialogue, and the appearance of the women themselves. As Fredrickson and Roberts (1997) described it, objectified media portrayals play an important role in socializing girls and women to perceive their own bodies from the perspective of another's gaze (Fredrickson & Roberts, 1997, p. 219).

As noted above, this self-objectification is manifested as "the tendency to perceive one's body according to externally perceivable traits (i.e., how it appears) instead of internal traits (i.e., what it can do)" (Fredrickson & Roberts, 1997, p. 218). This influence of mediated portrayal of women's bodies is especially problematic in terms of women's mental and physical health, as self-objectification is now proven to be a pervasive problem among women of all ages (American Psychological Association, 2010) that contributes to the onset of eating disorders, sedentary lifestyles – due largely of the phenomenon "feeling too fat to exercise" (Song et al., 2011) – body dissatisfaction,

and decreased performance on all types of skills tests – from spatial skills to throwing a softball (Fredrickson & Roberts, 1997).

The process of learning to critically deconstruct media messages, as taught in this first "recognize" step, can help to foster acceptance and understanding of diversity in many forms. This is possible in that it "empowers students to reflect upon their own commonalties and differences, and to respect their differences from others, while becoming critical of those who would suppress differences or present some differences (such as race, gender, and class) negatively, stereotypically, and pejoratively" (Kellner, 1998, p. 117). Additionally, it has been shown that critical deconstruction of media and health discourse about bodies can also foster acceptance of diverse body shapes and sizes while helping people become skeptical of sources that make some body types invisible or negatively stereotyped and ridiculed (Choate, 2007). Engaging in this critical analysis as a group – which could be feasibly done using this curriculum outside of this study – can be especially useful in considering diversity and multiple viewpoints.

Step 2: Redefine

Step 2: Redefine entails a health information intervention, which is necessary to shed light on the influence of beauty ideology in health discourse. In his call for more critical scholarship in health literacy, Nutbeam (2000) emphasized that a fundamental aspect of improving health literacy in a population is the transmission of health information. This section of the HML program includes the transmission of health information on three related topics through the lens of critical analysis: 1) common health definitions and measurements, along with their consideration of physical and cultural

diversity; 2) ways health and fitness are portrayed and promoted to women in social and mass media, and how to recognize if such messages are promoting true health or an objectified, profit-driven distortion of health; and 3) how health can be redefined away from appearance-focused measures through an emphasis on physical activity and self-efficacy to achieve health goals. (See Appendix F for an excerpt from the curriculum demonstrating this health information.)

The first section of Step 2: Redefine includes a discussion of the most common measure of physical health (both in scholarly research and public discourse): Body Mass Index (BMI), which includes a discussion of related anthropometric measures like body fat percentage and waist circumference. A rich body of research shows that health and fitness often has very little correlation to body weight or an individual's BMI, and that physical activity level is the best predictor of an individual's health (Calvert Finn, 2001; Heimpel, 2009; King, 2009; Macias Aguayo et al., 2005).

In the wake of high rates of obesity and related chronic diseases, health educators and medical experts are working to help people switch their focus away from weight loss and toward healthy behaviors that can increase physical and emotional health at any weight (Calvert Finn, 2001; King, 2009; Macias Aguayo et al., 2005). HML relies on the premise that beauty ideology that defines health according to appearance can be shaken by the understanding that activity level – rather than body weight – is a reliable indicator of a person's health. This focus on physical activity and capability rather than appearance or measurements is what Choate (2007) termed "positive physical self-concept." This is represented in one's attitudes toward physical activity, since physical activity is shown to lead to body satisfaction when girls develop an appreciation of what their bodies can do,

rather than how they appear to others. When women exercise to improve their overall fitness (versus working out to burn excess calories), they are more likely to possess positive body image (Song, 2011).

Furthermore, this "Redefine" step requires an accurate view of the ways distorted health ideals in dominant discourse marginalize many different groups. This important aspect of HML highlights disparities between the way health is represented and real people's health experiences, using both scholarship and reflection on personal experience. For example, in terms of health measurements, the BMI, which is the national standard for judging healthy weight, is proven to be highly inaccurate for non-White races and ethnicities since it is based on a U.S. Caucasian standard. It is also proven to be flawed for anyone under the age of 20 or over the age of 25 and for females. Particular attention will be paid to race and gender in this "recognize" stage of the HML curriculum, since race and gender heavily influence definitions, depictions, and discussions of health within media and public discourse.

An important component of the educational information in Step 1 and throughout the HML process is the infusion of empowerment and self-efficacy-focused messages encouraging women to use a variety of strategies to recognize and reject harmful messages about women's bodies and health. The presence of self-efficacy, which is confidence in one's ability to achieve a goal or complete a task, predicts the development of healthful habits in individuals (Rimal, 2000; Song, 2011). By focusing on redefining health in Step 2 in terms of how people feel and what they do, rather than how they look (or what they weigh, their BMI scores, dress sizes, etc.), I aim to introduce and cultivate feelings of self-efficacy in participants who may have previously defined health in

unattainable or unrealistic appearance-focused ways. While a woman may be unable to reach a certain weight, BMI score, or "fit look" and thus be discouraged and consider giving up healthy behaviors due to lack of results, she may be able to reach ability-focused goals like running a certain distance without stopping, exercising a certain number of hours per week, or maintaining a specific heart rate for at least 30 minutes each day through physical activity. Redefining health and fitness in ways that are achievable and yield actual physical health benefits is a meaningful avenue for promoting and cultivating self-efficacy to achieve physical health. (See Appendix F for an excerpt from Unit 2 of the HML curriculum, which includes the aforementioned information.)

The "Redefine" aspect of Step 2 requires critical, personal reflexivity concerning the ways media and distorted health discourse have potentially influenced each participant and those around them. Through Questionnaire #2 (also referred to as Q2), this step encourages participants to think of the ways they have previously defined health for themselves and the ways they have measured it. Several of the questions in this second questionnaire are identical to questions previously answered before beginning Step 1: Recognize. This is done intentionally to promote conscious awareness of the ways their answers may change in light of this potentially new information discussed in Step 2: Redefine. This step of the curriculum aligns with the "reflection" phase of Kline et al. (2006), which focuses on students' examination of the risks associated with their own media use and preferences. This reflection represents intuitive debriefing, which Baker (2008) says is a major goal of media literacy. Further, reflection in light of an educational intervention can also influence the value people place on different media content,

"thereby changing their consumption inclinations – a hoped for consequence more generally of teaching the literary canon in school" (p. 439).

In addition to the "redefining health" emphasis of Step 2, this unit of the HML curriculum offers each participant the opportunity to consciously choose to retain or reject aspects of media, health discourse, and her own beliefs or behaviors relating to health. Following the informational intervention component of this step, it is useful and necessary for participants to take stock of what does and does not fit with this potentially new view of health. If a participant sees fit to reconsider a way of defining or measuring her own health or to discontinue a particular behavior, this step can serve to initiate that process through critical questioning and deconstruction in Q2, which concludes Unit 2. This step also serves to provide participants with a framework for further, repeated critical analysis of media messages and health discourse.

Considering the media and health information coupled with critical literacy skills for both media and health cultivated in Steps 1 and 2, participants are asked to formulate their own personalized definitions of health and means for measuring it in Q2. But encouraging participants to understand and decide to define and measure health differently is not the only goal of Step 2. Instead, HML aims to facilitate actual behavioral change in the form of healthy lifestyle choices through the promotion of self-efficacy. For purposes of this project, self-efficacy is conceived of as a woman's belief in her ability to achieve a healthy body and positively influence those around her. Social cognitive theory states that a change in the level of self-efficacy can predict a lasting change in behavior if there are adequate incentives and skills. In this HML program, the incentives and skills are intended to be cultivated in Step 2 in the form of critical health

information that encourages the ability to recognize and reject harmful, distorted messages about women's bodies and health that emphasize unrealistic appearance goals, along with skills for critical deconstruction of all media messages, including personal reflection on the influence of such structures and messages. Incentives are presented in terms of improved (or maintained) physical and mental health, decreased body anxiety, empowerment to achieve healthy goals, ability to influence others for good, and other outcomes.

Too often, media health messages and the correlating cultural discourse about female health reflect the interests of outsiders rather than the wellness and ability of the woman herself (Fredrickson & Roberts, 1997). With encouragement and assistance to actively redefine health on an individual basis, women can create a much more empowering and beneficial view, and they can define what constitutes health for themselves. This "Redefine" step echoes the Kline et al. (2006) reconstruction phase of their "cultural judo approach" to critical media literacy. Like reconstruction, redefining health is based on creative engagement in strategies for changing beliefs and lifestyles through designing and articulating alternatives.

First, participants are asked to consider which aspects of their health beliefs, behaviors, and media choices they choose to reject and which they chose to retain. Incorporating the health information intervention of Unit 2, participants have the opportunity to exercise their critical health literacy skills in this "Redefine" step to articulate well-informed, personalized means for defining health in their own lives. This focus on participants' agency is a crucial step in critical media literacy, says Kline (2006). "Students are active agents in a process of gaining both power and responsibility

for their own well-being in a democratic society. … The objective of media literacy, therefore, must now include the goal of preparing students for citizenship in a risky consumer society" (p. 141).

In light of childhood obesity concerns, Kline implemented this goal into a critical media literacy intervention regarding youth consumption habits, including media consumption. Similar to HML, he provided a critical inquiry framework to help students become aware of the risks and benefits associated with media consumption and found the results encouraged such media literacy efforts. "Students supported in the development of critical skills and knowledge decided *on their own* to make healthy and responsible decisions about their media-dependent leisure. This project suggests that consumer literacy can counteract the promotional context of unhealthy lifestyles where billions of dollars are spent promoting energy-dense foods to children and very little is spent with equal vigour to communicate the risks associated with sedentary lifestyles" (Kline, 2006, p. 148, emphasis added). It is this promise of individual empowerment – cultivated through critical awareness of media structure and distortion of health messages – that HML is founded on. As noted above, profit-driven forces similarly seek to influence girls and women to accept certain views of their bodies at the risk of their own physical health.

Upon discovering or realizing that mediated definitions of health are not only unhealthy for most people, but also unrealistic and unattainable, some women may be tempted to abandon their health pursuits altogether. Studies have shown that the further a woman perceives herself to be from the ideal, the less likely she may be to strive to achieve it (Van den Berg & Neumark-Sztainer, 2007). The HML curriculum developed through this project may encourage women to abandon media's unattainable and

unhealthy appearance ideals while also encouraging them to focus on achieving more attainable, rewarding health and fitness goals through the promotion of health self-efficacy. Through an emphasis on health- and fitness-related goals, as opposed to appearance-related goals, HML is designed to help participants feel empowered to achieve health ideals that are more attainable and physically rewarding than unrealistic and perpetually out-of-reach beauty ideals. Kristen Harrison (2008) said, "Media is not being asked to abandon beauty, merely to redefine it" (p. 191). Similarly, HML is not asking participants to abandon health pursuits, but merely to redefine them.

Step 3: Resist

The resistance-focused critical humanist aspect of this HML program manifests itself in this final step, which consists of a two-part process for participants: 1) learning about the Chicana feminist tool of *testimonio*, with the opportunity to write and potentially share their own *testimonios* in the first week, and 2) learning about and sharing strategies for resisting distorted health ideals both personally and publicly in the second week. As indicated above, a resistance-oriented framework is not common in health-oriented fields, according to critical scholar Heather Zoller (2005), who said "any examination of the role of people's agency in resisting and transforming dominant power relations is relatively rare in health communication" (p. 351). In considering HML's reliance on empowerment and participant agency to recognize, reject, and redefine distorted health ideals, Zoller's definition of health activism aligns well with this program, since it works from a bottom-up (rather than top-down) approach to health communication. She describes health activism as: "A challenge to existing orders and

power relationships that are perceived to influence negatively some aspects of health or impede health promotion. Activism involves attempts to change the status quo, including social norms, embedded practices, policies, and power relationships" (Zoller, 2005, p. 351).

Calling for this critical stance in health communication scholarship, Zoller (2005) went on to say "existing work may be faulted for inattention to concrete methods of resistance and social change" (p. 351). This project emphasizes the identification and promotion of mechanisms by which women can resist distorted health messages and redefine health for themselves outside of appearance-focused terms. Through critical analysis of participants' responses to open-ended questions and their self-reported health beliefs and behaviors, this project focuses on what Zoller (2005) called "concrete methods of resistance." Several resistance strategies grounded in feminist scholarship served as a foundation for this final unit of the HML curriculum, including critical media literacy, collective disidentification, testimonio, and social support, as discussed in Chapter 2.

Susan Bordo called for a recentralization of the body in feminist scholarship in order to privilege "the authority of our own experiences" (1993, p. 238). One of the ways the HML curriculum seeks to do this is through encouraging participants to write a personal narrative on some aspect of their body image experiences. D'Enbeau and Buzzanell (2010) shared their stories of embodiment through personal narrative, including personal journaling, as their form of "ongoing sensemaking about embodied caregiving and motherhood" (p. 32). Similarly, those opportunities for shared experiences of unity and collective disidentification can be cultivated by the Chicana feminist strategy

of "*testimonio*" (Brabeck, 2003; Beverley, 1999), or giving voice to oppression through personal narrative. "Resist," the third step of the HML curriculum, begins with my own personal story of recognizing the distorted perception I had regarding my body and women's health in general. I learned to redefine health in ways that are beneficial to my health rather than industries' bottom lines and to resist distorted health discourse through my own research and activism. I share this look into my own adolescent and teenage struggles with cellulite and body shame and my journey to understand media influence and female empowerment as a way to prompt empathy, understanding, or small-scale collective disidentification with harmful body ideals – even if it is just one woman at a computer feeling solidarity with me through reading my words.

Along with my own personal story and discussion of a wide variety of resistive tactics, the third step of HML ends with a discussion of and invitation to participants to write their own *testimonios*. Although they are not required, *testimonios* are intended as a means for individual sensemaking and a therapeutic release of potentially personal and powerful experiences and beliefs. *Testimonios* are also a work that could be shared – if participants agree – through a private e-mail list or website and can serve to break the silence surrounding body shame by generating unity and solidarity among women whose experiences may resonate with others (Brabeck, 2004). The use of a theoretical construct like *testimonio* provides a uniquely empowering aspect that differentiates this project from other body image studies. Rather than using an experimental design or seeking to gather specific data through closed-ended questions, participants have the opportunity to literally give voice to their lived experiences, means for resistance, and their potential moments of transformation in this project through *testimonio*.

After providing a description and explanation of what a *testimonio* entailed in the curriculum, I encouraged participants to write their own using this invitation:

> To amplify the empowering potential of this curriculum and actively use the voices of study participants, I aim to utilize new approaches and perspectives that can contribute to the promotion of positive body image and healthy behaviors on a wide scale. By engaging with you and gathering responses in your own words, in the form of a *testimonio* (if you so choose), this project offers the possibility of shedding light on strategies women *already* use to lead healthy lives and feel positively about their bodies, as well as strategies you and others can learn and implement as a result of this study. A *testimonio* has no specific format, length or requirements. Share your own thoughts, experiences, a-ha! moments, strategies to promote real health and reject oppressive ideals, your privileges, your disadvantages, and anything else related to the fight to feel positively about your body and make positive health choices. Write from your heart, in whatever form you'd like. Give voice to oppression, injustice and *resistance*!

The first step, "Recognize," and second step, "Redefine," in the Healthy Media Literacy program, are geared toward revealing the pervasiveness of this outsider's gaze and objectification in the ways women perceive their own bodies and their own health. These first two steps of the HML curriculum are necessary precursors to the process of *testimonio*, which is why this component appears in the final unit. This is because an increased awareness of distortion in health ideals and critical self-reflection are integral for women to theorize about their own experiences from an empowered perspective. Accordingly, Bordo (1993) says the purpose of her critical feminist scholarship is to help produce awareness and enlightenment. She argues that self-reflexivity and awareness of the complex web of forces and power structures that reflect and construct the meaning of female bodies in this culture is a meaningful avenue for change. At the same time as it encourages increased understanding of media and health literacy, the HML program also aims to encourage consistent self-reflection and intuitive debriefing through the questionnaires, which represents a traditional critical theory underpinning. Within body

image and media literacy research, critical thinking skills are consistently found to be an important tool for cultivating body satisfaction (Choate, 2007) and resisting harmful messages. Those critical thinking skills include the ability to understand and question media and health messages as well as critical self-reflexivity, or the process of questioning one's own positionality, privilege, and biases.

CHAPTER 5

ANALYSIS AND DISCUSSION

After gathering and coding questionnaires from the 42 women, I undertook the analysis portion of this dissertation by employing ideological criticism to illuminate narrative evidence of the pressure many women feel to conform to a standard of "health" that is often based on flawed and profit-driven sources. In order to contribute solutions for combating negative body image, distorted health discourse, and unhealthy behaviors, my analysis also included a focus on ways participants actively resisted such influences. Through a critical analysis of submissions – both questionnaires and *testimonios* – I explored the means for resistance women have used, or plan to use, to redefine health in realistic and empowering ways. Further in this dissertation, this discussion of resistance will also highlight ways participants have promoted appropriate views on health and fitness and combated appearance-focused health ideals in their lives and circles of influence.

I have organized this analysis to progress from participants' responses to Questionnaire 1, which served as a foundation from which to gauge changes in their body and health perceptions, through their responses to Questionnaire 2, and finally Questionnaire 3. I will highlight noteworthy trends or themes I discovered in the responses, as well as any changes in body or health perceptions related to the material

presented in the three units of curriculum. Though I describe certain findings from the analysis of questionnaires in terms of percentages, they are intended only to provide general context and more effectively situate the critical qualitative analysis I discuss throughout this chapter.

In a mediated world that emphasizes women's bodies and appearance over all else, it is no surprise that when asked how they *feel* about their bodies, the majority of participants in this study responded with an answer that centered on how she *looks*. When reading these responses without knowing the question that was asked, one might imagine participants were asked how their bodies look, or how they feel about the way their bodies look. Seventy-one percent (30/42) of participants described their feelings toward their bodies (which can be termed their body image) from an outsider's perspective, in terms of what their bodies look like. This phenomenon clearly fits the description of self-objectification, which scholars describe as being manifested as "the tendency to perceive one's body according to externally perceivable traits (i.e., how it appears) instead of internal traits (i.e., what it can do)" (Fredrickson & Roberts, 1997, p. 218).

Research suggests a primary distinction between those who self-objectify and those who do not is that self-descriptions given by self-objectifiers focus on the appearance of their bodies, whereas non-self-objectifiers highlight their physical competencies – including their self-efficacy – in describing their bodies (Noll & Fredrickson, 1998). Correspondingly, the 12 responses that did not include (either partially or entirely) an appearance focus were either totally focused on how the participants felt about how their bodies worked or their health (Ex: "I appreciate my

body! It has been through a lot and always recovers really fast.") or were too vague to be classified one way or the other (Ex: "I am not satisfied with my body.").

When asked, "How do you feel about your body?" 31% of participants (13/42) offered responses that were mostly or entirely positive about their bodies (regardless of whether or not her response was self-objectifying), which I classified as "feels positively," whereas 19% (8/42) responded in a combination of positive and negative terms I classified as "mixed feelings," and 50% (21/42) responded in mostly or entirely negative ways, which I classified as "feels negatively." (See Appendix D, "Coding Sample.")

Examples of positive responses were:

> I feel pretty good about my body. There are some things I wish were different, but overall, I feel good about it. I feel really thankful for it, actually.
>
> Within the past year, I have had what I consider to be the most positive body image I have ever had. I am slightly concerned about my health and worry that I might be too thin but I feel comfortable with my body. I think it is beautiful and the things it can do are amazing.
>
> I feel pretty good. I think I would feel better about my body if I were more active. I feel like I am in a comfortable weight range. I feel good when people that know me make comments about me being thin and having lost weight since having a baby.
>
> Good. It works well and hasn't had any health problems!
>
> I feel pretty good about my body. I am not in the best shape of my life, but I am still athletic and proud of my body.

Examples of mixed responses were:

> I am not 'happy' with the way my body looks, but I'm not ashamed of my body either. I don't feel the need to wear shorts over my swim suit to hide my legs. I'm not afraid to get into a swim suit. I don't go out of my way to hide my flaws. I just try to dress for my body type. Sometimes this is depressing. Trying on outfit after outfit and finding nothing that looks good. It's a learning process.

> I think that I have mixed feelings about my body, I love it, I hate it, I know that it is something that is very important and should be treated with respect but we don't always do that.
>
> Depends on the day. I have always been insecure about my stomach and that haunts me daily, but I love my legs and butt so I feel very comfortable when clothing can hide my body well.
>
> For the most part I'm pretty confident about it. There are things on my body that I don't particularly care for, but there are also things about my body that I love and wouldn't trade. I don't like the fact that I have big love handles (or hips) but I definitely prefer curves compared to stick straight. And I really love my long legs.
>
> I love it mostly. I love that I can walk and run and move and enjoy beautiful places because of my body. I love that I have created life twice inside of this body and fed and nurtured my babies with this body. I don't love that I feel I have lost control over some of my body since having my babies. My stomach area is a disgusting mess of extra fat and skin that is gross.
>
> Examples of negative responses were:
>
> Currently, I feel frustrated. I'm 32 and had my first child almost 5 months ago. 'Baby weight' is no fun, even though plenty of people remind me that it's only been 5 months since having a kid. I miss being able to run without huffing or puffing, or being able to do sit-ups easily.
>
> I would like my upper thighs to be more toned and have less fat on them, as well as my upper arms and midsection area. I am 63" and weigh 135 and would prefer to weigh 120-125.
>
> Very self-conscious. It's never looked how I want it to. There is cellulite, scars, veins, things I try hard to keep hidden. I always think, "Why can't I look like her?"
>
> Not a happy subject. I am too thin, and not very attractive.
>
> Even though nobody wants to admit it, I am very self-conscious about my body. I often feel that I am fat, or not skinny enough for the world today. I feel like I have a lot to work on, and that I am not good enough for my husband because of my body.

Finding that almost three-fourths of the participants described their feelings toward their bodies in mostly or entirely self-objectifying terms was not particularly significant to me until I identified which participants offered which responses. Perhaps

not surprisingly, the participants who described their feelings toward their bodies in self-objectifying terms were much more likely to feel negatively toward their bodies. Of the 29 who felt negatively or had mixed feelings toward their bodies, 90% (26) mostly or entirely described their feelings in terms of how their bodies looked. Of the 13 who felt positively about their bodies, only 31% (4) described their feelings in terms that consisted mostly or entirely of appearance-based descriptions.

This could be attributed to the idea that mediated appearance ideals for women are largely unattainable or unrealistic for most body types, so basing one's body image on whether or not one meets a standard of beauty or physical attractiveness – as may be represented by such a high number of self-objectifying responses – is likely to yield shame, discouragement, and negative body image. Studies show self-objectification is correlated with plummeting self-esteem, starting at puberty for females but not for males (Fredrickson & Roberts, 2007), and has been linked to disordered eating, unhealthy sexual practices, diminished mental performance and athletic performance, anxiety and depression among White, Latina, Asian American, and African American women of all ages (Calogero et al., 2010; Fredrickson & Harrison, 2005; Fredrickson, Noll, Roberts, Quinn, & Twenge, 1998; Fredrickson et al., 2008; Gapinski, Brownell, & LaFrance, 2003; Hebl, King, & Lin, 2004; Impett, Schooler, and Tolman, 2006; Quinn, Kallen, Twenge, & Fredrickson, 2006; Tiggemann & Lynch, 2001).

The findings from this study indicate that it is unlikely for a woman to feel positively about her body when she defines health according to appearance-based measures. Only 5% of participants (2) expressed positive feelings toward their bodies and also expressed a view of health that prioritized physical appearance. However, it is

necessary to note that even though the vast majority of women who used self-objectifying terms to describe their body image were categorized as feeling negatively, 2 participants who described themselves in self-objectifying terms were categorized as feeling positively about their bodies. One explained her feelings this way: "I like my body right now. I am fit and have a cute figure and shape. I feel confident about it." Though not as common as feeling inadequate in comparison to body ideals, this small finding indicates it may be possible for girls and women to feel positively toward their bodies because of – rather than *in spite of* – the way their bodies appear, or because of positive reinforcement from others regarding the way their bodies appear.

Alternatively, when asked what influences or has influenced the way they feel about their bodies, participants who felt negatively toward their bodies were much more likely to describe influences related to "looking" – being looked at by others, looking at idealized bodies in media or at peers' bodies and making comparisons, and looking in the mirror at their own bodies. John Berger (1977) described the tendency as such:

> Men act and women appear. Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women but also the relation of women to themselves. The surveyor of woman in herself is male: the surveyed female. Thus she turns herself into an object – and most particularly an object of vision: a sight. (p. 47)

Of participants who felt negatively or expressed mixed feelings about their bodies, 76% responded to this question regarding body image influences in terms of looking at other bodies or being looked at by others, while 21% of participants who felt good about their bodies used such terms. One participant who felt negatively toward her body described her body image influences this way: "Sometimes the people I'm around or the shows I watch make me want to be skinnier. I have a few skinny 'perfect' friends

that make me jealous and want to lose weight." Another said, "Media. Actresses in movies. Just being observant of my peers and recognizing there is that potential of a healthier more attractive body within myself."

Alternatively, those who were categorized as feeling good about their bodies used terms that privileged how they felt in their bodies and what they could do to describe the influences to their body image, rather than what they or others perceived they looked like. One participant said, "Both of my parents have had health problems starting in their 40s and I don't want that. They lived average lifestyles, minimal exercise and poor eating, and I want more for my life than that. I want to be able to provide opportunities for my kids that I never had and that means pushing myself more physically and mentally to be strong, active, and healthy." Another said, "I think about this sometimes and I don't really know – but I am pretty sure it has to do with how I grew up. My mom and older sisters never really talked about their bodies, period; good nor bad. Our bodies were a tool to help us live fun and happy lives. I try to stay healthy so I can do the fun activities of life that I want to do."

Analysis: Recognize

With prior knowledge of the prevalence of self-objectification among women, I tailored the first unit of the Healthy Media Literacy (HML) curriculum to address media's objectified representations of women's bodies and the corresponding declines in women's body satisfaction. As Fredrickson and Roberts (1997) described it, objectified media portrayals play an important role in socializing girls and women to perceive their own bodies from the perspective of another's gaze (p. 219). Immediately following

submission of Questionnaire #1, participants were able to begin the curriculum in Step 1: Recognize, which starts with shedding light on the ways women's bodies have been represented in increasingly narrow and idealized ways in media. This step represents an introduction to critical media literacy that asks participants to question what they have seen in media regarding women's bodies and why those messages have been engineered in ways that emphasize beauty ideals so prominently.

Though the first two questions of Questionnaire #1 prompted participants to comment on feelings toward their own bodies in general, the following eight questions focused specifically on physical health. Participants were first asked, "What does it mean to be a healthy and fit woman?" Among the 21 participants who had positive or mixed feelings toward their bodies, 71% (15) responded to this question solely using terms I categorized as describing "internal health," which included descriptions associated with ability, internal indicators of health (like blood pressure, cholesterol, blood sugar, etc.), absence or presence of disease, and feelings of wellness. No participants who had positive or mixed feelings toward their bodies described a definition of health that exclusively or primarily used terms I categorized as "objectified health," which includes appearance-focused terms (including body weight, shape, etc.). One participant expressed her definition of health this way:

> Overall I think it means being able to use your body in the ways you desire rather than being limited by it. For example, being able to participate in any activities or take care of any problems or get anywhere you need to be or do anything you want to do without worrying that your health will prevent you from doing so.

Another expressed her perspective this way: "To be able to do the things that I love and to do and feel good doing them. To live freely without distractions of poor health from my body."

The remaining 29% of participants (6) in that same category of positive or mixed feelings responded in ways that described their definitions of health equally in terms of both internal health and objectified health. Examples include, "Being athletic, thin (but not too thin), eating well, not having medical problems" and "To be strong, lean. To eat healthy. To be able to put on anything and feel good." When analyzing the responses of participants categorized as feeling negatively toward their bodies, the number of responses that exclusively or primarily described internal health dropped to 48% (10), with an equal number (10 participants, or 48%) offering a definition that equally described both internal health and objectified health.

This finding stuck me as significant since it effectively represents a conflation of accurate health indications with objectified or appearance-focused definitions of health that are pervasive in media. For such a large number of participants (48% in the "negative" and "mixed" feelings categories, 29% in the "positive" category) to formulate a definition of what it means to be a healthy and fit woman using an equal number of appearance-based terms and actual health-based terms is highly demonstrative of the ways health and fitness are defined and represented in mass media like women's health magazines. Fitness regimens and nutrition tips are presented alongside headlines like "Bikini Body Now!" (*Shape* magazine, May 2013) and "Drop 10 lbs Fast!" (*Shape* magazine, June 2013) with full-page images of Photoshopped, bikini-clad models and actresses.

It was not surprising to see that one participant defined health and fitness solely in terms of objectified health, saying, "To look toned and tight everywhere," but even less surprising was the 38% of total participants who simply used a mix of objectifying terms

and health-focused terms in their definitions. Profit-driven media perpetuate the idea that health is defined by whether or not one's body meets appearance ideals, which any woman can achieve through proper food and exercise choices (or whatever pills, procedures, and services are being sold). The "Recognize" focus of this step relies on shedding light on these profit-driven motivations that perpetuate distorted health discourse. It makes sense, then, that many women correlated positive health choices like exercise and eating a balanced diet with being thin, looking toned, and weighing an ideal amount, and that they found it necessary to include both aspects in their definitions of health.

One participant in the "feels negatively" group articulated this sentiment clearly in her definition of health, stating:

> Having a healthy heart, blood pressure, healthy BMI, endurance/strength to do the activities that I need/want to do. I don't think it is any specific measurement or weight necessarily, but whatever those measurements need to be to achieve the healthy heart, blood pressure, and activity level. I also think that when those things are achieved, the look of my body will be its best look – nice fit curves, without excess 'hang over.'

After formulating a generalized definition of health and fitness for women, participants were asked whether they consider themselves to be healthy or fit and to describe why or why not. Of all 42 participants, 38% (16) reported that they considered themselves to be healthy or fit and only 14% (6) reported being unhealthy. Nearly half, 48% (20), reported being not quite healthy or fit, but almost all described working on it – which I coded as "almost healthy." When the responses were divided into categories of how women felt about their bodies, 100% of the participants (6) who considered themselves "unhealthy" were from the "negative feelings" category, and two-thirds of them (4) described their reasoning using self-objectifying terms (e.g., "I am overly thin"

or “I get LOTS of exercise. I get at least one workout in EVERY day, 7 days a week, but I still have weight to lose and muscle to tone.”). In the “positive feelings” category, 46% (6) described themselves as healthy, while the other 54% (7) described themselves as “almost healthy.” In the “mixed feelings” category, responses were split equally between “healthy” and “almost healthy.” In the “negative feelings” category, 28.5% (6) reported being healthy, 28.5% (6) reported being unhealthy, and 43% (9) reported being “almost healthy.”

Based on these responses, participants in the “negative feelings” group were much less likely to consider themselves healthy and fit than those in the “mixed feelings” or “positive feelings” groups, with only 28.5% in the negative group coded as “healthy” compared to about 50% in the other groups. However, it is important to note that this is a subjective self-report of health and not a clinical diagnosis, and almost all of the participants in the “negative feelings” group had previously demonstrated self-objectification in their body image statements. When analyzing the participants’ reasoning for feeling healthy or unhealthy, it was interesting to note the presence of self-objectifying terms that either justified their reasons for claiming to be healthy (e.g., “Yes, I am not fat or overweight.”) or prevented them from claiming to be healthy. One participant’s response demonstrates the latter:

> Well sort of. I exercise often and try to eat healthy, but I’m not super thin. I’m trying to do Weight Watchers. I attend exercise classes on regular basis and am training for several races, including Ragnar [a long-distance relay] and the Top of Utah half marathon.

Similarly, another participant said:

> Mostly. I am at the high end of my healthy BMI and want to be rid of some of the excess flab that built up since before I had children. But my blood pressure and

> other labs indicate that my body is pretty happy with the way things are. I am able to participate in all of the daily activities that I want.

More than half of all responses to this question from the "negative feelings" category used self-objectifying terms to describe why the participants were or were not healthy, while about one-third of the responses from the "positive feelings" category used such terms.

In Questionnaire #1, most participants identified a mix of sources from which they learned what it means to be a healthy and fit woman, including media, family, peers, school, and personal experience. Differences emerged between the participants who were categorized as feeling "positive" and "negative," with only 8% (1) in the "positive" group mentioning any type of media source for her health ideas and 57% (12) of the "negative" group specifically mentioning mass media as a source of health information. This finding may be attributed to the often unattainable and objectified messages about women's health that are found consistently throughout mass media. So, too, might the participant's explicit reference above to the Body Mass Index (BMI) as a measure of health.

After participants completed Questionnaire #1 and then Step 1: Recognize in the first week, the second week commenced with Unit 2: Redefine. This consisted mainly of a health information intervention that emphasized the flaws in some of the most commonly used methods for defining health and fitness for individuals. It focused heavily on both critical media literacy and health literacy that asked participants to question health discourse from mass media, social media, coaches, health agencies, and personal interactions – particularly those messages that privilege an objectified view of health or focus on appearance and weight/BMI over ability, feelings of wellness, and internal indicators of health.

One of the most prominent health measurements discussed in the curriculum through Step 2: Redefine is the BMI. A simple weight-to-height ratio, it has shown to be flawed and ineffective for individuals to gauge their healthy weight, which varies greatly among ethnic groups and ages and between genders. I included this research and discussion due to my understanding of the prominence of the BMI for determining healthy weight ranges, as well as my prior research on its ineffectiveness. As anticipated, several participants referenced the BMI in Q1 as a way they define health, or as a reason they believe they are or are not healthy.

One participant (in the "feels negatively" group) described working as an aerobics instructor, taking weight-lifting classes, hiking regularly, and exercising daily, plus trying "very, very hard to make healthy eating choices" every day. However, she described a strong desire to lose 5-10 pounds since it is a "target weight according to the BMI." Another from the negative feelings group said, "I do consider myself healthy and fit. I don't think I have met my potential, because I would like to lose about 10-15 pounds before I would consider myself in 'swimsuit' shape, but I do feel healthy and fit." Similarly, another participant stated, "No, but I'm working on it. My BMI is just on the cliff of the healthy to overweight category. I'm not back to prebaby and I'm working my way back to running a 10k (had knee surgery #4)."

Understanding that activity level – rather than body weight or BMI – is a reliable indicator of a person's health is a key to dismantling an ideology that defines health according to appearance-based measures. Considering that 38% (16/42) of participants' definitions of health were comprised of at least half appearance-focused terms, this focus on activity level over appearance proved to be highly relevant. Researchers are warning

against this objectifying, profit-driven tendency to focus on thinness rather than actual indicators of health and fitness (King et al., 2009; Neumark-Sztainer, 2007), which is why Step 2: Redefine is heavily focused on privileging physical activity and individualized definitions of health rather than achieving a "normal" BMI or ideal weight. King et al. (2009) demonstrated that "significant and meaningful health benefits can be achieved even in the presence of lower-than-expected exercise-induced weight loss" (p. 924). Their findings added to research that shows when people with serious health issues like Type 2 diabetes, cardiovascular problems, and high blood pressure start a meaningful exercise program, their health problems often disappear or greatly improve – regardless whether or not they remain overweight or obese. Through the skills and information acquired through the Healthy Media Literacy curriculum, especially in Step 2: Redefine, women can critically question and understand why health has been presented in such flawed and objectified ways through media, and then redefine health for themselves in ways that prioritize what their bodies do and how they feel, rather than how they look.

Throughout Step 2 during this study, I aimed to introduce and cultivate feelings of self-efficacy in participants who may have previously defined health in unattainable or unrealistic appearance-focused ways. I undertook this goal with the belief that redefining health and fitness in ways that are achievable and yield actual internal health benefits is a meaningful avenue for promoting and cultivating self-efficacy to achieve physical health. For example, though a woman may be unable to reach a certain weight, BMI score, or "fit look" and thus be discouraged and consider giving up healthy behaviors due to lack

of visible results, she may be able to reach ability-focused activity goals and recognize those accomplishments as results.

In order to gauge some sense of participants' health-related self-efficacy, Q1 included the question, "Do you believe it is possible for you to achieve health and fitness?" The presence of self-efficacy proved to be a significant difference between participants who felt positively about their bodies and those who felt negatively. Among the 21 who felt positively or had mixed feelings about their bodies, 100% believed they could achieve health and fitness – most answering with a definitive "Yes, of course" or "Yes, with enough effort, anyone can be healthy and fit." Alternatively, among those who felt negatively about their bodies, one-third (7) expressed feelings of having no self-efficacy. This finding aligns with research that has linked negative body image with low self-efficacy to achieve health (Song et al., 2011; Van den Berg & Neumark-Sztainer, 2007).

One participant said, "At times I have bursts of confidence that I can obtain health and fitness because I feel better about myself when I am striving towards this; however, then I remember I have a toddler, a full-time job, and am in a PhD program. I now feel hopeless." Another said, "I'm not sure. For someone else to achieve it, yes, but for me, perhaps no because I would feel too guilty for taking more time for myself after working at least 40 hours while my son is at daycare." Of the two-thirds (14) in the "negative feelings" category who did believe they could achieve health and fitness, 29% (4) expressed serious doubts and reservations (e.g., "Yes. It just seems daunting to start.").

Scholars have identified that an important aspect of promoting self-efficacy is removing barriers – real or imagined – that prevent people from achieving a certain goal

or completing a certain task. In the case of exercise-promoting campaigns, people need to be able to identify and remove barriers to physical activity in their lives that are holding them back from exercise. One of those barriers is feelings of previous failure at exercising, which holds particular significance for women since studies show women tend to associate weight loss with exercise "success," while many men who gained weight during a study period still considered themselves to have been successful at managing their health (Hawks, 2008; Timpiero & Hawkins, 2004). Timpiero and Hawkins (2004) warn, "It is possible that women's perceived lack of success in weight control when no changes in weight ensue may prompt the adoption of aggressive and possibly harmful weight-loss methods, and exacerbate negative body image and weight pre-occupation" (p. 215).

This perceived lack of success appeared in several participants' questionnaires – and was credited with leading to negative body image as well as both weight preoccupation and forfeiture of healthy behaviors. Multiple responses included feelings of shame or discouragement at not achieving appearance-related results from exercise or positive health choices. One participant described being enrolled in Weight Watchers, doing "P90X" and "Insanity" workouts, yoga, resistance training, and jogging, and hadn't "missed a day of working out for 3 months now." When asked if she believed she could achieve health and fitness, she said, "Yes of course. It just takes a lot of determination and hard work. Sometimes it gets discouraging when you don't see the results you want right away … but it's a lifelong battle I think." It is noteworthy to put her statement regarding "not see[ing] the results you want" into context with her reasons for pursuing

health and fitness, which she stated as: “I look in the mirror and see so much that needs to be improved. I’ve never been able to look in the mirror and feel satisfied.”

Another participant expressed similar discouragement at not “seeing” results from her exercise regimen. She wrote that she did think it was possible to achieve health and fitness, saying:

> A year ago, I ate really healthy and exercised every day. I was able to lose weight, but it was slow goings and it kind of went out the window… I know I’m overweight, like really overweight. I start thinking that I should start exercising, but then I think how ridiculously hard it is to ever see results and then I get frustrated and give up.

Another participant echoed this discouragement that results from an appearance-oriented view of health results:

> I have never been successful before by tracking my weight and calories (nor has my best friend that I exercise with). I am tired of playing the game: exercising and feeling good about it, just to check my weight and feel discouraged and lessen my exercise and healthy eating because I wasn’t seeing results.

Accordingly, researchers have identified body dissatisfaction as one of the major barriers to regular exercise for women. One participant described her reasons for not making positive health choices this way: “Feelings of inadequacy. I’m not pretty enough. My body isn’t built that way. The only way to lose weight is to starve myself.” In response to the question, “What, if anything, has previously prevented you or currently prevents you from engaging in healthy behaviors or activities?” 1 participant said, “My body shame. I would skip out on social outings or even group sports because I didn’t want to be the ugliest/fattest one there. I would avoid going to the gym because I was too self-conscious.”

Ball, Crawford, and Owen (2000) found one of the most significant barriers to exercise for obese people was their body image perception, with “feeling too fat to

exercise" showing up as one of the most common barriers, particularly for women. This finding demonstrates that self-objectification and preoccupation with appearance are powerful barriers to positive health choices like exercise, which makes recognizing and working against these tendencies a meaningful goal. A study based on data from the 2002 National Physical Activity and Weight Loss Survey found that body size satisfaction had a significant effect on whether a person performed regular physical activity, regardless of the individual's actual weight (Kruger, Lee, Ainsworth, & Macera, 2008). That is, those who were satisfied with their body size – regardless of their size – were more likely to engage in physical activity regularly than those less satisfied.

The HML curriculum is designed to promote positive body image through critical media and health literacy that can help to dismantle unrealistic appearance ideals, shed light on the pervasiveness of objectification and self-objectification, and provide strategies to recognize, redefine, and resist those harmful messages. When girls and women learn to value their bodies for what they can do and how they feel, rather than how they appear, they achieve a more positive self-concept (Choate, 2007), which is associated with more positive health choices. This study backs up that idea, as a vast majority of participants who felt positively about their bodies believed they could achieve health and fitness. On the other hand, one-third of participants who felt negatively about their bodies believed it was not possible for them to achieve health and fitness, and one-third of those who did believe they could achieve it expressed serious reservations. By identifying barriers to positive health choices that are common to women – such as weight preoccupation, body shame, and discouragement relating to misguided

expectations regarding "success" – the HML curriculum can help women to recognize and remove their own barriers to health self-efficacy.

Analysis: Redefine

After completing the second unit of the curriculum, Step 2: Redefine, participants were asked to complete Q2, which began by directly addressing their perceptions of the curriculum, including how the information presented in Step 2 might change their perceptions of health and fitness. Of the 42 who completed Q1, 35 went on to finish all of Step 2 (including the second unit of curriculum, "Redefine," and Q2).

One of the most interesting changes between the Q1 and Q2 responses related to the question gauging self-efficacy to achieve health, which appeared identically in both questionnaires. Of the 7 participants who reported no self-efficacy regarding achieving health or fitness in Q1, 1 did not complete Step 2, and 5 of the remaining 6 responded with answers that reflected an increased sense of self-efficacy to achieve health and fitness, though many included concerns or reservations. For example, 1 participant's response evolved from saying she wasn't sure it was possible for her, though she believed it was for other people, to "Absolutely, even though finding the time is hard." Another went from, "Sometimes. But most of the time I just get discouraged when, despite the time I spend working out, I still never see any difference in my weight" to, "Yes, for the most part." Despite the reservations about ability to achieve health that most of these participants expressed, all of their responses can still be viewed as an improvement over their initial responses, which reflected no self-efficacy whatsoever.

Of the 5 who initially expressed a sense of self-efficacy along with strong reservations or doubts, 1 did not complete Step 2, and the remaining 4 each responded the second time with full self-efficacy and expressed no doubts. Several of these responses reflected a new sense of confidence to achieve health that they attributed to the curriculum, such as, "Yes. And reading this stuff is seriously helping me feel that way." Even among participants who initially responded with answers reflective of self-efficacy to achieve health, several expressed increased motivation and excitement to achieve health and fitness goals in their responses the second time. One participant wrote, "This information is fantastic and inspires me to be more active even though it will not likely result in me losing 20 lbs."

This increased sense of self-efficacy among 90% (9/10) of the participants who initially expressed doubts or reported no self-efficacy at all is a promising result. It implies that shifting the focus from objectified health measures to internal, ability-based health measures is a meaningful way to promote a sense of empowerment to achieve health. By privileging the way women feel and what their bodies can do rather than what they look like or weigh, participants seemed to feel more in control of their health and fitness outcomes. This was illustrated in several responses:

> I just started training for a 5K with my friend. Already it feels way more satisfying to track if I can run for a longer period of time than if my weight is down. I'm really excited about it!
>
> I think it will be easier for me to be healthy and fit knowing that being active is always good for me even if I am not losing weight.
>
> I am excited to change my thoughts about health and make goals to have myself and my whole family be consistently active with the end goal of health in sight and not weight loss.

One important aspect of the "Redefine" step of HML is that it highlights disparities between the way health is represented through media and cultural discourse and real people's health experiences, using both scholarship and reflection on personal experience. Many participants expressed relief and overwhelming agreement in response to research demonstrating that activity level is a more accurate indicator of health than body weight and that BMI is a poor measure of healthy weight. This was most often based on their own lived experiences. For example:

> I know this is true. I see it in my life, and I feel it in myself. My positive feelings about my body come when I am active, even if that activity doesn't lead to weight loss.
>
> I like that idea and it will help motivate me to be more active.
>
> This actually made me feel a lot better. I've always been a pretty active person.
>
> I love that!!! I've always been an active person, and I love that even though I'm not the skinniest girl in town that I can be healthy.
>
> I just told my husband today that after reading this info I feel much better about myself. I have been well-educated on the lies of media formerly and I like to think I'm not affected by it, but I totally am. Reading and learning this again is empowering.
>
> I totally agree. It's nice to know those results and I feel it will really redefine the way I feel not only about my own health but those around me.
>
> I feel like I really needed to read this at this point in my life. I've obsessed over keeping my weight at the point where my BMI tells me I'm 'average.' I'm happy to know this now and will stop letting it influence the way I feel about myself so much.
>
> I was ALWAYS in the overweight category. It made me feel like a failure. Because even when I was working out EVERY day and eating barely 1000 calories a day and starving, according to my BMI I was still overweight. I never thought about whether or not it was an accurate assessment of my health or fitness. I realize now that it absolutely was not.
>
> It's comforting to me. As long as I can remember, I've been considered 'overweight.' Maybe now I can start thinking of myself as something else.

On the other hand, 1 participant from the "feels positively" group was not comforted by the research presented in Step 2 because it conflicted with her prior belief that thinness was equal to health. As a naturally thin woman, she described believing she was healthy and free from the need to engage in physical activity or healthy eating choices because she did not need to lose weight. While learning to gauge health and fitness according to ability and internal indicators proved to be comforting for the majority of participants who described never being able to achieve appearance ideals despite consistently striving for health and fitness, this participant's responses shed light on an alternative perspective. She wrote:

> This part actually made me feel bad, which I'm sure was not its intention. Or maybe it was? I am naturally thin even if I am sedentary, and it felt like there were subtle messages in this section that naturally thin people are probably unhealthy or not making good choices. Maybe it made me feel bad because I know it's true to a degree – I should be much more active.

Though this participant's view of her health was shaken, she also expressed motivation and intention to improve her health choices, regardless of whether it affected her appearance, which was similar to many other participants. Further in the questionnaire, she wrote:

> This section made me feel like I am not healthy even though I look healthy. I am not very active (I'm not completely sedentary either, I just have plenty of days where I do nothing fitness-related) and I sort of felt guilty about that after reading this section. I am going to try to be active in some way at least three times a week, even if it is just walking. I suddenly feel like I have not been doing enough, even though I've been content with my body and appearance.

One finding was unanticipated, and it was revealed through my analysis of Q2 regarding which participants openly described themselves as thin. Although no questions asked about participants' body types, builds, sizes, or any other descriptions of their appearances, several participants volunteered such information in their responses to Q2.

What struck me as important about this finding is that of the 8 participants who voluntarily described themselves as thin, 75% (6/8) of them were classified in the "feels positively" category (more than half of the participants in that category), with the other 2 falling into each of the other two categories, which were "feels negatively" and "mixed feelings." Most of these 5 women identified themselves as being thin in conjunction with their responses to the BMI research, stating that they were categorized as "underweight" according to the BMI.

In a 2007 study, Kantrowitz and Wingert found that the "underweight" women in their study group believed they were at their ideal weight and did not seem to understand the health risks associated with being underweight. The authors attributed these findings to the supportive cultural messages very thin women receive that help to keep them in that weight category. In this light, it makes sense that women who are thin are more likely to feel positively about their bodies. One participant even identified this as a factor that protected her from having a negative body image, saying, "I sometimes feel like I've always had [a] strong advantage from the get-go. I am naturally thin so I haven't had any reason to worry much about this stuff." Many from the "feels positively" category who identified themselves as being thin described constant positive comments from others on their thinness. One said, "When I was young everyone called me 'Skinny Minnie' and praised me for being so tall and slender. I felt like I had to maintain that and I recognized that this was something that was valued by others."

Importantly, as demonstrated by the 1 participant who identified as being thin who was categorized as "feels negatively," thinness is not an automatic indicator of positive body image – nor does it always draw positive comments from others. She

described her feelings toward her body as being heavily affected by social influences, saying, “I have always been tall and really skinny. Always thinner than it seemed I should be. I worried that people were talking about the way I looked whenever I was in public. A big factor is acquaintances that don’t know me, and make assumptions about my eating habits and possible disorders.” From these examples, it appears that thinness may be a predictive factor for positive body image, especially when it is openly valued and praised by others. However, social influences appear to play an important role in whether thinness is associated with a positive or negative self-perception, particularly in the context of whether a girl or woman receives regular positive or negative comments from others.

Another prominent change between the responses in Q1 and Q2 was the participants’ reasons for engaging in healthy behaviors. Both questionnaires asked the same questions: “Please describe any changes you intend to make to your health-related behaviors, for example, increasing or decreasing the frequency of a behavior” and “If you do intend to make any changes to your health-related behaviors, please describe why.” The first time participants answered this question (which was before starting Step 1 or Step 2 of the curriculum), about half answered in either a mix of objectified and internal health-focused terms or used entirely appearance-related terms, while half answered in purely internal health-focused terms. After completing Step1: Recognize and Step 2: Redefine, 89% of participants answered in purely internal health-focused terms, with no reasons for changing health behaviors relating to appearance or weight.

This change is particularly significant when considering individual responses. When asked why she might change her health behaviors in Q1, 1 participant said (as

previously referenced), “I want to continue to lose weight and get lean toned muscles. I want to look in the mirror and like what I see.” The second time she responded to this question after Step 2: Redefine, she said, “I want to continue to work out and get into shape so that I can feel good about my body. I want to be healthy and active and be able to run around with my little boy. I feel so good and invigorated after a workout and it makes me feel like I am working toward something worthwhile.”

Another participant initially responded with, “I think it’s because I want to be thin or look a certain way or get back to my old self. But one reason is that I’m tired of not being able to easily buy clothes that fit me. I’m tired of having to worry so much about what will be flattering or even possible to get on myself.” In Q2, she responded, “I want to do it because I feel happier when I take care of my body. And because after reading this, I feel super motivated to avoid the ‘too fat to exercise’ trap.” Although almost all of the participants articulated reasons for changing or maintaining their health-related behaviors that were entirely free of self-objectifying terms the second time around, the few (4) who maintained solely appearance-focused reasoning demonstrated how difficult it is to completely reject cultural beauty ideals. One participant said:

> I am still trying to get rid of the extra rolls I accumulated after this last pregnancy. They are almost gone. Maybe this falls under the working for an unrealistic image that has been glued to my mind by the media, but is it unrealistic if I know I can do it? I don’t want the deathly skinny look, just no muffin top. No muffin top I have done and can do it again. I know it.

Another participant simply wrote, “It’s just too hard to be overweight in this society. I feel so ugly. I have to be skinny.”

Analysis: Resist

The final portion of the study, Step 3: Resist, consisted of a unit of curriculum that focused on strategies for resistance to the distorted health ideals illuminated and discussed throughout Steps 1 and 2. In addition to description of media literacy-related strategies like critical questioning of media messages and critical self-reflection regarding body-related feelings and behaviors, this unit of curriculum included my own personal narrative (see Appendix G) about learning to recognize my distorted health perceptions and resisting them through my own research and activism, which will be discussed later in this chapter. My objectives for this unit included sharing research-bases strategies for resistance to distorted health discourse that could be utilized by participants as well as gathering participants' personal strategies used in the past or present to resist unhealthy ideals.

Twenty-five of the original 42 participants completed the entire curriculum and responded to Q3, which was given 2 weeks after the curriculum ended. This final set of questions was nearly identical to Q1, until the ending questions that focused on strategies for resistance. Before beginning the curriculum, when participants were asked, "How do you feel about your body?" Thirty-one percent of participants (13/42) were classified as "feels positively," while 19% (8/42) were "mixed feelings," and 50% (21/42) were categorized as "feels negatively." Once again in the final questionnaire, participants were asked how they felt about their bodies. By this time, 56% (14/25) were classified as "feels positively," while 32% (8/25) were classified as "mixed feelings," and 12% (3/25) were classified as "feels negatively."

Although several participants did not complete the entire study, which had been anticipated, these results are still noteworthy when considering changes among individuals. All of the participants who were originally classified as "feels positively" and completed the study remained in that category based on their final responses, but 4 participants who were originally in either the "mixed" or "negative" categories moved to the "positive" group by the end. Seven participants who started in the "feels negatively" group transitioned to the "mixed feelings" group in Q3. In total, 79% (11/14) of participants who were originally classified in the "mixed" or "negative" feelings groups demonstrated a significant shift toward a more positive body image by the end of the study. Three participants (14 %) of the 21 who were originally classified in the negative feelings group remained in that category based on their final answers.

As discussed previously, 71% (30/41) of participants in Q1 described their feelings toward their bodies in mostly or entirely self-objectifying terms. Of those who felt negatively about their bodies, 90% gave self-objectified responses. By the end of the study, only 16% (4/25) of participants described themselves in mostly or entirely self-objectifying terms – and all of these participants had originally self-objectified. Significantly, 33% (4/12) of participants who originally described themselves in self-objectifying terms responded to Q3 in non-self-objectifying terms, which represents an improvement in their physical self-concepts. The evolutions in their responses demonstrated a shift in the ways participants viewed and thought about their own bodies, from initially prioritizing appearance to finally prioritizing their bodies as instruments. For example, in Q1, one participant wrote:

> I don't really like my body. I can't remember a day that I woke up and was glad to be in the body I'm in. My thoughts are often about how I could or should lose

> weight and I feel very guilty if I eat food that I know will cause me to gain weight. I'm grateful for my body but I wish it looked different, mostly just that I was thinner.
>
> In response to the same question in Q3 5 weeks later, the same participant said:
>
> I am grateful for my body especially because I am very healthy compared to a lot of ailing people in the world; I have all my limbs, my organs function properly, I don't experience pain every day, etc.

Another participant responded in Q1 this way: "Very self-conscious. It's never looked how I want it to. There is cellulite, scars, veins … things I try hard to keep hidden. I always think 'why can't I look like her?'" By Q3, her response had changed to:

> I still feel like it's a work in progress. It's imperfect and chubby, but it's mine and I am working on making myself feel good about it. I think our bodies are amazing really. They are capable of SO much when/if we push them to do so. When I focus on that I feel much better about my body. I am so impressed with my body that I was able to complete a 12-mile obstacle course 5 months after having a C-section!!
>
> One participant started Q1 saying:
>
> My body can be frustratingly flawed in looks and performance. It aches and gets tired, and certainly not very pretty to look at (especially without clothes). I don't like the 'muffin top,' flat chest and cellulite on my legs. But even still, looking in the mirror sometime, I can appreciate the beauty of all the curves and how it fits together. Unfortunately, when I see other's bodies, I realize again how my body doesn't look nearly as artistically beautiful as theirs, and how much better it would look if I just trimmed off a few inches here and there. I try to stay pretty content with my body if I don't see all the other images or a particularly unflattering picture of myself.
>
> In response to the same question in Q3, she said:
>
> Well, after reading this curriculum, I feel much more satisfied with it. I know that my body has the energy and strength to do fun and active things with my family. I still have that drive to want to fit back in the size 12 pants I did before my last baby. I am trying to reconcile that motivation with the idea that I felt healthier at that size rather than that I liked how I looked at that size. Honestly, I don't think at any size I will think my body looks amazing, so I am going to try to stop defining my satisfaction with it by how I look. I feel tough and strong and like I can keep up with any task given to me.

In Q1, I asked participants to indicate what their media usage looks like in a typical week in as much detail as they could. I took note of the participants who described significant time spent engaging with media, whether TV, movies, magazines, Web surfing, or social media. At Q1, participants who reported substantial time with media were found throughout the "feels positively," "feels negatively," and "mixed feelings" categories, though were most prominent in the "feels negatively" category, with 71% (15/21) reporting significant media usage every day. Though specific TV shows or genres varied significantly in responses, social networking dominated participants' media consumption, with most reporting at least 1 hour on Facebook every day, and some much more than that. Participants in the "feels negatively" category overwhelmingly reported significant social media use. Responses from this category included 1 woman who wrote:

> I am involved with organizations that require me to be on the computer a lot. And Facebook is more of a hobby than anything, I check it so many times during the day and at night it seems to consume my time.

Another wrote:

> As for social media, I blog for a living, so I'm involved in that, but I don't read blogs anymore (too time consuming and hard on the ego). And I check Instagram often...maybe once an hour.

At the end of the study, in Q3, participants were asked the same question about media usage. Several reported intentionally decreased media consumption, most specifically mentioning their interest in the strategy of a "media fast," which was presented in Step 3 of the curriculum, along with other practical tactics for resisting distorted health ideals publicly and privately. One participant said, "I spent less time reading blogs, and looking at Facebook. Although it's hard to do, a media fast is such a great idea." Another wrote, "I don't use Facebook as often as I used to and I am actually enjoying the change."

Though there was no detectable decrease in media consumption among most participants, 1 woman who moved from "feels negatively" to "mixed feelings" reported canceling her longtime subscription to *Cosmopolitan* magazine in her efforts to avoid objectifying media.

Along with continuing to describe their feelings toward their bodies in self-objectifying terms, the 3 participants who remained in the "feels negatively" category also shared another distinguishing characteristic – consistently high media consumption, particularly social media. These three reports, which did not change between Q1 and Q3, included:

> I watch TV shows on Netflix – currently The Office (20 hours per week). I read *Vogue* and *Elle* (1 hour per week). I spend extensive amounts of time on Facebook, Twitter and online reading current events, posting, etc. About 70 hours [per week].
>
> Twitter: 40 hours, Facebook: 30 hours, Reddit: 10 hours, Buzzfeed: 40 hours. Netflix: 21 hours.
>
> TV about 4 hours a week: Revenge, Celebrity Apprentice, Modern Family, the Bachelor, Grey's Anatomy, Revenge, and some sports. Magazines about 15 minutes per day: *Shape*, *Parenting*, *Real Simple*. Facebook/Instagram/Pinterest, and blogs about 10 hours a week.

Each of these 3 women reported being highly influenced by media in how they perceived their bodies and health, and all 3 consistently described their feelings toward their bodies and their health goals in terms of appearance ideals. When asked in Q3 why she intends to make any health-related changes to her behaviors, 1 of these participants said, "Why I want to change: because I look in the mirror and see fat. " When asked if she helps herself differentiate appropriate health and fitness messages and beliefs from distorted, profit-driven messages and beliefs, the same participant simply stated, "I try,

but it's difficult to look at the images of healthy women in *Shape* and not want to look the same."

More changes in both collective and individual responses to questionnaires appeared in connection with the question, "What does it mean to be a healthy and fit woman?" In Q1, 62% of participants responded to this question solely using terms I categorized as describing "internal health," which included descriptions associated with ability, physical measurements of health (like blood pressure, cholesterol, blood sugar, etc.), absence or presence of disease, and feelings of wellness. By Q3, 100% of participants responded in terms that exclusively described internal health or an instrumental view of the body, rather than appearance-oriented views. Interestingly, even the 3 participants categorized as feeling negatively toward their bodies and self-objectifying in both Q1 and Q3 offered definitions of health and fitness that were entirely free of appearance-focused terms.

Changes in individual responses to this question from week 1 to week 5 were noteworthy. For example, in Q1, 1 participant described a lifetime of body shame, disordered eating, and discouragement at never being able to lose as much weight as she wanted no matter how much she starved, or even how healthy and active her lifestyle. By Q3, she noted some major changes in her perception of what it means to be healthy and fit, saying:

> I've realized that it doesn't mean to be thin!!! It means that she exercises and pushes her body to reach fitness goals and eats a well balanced diet. She is positive and realizes that her body is beautiful as it is. I think being healthy includes not obsessing about your body and unrealistic expectations. Through this curriculum I've understood health and fitness. I guess I've just hurt myself by assuming that I wasn't really fit until I was thin like the girls in the magazines.

Another participant initially defined health in Q1 this way:

> Having a healthy heart, blood pressure, healthy BMI, endurance/strength to do the activities that I need/want to do. I don't think it is any specific measurement or weight necessarily, but whatever those measurements need to be to achieve the healthy heart, blood pressure, and activity level. I also think that when those things are achieved, the look of my body will be its best look – nice fit curves, without excess 'hang over.'

In Q3, her response became: "Free of disease or injury caused from poor eating and lack of exercise. Possessing the strength and energy to perform any task (fun or work related) presented to it."

Another participant described a difference in her health beliefs and behaviors since beginning the HML curriculum, saying:

> They have changed slightly. It was interesting and informative to learn about how the fitness industry still bases health off of appearance. I wasn't really aware of that before, but now it is so obvious – the fact that the media says to be healthy you have to look a certain way. I was falling into that trap and thinking I was healthier than I am because I am not fat, I have a thin stomach and I am confident about the way I look in a swim suit. In fact I have very little endurance and I am not as fit as I might appear, simply because I don't exercise during the week as much as I should to actually be as fit as I want to be.

One participant went from an initial definition of health that included the statement, "To me, being fit means having fat percentages and muscle mass that are ideal for your age, body size, and type," to this:

> Being a healthy and fit woman means appreciating the beautiful uniqueness of your body. Being healthy means not measuring yourself against other women or basing you body size on appearance, but instead on what is healthy for you. Being fit means being active and using your body so it is strong and able to accomplish the activities you are interested in. A healthy and fit woman makes decisions on what to eat and what exercise to do based on an overall feeling of well being, health, and comfort and not appearance or being a certain size or weight. A healthy and mentally fit woman recognizes that her self-worth is not connected at all to her appearance. A healthy and fit woman has high self-esteem, loves herself, takes care of her body, and teaches others how to love themselves.

In line with changing definitions of what it means to be healthy and fit, participants also expressed greater feelings of self-efficacy to achieve health and fitness.

Both Q1 and Q3 included the question, "Do you believe it is possible for you to achieve health and fitness?" The presence of self-efficacy proved to be a significant difference between participants who felt positively about their bodies and those who felt negatively in both Q1 and Q3, with 100% of those who felt positively about their bodies believing they could achieve health or fitness. Alternatively, among those who felt negatively about their bodies in Q1, one-third (7) expressed feelings of having no self-efficacy. In Q3, all of those who previously described no self-efficacy expressed increased feelings of self-efficacy – some with doubts and reservations, but some with full confidence that they could achieve health.

One example of a participant who went from a weak sense of self-efficacy, full of doubts, to a sure sense of self-efficacy is a young woman who originally stated, "Sometimes. But most of the time I just get discouraged when I have lots of hunger or sugar cravings that I can't seem to control or when, despite the time I spend working out, I still never see any difference in my weight." In Q3, when asked the same question about whether or not she believed it was possible for her to achieve health and fitness, she said, "Yes, I think when I come to accept my body and love who I am then health and fitness come naturally."

Strategies for Resistance

Testimonio

I included my own personal narrative in Step 3: Resist as a way to prompt empathy, understanding, or small-scale collective disidentification with harmful body ideals – even if it is just one woman at a computer feeling solidarity with me through

reading my words. Since the personal narrative section of the HML curriculum was purely voluntary (and not required for entrance into the drawing for the gift card), I was pleasantly surprised that half of the participants freely shared their own version of a body image *testimonio*. Their stories did not actually fit the description of a *testimonio* as outlined in scholarship, but many of these personal narratives held obvious significance for their authors and provided a meaningful outlet for breaking silence, voicing pain or struggle, and privileging the lived experience of these women. One of them impacted me deeply. It was from the same participant who had stated, "It's just too hard to be overweight in this society. I feel so ugly. I have to be skinny." For convenience in referring back to her responses in this discussion, I will call her "S." I received S's narrative via e-mail when pulling into my apartment parking lot late one night and found myself sobbing in my car as I read it. Since she asked that her *testimonio* not be shared with anyone but me, I have removed any identifying information from the portions I will share. The empathy, compassion, and sincere solidarity I felt for this young woman because of her painful experiences, courage, and honesty was powerful, and it reinforced to me the potential power and impact of *testimonio* in this curriculum and for promoting positive body image in general. S introduced her story this way:

> I want to start out and tell you the majority of what I'm writing are thoughts and feelings I've never ever shared with anyone before in my life. I haven't even shared a lot of this with myself, because I'm afraid to remember a lot or admit a lot of my true feelings about my body. This is also the first time I've written down these thoughts. I've been terrified to make any sort of record of my hurt and loathing for fear that someone would find my journal and only ridicule me further. This email, this testimonio, is truthfully the most honest I've ever been about my body in my entire life. To anyone. For some reason I feel like I can share this with you, but I'm not ready to share it with others yet.

Her 2,500-word narrative eloquently detailed a lifetime of experiences that taught her to hate her body, including a grandfather who chastised her for gaining weight in elementary school and told her it would ruin her life, being bullied in school for her weight, excelling in competitive swimming and other athletics but feeling excruciatingly self-conscious while competing, parents who put her on the dangerous HCG diet (among many others) as a teen, a sister who is anorexic and suffering, and her constant immersion in objectifying media that she compares herself to endlessly. She described being disgusted with her body but said, "I hide my hate. I'm confident, social, smart, successful, and creative. I have a lot of friends and I love my life. I act so happy, and I really am happy a lot. But underneath there's so much sad. So much loathing." She concluded this way:

> I know you probably want me to tell you what works in helping women feel better about their bodies, but I don't really have a lot of that for you. I struggle with it every day. I'm not a success story with answers. I'm a work in progress. And this study has been interesting and I'd like to think it has helped me, but it hasn't been any sort of breakthrough for me. Because unfortunately, no matter how comfortable I am with my body, I know other people don't find me as beautiful as a skinny girl. And no matter how screwed up that is, to care so much about other people's opinions, it does matter to me. It matters a lot. And I wish it didn't. I'm currently a member at Curves. I'm trying their weight loss plan. I've been on it a month and I've lost 1 pound. I feel like I'm working my butt off, but apparently not. I guess this is my story up to now. Thanks for listening.

Though I had not intended to converse with any participants until after the study (unless they specifically asked me a question), I felt compelled to immediately respond to this young woman who had shared so much with me. I believe the feelings her *testimonio* invoked in me were representative of how others might feel when reading these or another woman's deeply personal words, which is one reason I share portions of my response here. Additionally, my quickly-written response to S's e-mailed *testimonio*

works as a framework from which to discuss the themes of resistance that emerged from the other participants' narratives. I replied to her with this:

> Thank you so much for sharing your story. So much. I know your pain so well. Not all of it, but lots of it. I'm really grateful that you felt comfortable opening up about this stuff that is so much a part of your life, but a secret part of it. Maybe going through this process hasn't felt transformational to you at this point, but I really believe it has been and still could be. Think about it: you just told me – eloquently, BEAUTIFULLY – about experiences and feelings you've literally never fully shared with anyone before. Whether it feels like it at this moment or not, that is liberating. You've now shared a burden that you have carried alone for 20 years. I can assure you that I now carry that burden of your pain along with you. I cried as I read your story, sitting in my car alone, because I know exactly what you're feeling and I've heard countless other women's stories that sound shockingly similar to what you have shared. I'm often unfazed by those stories because I've heard so many, but not yours. My tears weren't just in empathy with you, they were out of hope for you. You know as well as I do that this story is unfinished. The ending you wrote stands in stark contrast to the whole of it, and it's not an ending – it's a cliffhanger! It's a turning point. I know the story you told me is only your Part 1 of a 2- or 3- or 10-part series of stages in your life with your body.

Resilience

The remainder of my response to this participant represents a personalized introduction to one of the most important means I identified for resistance to distorted health ideals through this study: resilience. I included some discussion of resilience, or "positive adaptation despite adversity" (Fleming & Ledogar, 2008; Luthar, 2006) in the curriculum as a hoped-for outcome of engaging with the HML curriculum (see Appendix H for an excerpt from Unit 3.). Participants' *testimonios* and responses to Questionnaire 3 demonstrated compelling evidence of the development of resilience and recognizing opportunities for using body image challenges as impetus for becoming more resilient and making more positive health choices. In research, resilience is characterized as both a trait and a process, with "resiliency" referring to the process of "being disrupted by

change, opportunities, adversity, stressors or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption," (Richardson & Waite, 2002, p. 65). The Richardson et al. (1990) Resiliency Model outlines a framework of three possible outcomes for individuals dealing with adversity: reintegration with loss, reintegration back to the comfort zone, and resilient reintegration. The possibility of resilient reintegration, or growing and thriving through adversity and in spite of it, is an inspiring ideal that was demonstrated throughout several participants' writings.

Almost every personal narrative submitted for this study referenced some sort of body image or health-related adversity, which can be referred to as a disruption from someone's comfort zone – or what resilience theorists termed "biopsychospiritual homeostasis" (Richardson et al., 1990). Unfortunately, as this study and many others suggest, a widespread state of "normative discontent" exists among females in contemporary culture, with the majority of girls and women dissatisfied or even disgusted with their bodies (Levine & Smolak, 2002; Rodin et al., 1985). I argue this "normative discontent," which is so pervasive that it goes unquestioned and unnoticed, can be equated with most girls' and women's "biopsychospiritual homeostasis," or comfort zone. Richardson (2002) calls this "a point in time when one has adapted physically, mentally and spiritually to a set of circumstances, whether good or bad" (p. 311). Normative discontent regarding body image represents an adapted state or comfort zone, though it certainly is not comfortable for the girls and women who are constantly preoccupied with their appearance, self-objectifying, and engaging in dangerous practices like disordered eating or sedentary lifestyles as a response to body anxieties.

The push to move someone from that state of homeostasis, whether by her own choice or an unplanned event, is what Richardson (2002) calls a "life prompt," which can originate from within a person or externally – new experiences, information, thoughts, or feelings. The HML curriculum and questionnaires were designed with the aim of initiating prompts through new health and body-related information and feelings that can arise from such information. In resiliency theory, the more significant or serious prompts can act as a stimulus to move someone out of homeostasis, which makes them a "disruption." A disruption can be positive or negative, but it requires a response, which is where a person has an opportunity to demonstrate and exercise resilience. "Almost all, if not all, disruptions have an opportunity for growth," says Richardson (2002, p. 312).

In bridging critical feminist research with the psychospiritual health-oriented field of resilience, one shared connection between the fields is particularly significant – the idea of disruptions. Judith Butler's (1993) canonical work *Bodies That Matter: On the Discursive Limits of Sex* described reiterations and repetitive performances of power-laden gender norms, including a discussion of "enabling disruptions," which are opportunities to shed light on ideology and spark resistance. Indeed, Richardson's (2002) theorization of disruptions can very much be classified as "enabling." As he describes it, "Disruption is required to access the components of innate resilience because biopsychospiritual homeostasis makes no demands for improvement or growth" (p. 312). I recognized the possibility for an enabling disruption in S's *testimonio*. My response to her continued this way:

> Of course reading a curriculum about recognizing and rejecting unreal ideals for beauty and health isn't going to suddenly convince you that you are perfect, that it doesn't matter what others think, that thin body types won't be more privileged in many many ways, that weighing more than your family and your ideal self is a

> problem you can just forget about. I would never claim that to be the case – especially not for someone who has lived a life of regular body shaming from the ones you love most. But remember that part in Unit 3 about enabling disruptions? I know that you could consider this point, after sharing those deep dark secrets, as a disruption. Disruptions in life can go three ways: 1) You could let the burden of your pain sink in and overwhelm you and leave you buried in shame that keeps you self-conscious and isolated. 2) You could forget about this experience, the curriculum, the things that you read and KNEW were true, the things you shared, and dismiss it all because thin women will still be considered by many to be more beautiful than larger women, and because your self-worth depends on losing weight. That's your comfort zone. It's where you have been living forever. OR 3) You could recognize that your comfort zone is not a great one, and let this moment be your turning point to change – to take serious steps to see yourself as much, much more than just a body that doesn't look or weigh how you want it to. That's called "resilient reintegration" and it will be the best thing that ever happened for your health or happiness.

Several *testimonios* included descriptions of past disruptions, such as deaths of family members, insulting comments from others, pregnancy and giving birth, along with accompanying stories that explained how the disruption resulted in the resiliency process – 1) the participant reintegrating with loss, 2) reintegrating back to the comfort zone, or 3) resiliently reintegrating. One participant's example of experiencing a life prompt that started her on the path to resilient reintegration through healthier choices is this:

> The media I'm sure has an impact on how I view my body. Wanting to always be thin and beautiful. Fit into the most popular trends. I always knew my body shape was not the same as those models. So, I spent a lot of time working on getting my body to be as skinny as I could make it. Throughout junior high and high school, I went through small bouts of anorexia without knowing it. Nothing that required medical attention or fixing, but it wasn't until I was sitting in my Medical English class my senior year that I realized what I had been doing. It made me physically ill. So, I guess you could say that my interest in Medicine brought me to a full awareness of what is healthy for everyone, that the measure of healthiness is not the same for everyone, and the requirements to keep oneself healthy is not the same. I have always been an exercise/healthy junkie since then.

Pregnancy proved to be a significant disruption to many participants' body image, whether leading to resilient reintegration or reintegrating with loss. One *testimonio* said this:

> Weight and body image haven't ever really been an issue for me, that is, until I got pregnant with my first child. When I got pregnant, I gained more weight, as is normal. I didn't really think much of my weight gain until my doctor made it a point in every appointment to point out how much weight I had gained in the previous month, 2 weeks, etc. Each appointment I heard something like, 'Wow! You gained 10 pounds this month, you really need to be watching how much you gain.' … But by all standards, the baby and I were healthy.

She went on to say she was very dissatisfied with that doctor (who failed to diagnose her with a serious condition that caused her to swell), and had since found a new one, but the adversity of the constant attention to her growing body she received in the past has followed her. Her experience reflects the process of experiencing a disruption in her body image and then reintegrating with loss.

> But because of her preoccupation with my weight while pregnant, I have developed a preoccupation with my weight while pregnant as well. I am now pregnant with my third child, and find myself saying and thinking things that I shouldn't but should celebrate more the wonderful thing that is going on inside my body. I find myself comparing my belly to other pregnant women much further along than me, etc., and telling them how jealous I am. I hate that I do this because we are all different people with different body types and I should celebrate those differences and not be jealous of them.

Another *testimonio* illustrates an example of experiencing a body image disruption and reintegrating with loss. She described being an average size all through high school and feeling fine about her body until she experienced adversity through dating a young man who constantly commented on her weight. "Ever since breaking up with him and finding out from mutual friends that he had called me fat and said that I was too big, I started to question myself and started to feel self-conscious. I kind of spiraled the opposite way though, and managed to gain 20+ lbs."

Happily, not all *testimonios* that described disruptions and reintegration with loss ultimately ended up that way. Many demonstrated varying paths through the resilience process, including starting out on a path toward increased body shame or unhealthy

behaviors and then identifying or gaining some power to take a path toward resilient reintegration. One example of this is as follows:

> Growing up, I never really cared too much about whether I was thin or not. When I got to college, I stared going to the gym because that is what my friends did. My dad got diagnosed with cancer and I really lost it. My way of controlling my emotions was by exercising. I became obsessed. I would work out way more than normal in a day and pushed myself to my limits. Despite my excessive exercising, I never once felt good about myself, and when I would look in the mirror, I focused on the bad, telling myself that I wasn't good enough. That I was worthless.

Fortunately, her story did not ultimately end with this loss, as she went on to describe another disruption that could this time be classified as "enabling." She said, "It wasn't until I served a mission and wasn't able to exercise myself to death that I realized how stupid that all was. I was able to realize the importance of who I was and not what I looked like."

Over and over again, participants' narratives described experiences of adversity, disruptions, and often reintegrating with loss at first, but later transforming a disruption into an enabling one and reintegrating resiliently, healthier and happier than before. One participant described being a confident young girl who always weighed less than 100 pounds, until ninth grade. "I noticed myself starting to obsess about how much weight I was gaining. I was on the scale every day to see how many pounds I had gained. I started obsessing about ways I could lose weight so I wasn't over 100 pounds." Her story goes on to demonstrate an example of an enabling disruption that was not caused by an outside force or event, but simply an internal prompt.

> One day, I was weighing myself in the bathroom and I realized that if I didn't stop this obsession, it was going to destroy my life, so I vowed to never look at the scale again. From that day on, I decided that if I liked who I was and if God liked how I am, then I was OK with who I was and how I looked. I decided to start

> judging my health by how I felt instead of how much I weighed. I did not own a scale until I got married.

One participant's *testimonio* described having her first baby, losing all her "baby weight" quickly and effortlessly, and feeling great. After giving birth to her second baby, she experienced a disruption to her body image. "This time it was a little more difficult. I was very active through the pregnancy and the delivery was great, I just had a hard time losing the weight. Months went by and no change!!" In response to this disruption, she considered reintegrating with loss. "As hard as it is to admit, I considered vomiting after meals to lose weight. I once kneeled at the toilet for minutes (what seemed like hours), debating if I could do it." But she viewed this action as a wake-up call and made the choice to turn this experience into an enabling disruption.

> I couldn't! I refused to allow myself to do it. I knew better. So I worked even harder and ate healthier! I am now in the best shape I have ever been in. I know the media world puts so much stress on women to look a certain way, and yes, it's stressful, but I also know it's not the most important part of my life. Being happy is! And being fit and healthy makes me happy!

Another participant described growing up surrounded by grandparents, extended family, and parents that made such poor health choices that they couldn't properly care for themselves and eventually suffered complications from diabetes or died from cancer. She described watching her father have both feet amputated and undergo a quadruple bypass, and being there when he died at age 63 in his home. Rather than allowing this adversity to drive her toward unhealthy ways of dealing with the heartache, she chose to reintegrate resiliently by dedicating herself to maintaining her health so her daughters will never suffer as she did through the premature deaths of her family members.

Another participant described her process of being disrupted by an embarrassing experience, reintegrating with loss, and finally finding a path to resilient reintegration:

> Because I was so thin, I was afraid to eat in public. One day, my brother brought a girl home that he was engaged to. The family went to dinner. It had been a long day, and I was hungry, so I ate a big hamburger. It happened to be really messy, so when I was done, I went to the restroom to wash my hands. As soon as my brother's fiancé saw me walking out of the restroom, she yelled across the restaurant "are you bulimic or something?" I was horrified! I was always worried that people thought I had an eating disorder, and she had just confirmed what "they were all thinking." After that, I got really distant, and would not eat in front of anyone. It seemed like the more I ate, the more weight I would lose. It was so frustrating. After high school, I realized that there was nothing I could do about my weight, and I was missing out on a lot of fun times with friends and family. I gave up on worrying about what people would think or say when they saw me eating. It was not until about a year ago that I found out that I had a food allergy that was causing my body to not be able to retain the nutrients that it needed to be a healthy weight. As I have learned more about myself, I have come to realize that it doesn't matter what my body looks like as long as I am able to do the things I love with the people I love.

Through analyzing the personal narratives and *testimonios*, it appeared that several participants viewed aspects of the Healthy Media Literacy curriculum as an enabling disruption that served to destabilize the painful but unquestioned comfort zone of body shame and self-objectification. These responses demonstrate that the critical awareness of distorted health ideals and their influence on women's body perceptions that can be developed through Steps 1 and 2 have power to shift someone's worldview of health, thus prompting a disruption that can lead to resilient reintegration. One woman described being in seventh grade and being incredibly self-conscious about a tiny pinch of skin between her armpit and her chest that showed in her strapless dance costume and later realizing "how petty it was to be so concerned about a pinch of skin when I looked like a twig!" She went on to describe a disruption she was experiencing as a result of reading my *testimonio* in Step 3.

> I now wonder if I'm doing the same thing to myself when I critique my body in a swimsuit. The sentences in your dissertation: "I have not missed an opportunity to go swimming in the past several years, and have never once regretted that — no matter what I looked like in a swimsuit. I decided that I will always choose fun,

> friends, and active experiences over body anxiety, and that empowering decision has brought me more happiness than avoiding pools and beaches *ever* could. 'Bikini body' or not..." really struck me. I dread summer gatherings at the pool, beach, lake, or hot tubs because I do not feel comfortable with my body in a bikini, and I know that I have made excuses, faked illnesses or accepted other invitations only to avoid these situations. I stress out until I find a suitable reason not to attend (and not an obvious reason – of course – because I want to appear to others like I am comfortable in a bikini).

Here, she turns the experience of reading a *testimonio* that resonated with her into an opportunity for an enabling disruption that can improve her self-concept:

> Reading those sentences that you wrote made me regretful, hopeful, and scared at the same time. I know that I am not overweight – I do not look like a swimsuit model, by any means – but I'm fit and I'm healthy. I regret all of the fun times that I've missed, I'm hopeful that I can change my thinking and start to feel comfortable in my own skin, but I'm scared at the same time because I have a long way to go before I can change my thinking. I'm scared to be "ok" with myself and no longer strive for a better body or to lose my belly fat, because in some sense, it feels like failure, but I know that I will be happier once I do achieve it – despite what I may think. I plan to no longer critique my body and, if I'm feeling down, focus instead on how I can make better eating and exercise choices tomorrow.

This participant's description of being scared to give up on achieving appearance ideals is noteworthy, since so many women have been trained to seek for physical perfection throughout their lives with the promise of happiness, success, love, and desirability upon achieving those ideals. Forfeiting those lifelong aspirations – despite how unattainable and harmful they may be – can be a challenging process.

After spending her entire life trying to achieve those ideals, 1 participant described heart-wrenching experiences with disordered eating, sneaking diet pills as a teenager, and excessive exercise as an attempt to "try and get skinny" and look better in her softball uniform and lifeguard attire. "It seems like I've been in a battle with my body forever," she said. "And no matter how hard I'm working, I have yet to be satisfied! By worldly standards, I'm never going to be pretty!" From her self-objectifying and self-

deprecating responses in Q1 to this *testimonio*, it became clear that this participant experienced a dramatic disruption in terms of a change of heart, which she described as such:

> I'm coming to realize that 'worldly standards' are unrealistic and false. I need to appreciate my body for all the good things it is, and not the fact that it isn't a dancer's body or a rail-thin model's body. It is MY body, and my husband loves it … why shouldn't I?? I want so much to like my body, to be comfortable in my own skin and not let what I think others are thinking of me bother me. I want to see what my husband sees and be happy with it. That's my goal now! Not to reach a certain weight or wear a certain size. I'm not even going to step on a scale for now. My goal is to accept me for me and know that I am working hard to be healthy and fit, and that is what is important.

Shortly after, the same participant e-mailed me again to add another section to her *testimonio*, saying she thought this experience was a good sign of her progress. She explained that a couple of months before she started the study, she had signed up for a 12-mile obstacle race and had been training to prepare for it after having a baby via C-section and struggling to recover. "I didn't look or feel how I wanted to by the time the race came up. I felt like I'd be the fattest slowest girl on the team and knew I wasn't going to look good in my tight pants for the race. I considered postponing – how ridiculous!! – and waiting for the next one, thinking I may LOOK better by then." After completing Units 1 and 2 of the HML curriculum, she started to reframe her thinking about her body, and decided to complete the race during the third week of the study. Her experience represents an example of resilient reintegration, starting with a lifelong state of normative discontent and then choosing to use the knowledge she gained through this curriculum as an enabling disruption. She wrote:

> I made myself realize how far I had really come and how incredibly hard I had been working and said WHO cares what they may think I look like! Or more realistically, who cares what I think I look like!! I'm going to do this!! So I did and it was hard and amazing and so fun! And at the end, I felt so empowered that

> I had finished and accomplished this goal of mine. And honestly, I feel better about my body just in accomplishing this goal. I think it has been a huge stepping stone for me in helping me realize that what I think I may look like should never stop me from pushing myself and trying new adventures to help my life be the fullest it can be. I have let it stop me before. I'm not in the future.

Richardson and Waite (2002) said, "The resiliency process is the experience of being disrupted by change, opportunities, adversity, stressors, or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption" (p. 313). There is no doubt that body shame, disordered eating, and other issues participants described in their *testimonios* can be considered "adversity, stressors or challenges," as referenced in this definition of the resiliency process. Unfortunately, statistics show that too often women seem to be reintegrating to a homeostasis of "normative discontent" in the face of such adversity, rather than flourishing through the process of recognizing distorted body ideals and health perceptions, then redefining and resisting them. By utilizing a process geared toward critical health and media literacy, such as this HML program, women can choose to experience an enabling disruption and achieve resilient reintegration to improved body image and health. This process can represent the means to "access personal gifts and strengths to grow stronger" (Richardson & Waite, 2002).

Analysis of participants' personal narratives and *testimonios* proved to be a meaningful avenue to gather understanding of women's barriers to positive body image and physical health, as well as strategies to resist those barriers and associated distorted health discourse. Many of those strategies for resistance align with traits and skills that researchers have identified as being key to resilience, including characteristics specific to body image resilience.

One participant, whom I will call "M," described 9 years of exercise obsession and constant bingeing and purging because "I wanted to be thin. I wanted to be beautiful. I wanted to be on Broadway. I wanted to fit in my cheerleading uniform and be the smallest on the dance company." This state of suffering was absolutely her homeostasis for about a decade, according to her narrative, but now – just a few years later – she fits in the "feels positively" category from Q1 and describes herself as having overcome her addiction and being "very healthy and strong." How does this happen? What are the strategies or traits that can be accessed or cultivated to help someone on the path to resilient reintegration, as opposed to remaining in a normative state of disordered eating, body shame, or poor healthy choices? M's *testimonio* gives some ideas that align with what resiliency research shows.

Spirituality

Among the positive influences that helped her overcome her eating disorder, M specifically credited a "spiritual connection" and described a new knowledge that she was "more than just a body." Spirituality is well documented as a key to resilience, as contemporary resiliency research incorporates a focus on spiritual dimensions of internal motivation and power. Richardson (2002) says resilient reintegration, or experiencing insight or growth through disruptions, requires increased energy to grow, and resiliency theory posits that the source of that energy is a spiritual source or innate resilience. Similarly, resilience pioneers Werner and Smith (1992) referred to this force as an "innate, self-righting mechanism" (p. 202) and Native American educator Iris HeavyRunner called resilience "our innate capacity for well-being" (HeavyRunner &

Morris, 1997, p. 2). The idea that humans are "genetically predisposed with more potential than they are conscious of" (Fleming & Ledogar, 2008, p. 15) is an inspiring notion that has broad application to health promotion programs that aim to promote self-efficacy and hope in individuals struggling through disruptions or trials.

M's *testimonio* offered an example that clearly aligns with this research, as she described confiding in her Mormon bishop at the height of her eating disorder.

> My church congregation was led by an impressive man. I met with him one day to talk about some of my struggles … I brought up my eating disorder. He looked me straight in the face and said, 'If you can overcome this, you can overcome anything.' That really hit me. If I can overcome bulimia, I can overcome ANYTHING? Really? That motivated me. It really did.

For this participant, an expression of confidence from her spiritual leader provided a bit of empowerment she had not previously felt. After she confided in her bishop about her illness, M said she began to see herself in a more holistic way, stating:

> [Bulimia] is the product of basing your entire identity on your physical form. But all physical forms pass away. And who I am is so much more than my body. Especially when I am the only one seeing my body through a distorted mental image – not what it really is. Bit by bit, these truths sank into my soul. And the healthier my thoughts became, the healthier my eating became, and the healthier my body.

Choate (2007) developed a body image resilience model that includes five protective factors, one of which is "holistic wellness and balance," based on the Wheel of Wellness model of Myers et al. (2000), which privileges spirituality as central to achieving health at all levels. Choate (2007) found:

> There exists a positive relationship between spirituality, mental and physical health, life satisfaction, and wellness. It follows that if a woman draws her sense of meaning from a spiritual force that goes beyond herself and that provides coherence and purpose to the universe, she will find less need to focus on her weight, shape, and appearance in an attempt to find happiness or life satisfaction (p. 323).

Though media and corresponding cultural discourse perpetuate a focus on only one area of life for women – physical appearance – Choate (2007) emphasized the importance of encouraging females to develop and value their strengths in multiple aspects of their lives. "If women learn to experience fulfillment in all life dimensions, they will place less importance on weight, shape, and appearance, thus strengthening their body image resilience. Spirituality can therefore serve as a buffer against sociocultural values espousing thinness as the only avenue through which happiness may be achieved" (Choate, 2007, p. 323).

Participants' writings echoed the importance of spirituality as a buffer against distorted ideals of health and fitness:

> Joining the Church of Jesus Christ of Latter-day Saints when I was 18 improved my body image. Believing that I was made in the image of God and that I was given a body for a specific purpose on earth has made me conscious of the way I treat my body. I want to treat this gift from God with respect and love because I know God loves me. I also respect and love my body because I hope to someday have children and I think the things our body does are so amazing.
>
> My faith and belief that my body is a divine gift and has eternal significance is a great influence for good.
>
> My spiritual learning, that my body is a gift from God and needs to be taken care of and not used as an object. (In response to what sources influence the way she defines health and fitness.)
>
> I learned self-worth from my religion.
>
> I believe in God and that my body is a great gift from him.

In my response to S's *testimonio*, I reiterated a couple of sources of help as strategies for her to resist the crippling body shame she described. I expressed confidence in her and tried to provide a new, more holistic context through which to think of herself and her body.

> If you don't already know it, let me tell you that you are capable of so much more than looking "hot" by the standards you're so used to. You are ridiculously smart, beautiful (yes.), generous (apparent by your time and feelings), strong (physically and emotionally, clearly) and more ... We have really similar stories, and your story doesn't continue the way you described. I can feel it. I want you to know I am so grateful for your openness and I feel a lot of love for you. I'm weirdly excited for you. Please go back and consider some of the strategies I described in the last couple of units and humor me by testing out one or two of the ones you feel are most relevant to you. And please consider how different your life would be if you saw yourself as more than just a body that doesn't look how you think it should. What have you gained from experiencing what you have been through? How would your life, personality, choices and strengths be different without struggling with your body image? … I really believe that if you are open to it and looking for it, you will experience some small changes that could have major positive consequences for you and start you on a new path. I'm not saying quit trying to lose weight or disregard your appearance. I'm saying your value as a person is so tied up in a bunch of lies about what acceptable bodies look like, and it doesn't have to be. I don't know if you are a spiritual or religious person at all, but this is a tremendously spiritual journey for everyone who works to see themselves as part of a bigger picture than the limited, limiting cultural picture we are taught to view ourselves in. Spirituality, or tapping into a higher source of power in order to overcome challenges and feel peace, is an extremely important strategy for resilience, but it's one that is difficult to talk about in an academic setting. I hope if you are spiritual or religious in any way, that you'll consider how to utilize that power in your body image battle. I will on your behalf too.

S's response validated and demonstrated a few of the strategies for resistance I hoped the HML curriculum would cultivate in participants – or help them cultivate in themselves. Specifically, these include the potential for developing resilience; the power of *testimonio* to give voice to oppression, to spark critical self-reflection, and prompt a start to the resilience process; and the power of social support to provide a sense of solidarity and spark feelings of empowerment to achieve health. I will use S's response to me as a framework from which to discuss the aforementioned strategies for resistance.

> Lindsay. Thank you. I'm sitting here crying and crying and crying. But it isn't a sad cry. It's a release cry. I think I really needed to get all of that out. I've tried ignoring it for so long that I didn't even realize what a burden it was. Thank you so much for listening. Thank you so much for responding. Even though I've never met you it means a lot to hear you say the things you did. Sometimes it's just nice to know there are people out there rooting for you. Yes I'm religious. I'm LDS.

> And I will try your 3rd option. I really will try. It's time for change. And I'll keep you posted. I think I'd actually love to keep emailing you. Maybe all this time it's been my silence that has kept me so crippled.

Critical awareness of distorted health discourse can shed light on women's internalized body shame that often goes unchallenged. This awareness, especially when sparked by a curriculum like HML that incorporates a focus on resistance, can feed into a cycle of sharing stories, identifying with those experiences, uniting with other women and prompting continued resistance and change. By including a discussion of resilience that emphasized recognizing enabling disruptions as opportunities to develop and demonstrate resilience in body image and physical health, in conjunction with a prompt to write one's own *testimonio*, the HML curriculum provided a means for participants to give voice to body-related oppression and invite empathy and solidarity. Open, honest sharing of personal experiences can serve to break the silence surrounding body shame by generating unity and solidarity among women whose experiences may resonate with others (Brabeck, 2004).

S's experience with sharing so much of her pain through *testimonio* represents a disruption in her life of body shame that proved to be an enabling one. That disruption started her on a path toward resilience and resistance with new feelings of self-efficacy to change her not-so-comfortable comfort zone of being crippled by her silence. I see S's experience with completing the HML curriculum and breaking her silence through *testimonio* as exemplifying the power of critical awareness of body shame and starting the path to resilient reintegration. A quote by Chicana feminist scholar Gloria Anzaldua (1999) describes this process eloquently:

> Every increment of consciousness, every step forward is a *travesia*, a crossing. I am again an alien in new territory. And again, and again. But if I escape conscious

> awareness, escape 'knowing,' I won't be moving. Knowledge makes me more aware, it makes me more conscious. 'Knowing' is painful because after it happens I can't stay in the same place and be comfortable. I am no longer the same person I was before. (p. 70)

Sports and Exercise as a Means to Develop Positive Physical Self-Concepts

An interesting theme throughout many of the *testimonios* and questionnaires was the presence of positive statements participants made in relation to competing in sports or engaging in physical activity of many sorts. Even S, who provided a detailed account of crippling body shame she lived with since adolescence, described a deep sense of pride in her athletic accomplishments and abilities. She expressed a dislike of always being compared to her very thin sister who never exercised and ate whatever she wanted, but found comfort in her abilities despite her appearance. "I work out 4-6 times a week and remain overweight. The only thing that makes me feel better about that is I know I'm stronger than she is. I can swim faster and longer and lift more than she can by FAR. I look less healthy but I know I'm not." Other participants described their feelings about athletics or physical accomplishments these ways:

> I miss the feelings of accomplishment I used to get from swimming. Rock climbing is fun, but I know it will be even more fun when I get better and have more climbable routes.
>
> When I was playing sports, I felt a lot better about everything in life. I had more energy and was all around more happy.
>
> Recently, I have started biking and I am super excited by the way my body has responded. I have quadrupled my distance within 3 weeks, even after having the flu last week.
>
> While working out to prepare for this race … I felt soooo good about myself going into the race! I was confident and happy with what I had achieved in my three months of preparation. I need to remember that!

> [One] major thing that influences the way I feel about my body is playing sports in high school and competing in college athletics …. Competing in sports made me feel good about my body.
>
> In the last year I feel like I was at the fittest I have been in my adult life as I was training for and completing a marathon. I can't describe what an incredible feeling it is to just go out and run for pretty much as long and as far as you want and not feel like you're dying.
>
> My proudest moment happened in high school. The Army was there trying to get students to enlist. They had set up a pull up bar and were giving away prizes for male students that could do 15 or more pull-ups. They only were letting girls do the bent arm hang. I was so pissed off! So I told them that they were being stupid, by not allowing girls to do pull-ups. I got on the bar and did 20 pull-ups. I was so proud of myself when I finished.
>
> I feel happier when I exercise regularly and I love the feeling of improving – of being able to run faster than I could before, or dance all through Zumba easier than I could when I first started going.
>
> In junior high, I spent all my time wrapped up in athletics. It's what I loved and I excelled at it. … I was a softball player. A catcher. A short setter in volleyball. I was proud of my physical abilities, believing I could do anything I put my mind to. I LOVE exercise. I love the way it makes me feel. Is it because I need to fit into a size 2 pant or a size small shirt? No. It's because I want to be able to feel strong, powerful, and confident. There is a sense of accomplishment when a certain speed or mileage is accomplished – a joy that cannot adequately be described. Everyone can and should participate in some form of physical activity. Not just to keep their bodies healthy and strong, but to improve their own belief in their physical abilities and to encourage others along the way.

These overwhelmingly positive statements regarding sports and exercise are reflective of research that shows physical activity promotes positive body image in girls and women. A focus on physical activity and capability rather than appearance or measurements is what Choate (2007) termed "positive physical self-concept." This is represented in one's attitudes toward physical activity, since physical activity is shown to lead to body satisfaction when girls develop an appreciation of what their bodies can do, rather than how they appear to others. When women exercise to improve their overall

fitness, rather than to improve appearance, they are more likely to possess positive body image (Song, 2011).

Alternatively, more aesthetically focused activities like cheerleading and dance did not seem to be associated with such positive feelings among participants. Instead, participants tended to connect memories of involvement in those activities with instances of body shame or self-consciousness, or a heightened awareness of body ideals.

> I grew up dancing and cheerleading. These are two sports where your body image gets seriously distorted. I lost a lot of weight in high school and was probably too skinny for my frame. I did it mostly in a healthy way but was obsessed with exercising. I would run a few miles before going to dance practice for 3 hours and then run home as well. I remember when I started at a new cheerleading club in 8th grade and my mom told me that we should make some changes if I wanted to look like the other girls … I've always been very aware of my own body and other people's bodies. I don't know if it is about average or if I think about it more than other people. I would say I probably think about it more than average. I don't know if this is because of media, being involved in dance and cheerleading when I was young, or what. I'm just very aware.

A professional dancer and choreographer, M created a *testimonio* that detailed a driving force behind her bulimia. "I wanted to be thin," she wrote. "I wanted to be beautiful. I wanted to be on Broadway. I wanted to fit in my cheerleading uniform and look darling in my gymnastics leotard and be the smallest one on the dance company." While recovering from her eating disorder, M said her involvement in aesthetically focused activities proved to be a barrier to achieving a positive physical self-concept. "I was still heavily involved in dance and theater – thus subject to what seemed like constant body scrutiny. No matter what anyone says, looks matter in show business. I was talented enough, but I was busty and short and fiery with a small stature but huge voice."

Self-objectification research indicates that girls and women who are able to learn and access a positive physical self-concept as a way to experience a powerful, instrumental sense of self are less prone to self-objectify. While studying the effects of coverage of female athletes, Daniels (2009) sought to find out how objectifying images affected female viewers. She selected images of women portraying sexualized athletes, performance athletes, sexualized models, or nonsexualized models, and asked nearly 600 participants ages 13-22 to complete worksheets measuring self-objectification after being selected to view certain images from one of the four categories. Those who had looked at images of athletes doing athletic things (action shots, active poses) self-objectified much less than those who saw the sexualized images. The reverse was also true, as participants who had viewed sexualized images reported more sexualizing and objectifying statements about themselves than those who had seen the performance-based images. Participants were more likely to describe themselves in terms of beauty or appearance on their worksheets, and used more negative descriptors about their looks and feelings toward themselves.

Significantly, the girls and women who saw the performance-based images wrote more physicality-based statements that described feelings of empowerment based on their bodies as instruments instead of objects, and those statements were mostly positive in tone. This research brings to light the influence of objectifying media representations of women, but also the potentially powerful influence of nonobjectifying, athleticism-focused images that can prompt more positive physical self-concepts in viewers. Daniels' (2009) found participants who viewed images of women playing sports in active poses, rather than the more common objectifying, passive positions, were influenced to turn

their focus to what their own bodies could do, rather than how they looked – which is the definition of a positive physical self-concept. Furthermore, viewing those positive, powerful images did not trigger self-objectification in participants, and may have caused it to subside for some participants.

Correspondingly, 1 participant in my study described a similar experience viewing an image of female athletes that affected her positively at a young age and remained in her memory ever since.

> I remember being really inspired by a picture of Stanford's women's swim team. It was a really cool photo. They had their swim caps on and were facing away from the camera. The team had rolled their swimsuits down to look like men's speedos. All the women were flexing and their backs looked just like guys. That was the best part. People thought it was a picture of the guys' swim team until they looked close or read the caption. It was so cool to see these female athletes, not be afraid to be strong.

Critical media and health literacy requires an emphasis not just on media consumption, but also on media production. Representing female bodies – especially female athletes' bodies – in ways that emphasize athleticism and strength rather than appearance and sexuality is a promising way for media creators to promote positive physical self-concepts. This knowledge is also of great benefit to media viewers who wish to avoid media that prompts self-objectification or seek media that promotes positive physical self-concepts.

Critical Questioning

An integral component of critical media literacy in general and the HML curriculum in particular is critical questioning – both of media or cultural discourse and personal self-reflection. Whether prompted by the questionnaires, some stimulating or

disruptive aspect of the curriculum, or the opportunity to write a *testimonio*, participants who were critical of their health perceptions and choices or body image feelings proved to be more likely to experience and demonstrate body image resilience. Choate (2007) identified critical thinking skills as a buffer to thin ideals and body dissatisfaction in her research on body image resilience, and participants also identified this skill as crucial to developing and maintaining a positive body image. M's *testimonio* specifically acknowledged intelligent self-reflection as a key to her recovery from a decade-long eating disorder and continuing distorted self-image. She described seeing a therapist who assigned her to identify which emotions she was feeling throughout the week and when she was feeling them. "I was trained to be very in tune with my emotions – when I was feeling them, why I was feeling them, how to manage what I was feeling. I am very grateful that I was given opportunities to develop this skill and sharpen my emotional intelligence. It has been a great blessing in my life."

Critical questioning of media also proved to be a strategy that participants recognized as being crucial to their own body image perceptions. Whether the result of learning about media literacy through the HML curriculum or through a past job or class, several women described their ability to critically question and understand media messages as an important means for recognizing and rejecting distorted health ideals. After being asked if she helps herself differentiate appropriate health and fitness messages and beliefs from distorted, profit-driven messages and beliefs in Q3, 1 participant described her newfound health and media literacy this way:

> I do now. I can recognize and acknowledge images as being touched up and unrealistic. I even alerted my husband to the fact, and we are always pointing examples out to each other now. Recognizing that just because I don't look the same in an advertised outfit that is being modeled, does not make me unhealthy or

> unattractive. I didn't realize before that a lot of the 'motivational' fitness messages out there were really just making me feel worse or motivating me only to want to look a certain way, not necessarily to be healthy.

One participant said, "As I read magazines, watch TV, and see different images that distort what I believe, I have to remind myself what is important to me, what my priorities are, and what I believe. I also tell myself that half these ads are faked with Photoshop. They are not real. Sometime you have to take a step back and reevaluate things."

Another described working at an eating disorder treatment center during college, saying, "It was here that my body image only improved. By accompanying patients to different types of therapy, I learned more about media and body image and health and body functioning than I had known before and I gained a better appreciation for a HEALTHY body and not a skinny body." Another participant said, "In high school, I did learn about the way advertisements try to tell you to look a certain way in order to sell a product. It was awesome to have that education in high school about the media, but having a reminder certainly helped. Maybe it is because I had that education when I was younger that I do feel confident about my body and less concerned to look a certain way."

Through critical self-reflection, 1 participant described being able to understand one of her barriers to engaging in healthy behaviors, saying, "I feel like, compared to others, I am good enough. I'm not particularly healthy or fit but I am healthier and more fit than most people I see so I am not very motivated. I realize that this is an unhelpful mentality but have discovered this is the main reason I don't do more." She went on to say:

> I didn't think I had very many body issues until I started thinking more critically about it and have made several helpful realizations. I was impressed with the idea that it is not useful to compare my body to anyone else's or think badly about others because of the way their body looks to me.

Social Support

Honest self-reflection led multiple participants to consider the ways their interactions with others had impacted their body perceptions both positively and negatively. A few expressed a desire to allow themselves to be supported by others after struggling alone with body shame for too long. More than a month after S and I had our exchange following the submission of her *testimonio,* I was excited to hear from her again via e-mail. She wrote:

> You said it was OK if I kept emailing you, so I just wanted to let you know that two nights ago I had a really good talk with my parents. We were able to be really open and honest about body image and it's helped both of us forgive past hurts. It's still a process, but I can tell this is a really good step. I wanted to thank you again, because I wouldn't have talked to them if I hadn't written out the testimonio you told me to write. I told them about my experience with you and this study and we're all ready to move on and forward!

S's step of reaching out to her parents in open conversation represents a powerful strategy for cultivating positive body image and resisting distorted ideals: social support. Research shows one of the major factors that contribute to body satisfaction is social support (Choate, 2007), and the writings of participants in this study echo that finding. S provided a clear example of one way a *testimonio* could invite solidarity, empathy, and both peer and family support. Another participant echoed this sentiment, saying, "I do believe my most favorite [part of the study] was the personal story and the actual struggles that you went through. It is refreshing and reassuring to know that none of us

are alone in our insecurities. I feel like we can learn from each other and teach each other through our own personal struggles."

In addition to confiding in a spiritual leader and learning to view herself in a more holistic manner, M named "being unafraid to ask for and receive help" as a key factor in overcoming her unhealthy views and behaviors.

> A coworker of mine stood outside the bathroom one day as I was purging the doughnuts the front desk staff had just given us. When I came out of the bathroom, she kindly confronted me about the issue. It was the first time I had ever spoken to a peer about it. She told me it was unhealthy and I knew she was right. But I wanted so badly to be thin! I would do anything! Our conversation helped. Therapists helped.

Aligning oneself with a group is a crucial aspect of feminist scholar Cynthia Dillard's (2000) strategies for resisting dominant ideologies, and this requires openness and honesty. It was also one of the first and most prominent strategies mentioned by participants as a means to fight appearance obsession or distorted ideals about health. As in M's case, peer support even led to professional help at times when it was necessary. A follow-up e-mail from S several weeks after the study ended demonstrated that her path toward resilient reintegration continued long past the study and also included seeking professional help. She wrote:

> Hey! I'm doing great! My summer has been different than what I planned (I was supposed to be on a study abroad but it was cancelled) but despite my initial disappointment somehow, the summer has turned out absolutely great! I've also been really working on improving my outlook on body image. I've actually been meeting with a few healing coaches trying to work through it all. I really didn't know what a burden it has been on me before you and your wonderful study and friendship. :) I've still got a way to go but the improvement in my life is visible. Thank you so much. You have been a tremendous blessing to me. Keep up this wonderful work and I look forward to continuing our conversations!

By confiding in or bonding with other women, participants described overcoming obstacles that prevented them from making healthy choices. One described teen years

filled with embarrassment at "being so skinny," and a desire to go to the gym and lift weights in high school, "but I couldn't bring myself to go because people might notice the lightness of the weights I would start on. I never went." Peer support proved to be the turning point, as she went on to describe:

> When I got to college, the best thing that could happen to me was to live with a bunch of other women, who all had their own body issues. That's when I finally realized that unlike my five brothers, many or even most women were embarrassed about their body in some way. Together, we attempted to conquer our embarrassment. One of the things that we did is we went to the gym together. I was doing bicep curls with a very light bar, but my roommate was standing next to me counting and supporting. Years later, I would be confident enough in myself to lift weights with my brothers, then with several male friends, and eventually with my husband. I was finally okay with grabbing the lighter weights, but at that point, they were actually twice as heavy as what I had started with. It felt great to realize that I had become stronger.

This is an instance where social support led directly to a participant's appreciation of physical health in terms of what her body could do.

Social support was described as coming from a variety of sources, including husbands, parents, work or school associates, and in the case of one very tall participant, comments her grandma made to her as an adolescent.

> My grandma tried for years to help me see the beauty in being tall and slender. She tried hard to instill confidence in me by encouraging me to stand up straight, to hold myself and walk with dignity. She didn't want me to slouch and hide from who I was. As I look at my three daughters, I find myself saying those same things to them that Grandma said to me. 'Honey, hold your head up. You are gorgeous. Be proud of who you are, you don't need to look down or feel ashamed.'

In recognizing the power of positive social support to prompt feelings of body satisfaction and motivation to make healthy choices, participants also expressed a desire to provide support to others. Many women reported a desire to share the information they had learned throughout the HML curriculum with friends, family, or students, and many

also shared experiences of talking to others about what they learned. One said, "I try to disagree with negative body statements others make and to point out negative media to friends and family. I want to share good messages about bodies and help women understand that size does not equal health."

Several participants specifically expressed a desire to be a positive influence through their health choices for their children.

> I want my kids to know me and I want to be able to play with them and their kids for a long time. These girls, while they drive me crazy sometimes, are why I run. They are why I bike. They are why I am strong, and they are what I am strong for. I want them to grow up and know what healthy looks like, not have to figure it out on their own.
>
> I do not want my son to grow up feeling bad about his body, so I am trying to be a good role model.
>
> I am going to encourage my husband and my children to not worry about what they weigh and focus on getting outside more often. I do not want my two daughters to grow up with unhealthy ideals from inside the home because they are already hounded with it outside the home. Hopefully I can teach them to love themselves so they can combat the bad outside influences.

This desire to positively influence others in terms of their health perceptions and body image is similar to a variable Neumark-Sztainer et al. (2000) measured in a study geared at eating disorder prevention among adolescents, which they termed "self-efficacy to impact weight-related social norms among peers." In this experimental study that included a media literacy intervention, the researchers found this variable to be significantly improved in both short- and long-term testing. A major objective of the study was to "increase the girls' understanding that they do not need to be passive recipients of potentially harmful social norms, but rather that they have the ability to advocate for change" (p. 1471), which strongly resonates with the goals of this study. Rimal (2000) echoed several other studies that have shown health knowledge gets

translated into healthful habits through the mediation of perceived self-efficacy**.** Self-efficacy to not only achieve health for oneself, but also to be an advocate through promoting understanding of health among one's friends and family, is a crucial component of the fight against widespread body hatred and unhealthy behaviors among women.

One participant, who moved from the "feels negatively" category at the beginning of the study to the "feels positively" category by the end, expressed her self-efficacy to affect weight-related norms among peers this way:

> I think I have come to understand a lot better the impact that the media is having on me and on girls all around the world and the vicious lies that it is continually spreading. And I need to decide now to stand against them and to help other women do the same. We are all fighting against the same enemy. It has been a great experience for me to participate [in this study] as it has brought about many meaningful conversations with my mom and my little sisters especially as my mom and I are striving to help my younger sisters understand the truths about their bodies. It was helpful for me to share what I was learning with them.

Though long-term results are not visible through this study, some of the most promising statements came in terms of the hope participants expressed because of their attitude changes. One participant said, "I don't think I have any major changes yet but I do feel that a mental shift has begun which I do think will, over time, have big results."

CHAPTER 6

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study, though limited in scope and time, suggests that there are perceptible benefits from engaging with the Healthy Media Literacy curriculum. This chapter revisits the design of the research, then situates this work within academic literature and praxis. It concludes by suggesting the contributions this study makes to current knowledge about the relationship between self-efficacy and women's health and by mapping out areas of future research. Specifically, it suggests that informed by critical media and healthy literacy and the example of *testimonio*, women can increase their self-efficacy and cultivate strategies for resistance to distorted health ideals through writing narratives that bear witness to their own lived experiences.

To investigate women's resistance to appearance-focused health ideals, I created an online curriculum designed to promote health and media literacy (titled "Healthy Media Litearcy" or HML) and recruited 42 women from northern Utah, ages 18-35, to engage with the curriculum and respond to questionnaires interrogating their body image, health perceptions, and strategies to resist distorted health perceptions. At the beginning of the study in Questionnaire 1 (Q1), 31% of participants reported feeling positively about their bodies, 19% reported mixed feelings, and 50% reported feeling negatively. At that time, 71% of participants described their feelings toward their

bodies in appearance-focused, self-objectifying terms, with 90% of those who felt negatively about their bodies describing themselves from an outsider's perspective. As noted above, percentages are included to provide general context for critical qualitative analysis. These findings indicate that it is unlikely for a woman to feel positively about her body when she views her body in a way that privileges an outsider's perspective.

When participants were asked how they defined health and fitness, responses differed but fell into three categories – those entirely consisting of terms focused on "internal health," which included descriptions associated with ability, internal physical indicators of health (like blood pressure, cholesterol, blood sugar, and so on), absence or presence of disease, and feelings of wellness; those entirely consisting of terms focused on "objectified health," which prioritized physical appearance, including body shape, weight, and the look of body parts; and "mixed health," which were responses comprised of a combination of both internal and objectified health descriptors. Among participants who had positive or mixed feelings toward their bodies, 71% responded solely using terms of internal health, and 29% offered a mixed definition of both internal health and objectified health. Among participants categorized as feeling negatively toward their bodies, half exclusively or primarily described internal health and the other half offered a mixed definition of internal health and objectified health. These findings suggest women who base their health perceptions on factors other than meeting appearance ideals – such as valuing their bodies as instruments for what they can accomplish and how they feel internally – may be more likely to feel positively toward their bodies. Only 5% of participants expressed positive feelings toward their bodies and simultaneously described a view of health that prioritized physical appearance. Accordingly, women who perceived

their bodies and their health from an objectified perspective were more likely to feel negatively about their bodies.

The presence of self-efficacy proved to be a significant difference between participants who felt positively about their bodies and those who felt negatively. Among the 21 who felt positively or had mixed feelings about their bodies, 100% believed they could achieve health and fitness. Alternatively, among those who felt negatively about their bodies, one-third reported having no self-efficacy. Of the two-thirds in the "negative feelings" category who did believe they could achieve health and fitness, 29% expressed serious doubts and reservations. Participants' feelings of self-efficacy to achieve health significantly increased after completing Step 1: Recognize, and Step 2: Redefine, of the HML curriculum, which consists of media literacy training focused on female body ideals and a health intervention focused on accurately defining health.

Six out of 7 participants who reported no self-efficacy to achieve health or fitness in Q1 reported an increased sense of self-efficacy to achieve health and fitness in Q2. Despite the reservations about being able to achieve health that most these participants expressed, all of their responses can still be viewed as an improvement over their initial responses, which reflected no self-efficacy at all. Of the 5 participants who initially expressed a sense of self-efficacy along with strong reservations or doubts, 4 returned to complete Q2, and all responded the second time with full self-efficacy and expressed no doubts that they could achieve health and fitness.

This increased sense of self-efficacy among 90% of the participants who initially expressed doubts or reported no self-efficacy at all is a promising result. It implies that shifting the focus from objectified health measures to internal, ability-based health

measures through an online health information intervention is a meaningful way to promote a sense of empowerment to achieve health. After engaging with a curriculum that highlights disparities between the ways health is represented in media or health discourse and real people's lived experiences, using both scholarship and reflection on personal experience, women were able to recognize distorted and objectified health ideals and reframe their perceptions. Participants' responses to Q2 reflected feelings of being more in control of their health and fitness outcomes by privileging the way they feel and what their bodies can do, rather than what they look like or weigh.

Another prominent change was manifested in participants' responses after completing Step 1 and Step 2 of the curriculum. This was reflected in their reasons for engaging in healthy behaviors. In Q1, about half answered with either a mix of objectified and internal health-focused terms or used entirely appearance-related terms, while half answered in purely internal health-focused terms. In Q2, 89% of participants answered in purely internal health-focused terms, with no reasons for changing health behaviors relating to appearance or weight. Responses to Q2 also reflected an improvement in the way participants felt about their bodies, with the number of women who felt positively increasing from 31% to 56%, the number of those with mixed feelings increasing from 19% to 32%, and those with negative feelings dropping from 50% to 12%.

Following the opportunity to write a *testimonio* relating to their body image experiences and finishing Step 3: Resist, which highlighted means for resistance to distorted health ideals, participants' responses to Q3 revealed a dramatic decrease in self-objectifying responses to the question, "How do you feel about your body?" Those who

described their feelings in mostly or entirely self-objectifying terms decreased from 71% in Q1 to 16% in Q3, with about a third of those who originally described themselves in self-objectifying terms responding to Q3 in nonobjectifying terms. That represents an improvement in their self-perceptions. Although 62% of participants initially described health and fitness in exclusively objectifying, appearance-focused terms, by Q3 all the participants responded in terms that exclusively described internal health or an instrumental view of the body.

In line with changing definitions of what it means to be healthy and fit, participants also expressed greater feelings of self-efficacy to achieve health and fitness in Q3. The presence of self-efficacy proved to be a significant difference between participants who felt positively about their bodies and those who felt negatively in both Q1 and Q3, with 100% of those who felt positively about their bodies believing they could achieve health or fitness. Though one-third of participants who felt negatively about their bodies reported having no self-efficacy in Q1, 100% of those participants reported increased feelings of self-efficacy in Q3 – some with doubts and reservations, but some with full confidence that they could achieve health.

While analyzing participants' personal narratives or *testimonios*, in addition to responses to all three questionnaires, I was guided by the following research questions:

RQ 1: What are the mechanisms by which women redefine health for themselves outside of appearance-oriented ideals and resist distorted health discourse in the media and elsewhere?

RQ 2: How are these mechanisms acquired and/or developed?

Resilience, or the process of "being disrupted by change, opportunities, adversity, stressors or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption" (Richardson & Waite, 2002, p. 65), proved to be a guiding framework for identifying the means by which participants were able to resist distorted health ideals and redefine health for themselves. The *testimonios* reflected the three outcomes for individuals dealing with adversity that were described in the Richardson et al. (1990) Resiliency Model: reintegration with loss, reintegration back to the comfort zone, and resilient reintegration. As noted below, use of *testimonio* led participants to create narratives that suggest ways in which such narratives can contribute to women's self-efficacy and cultivate resistance strategies.

Almost every personal narrative submitted for this study referenced some sort of body image or health-related adversity that could be viewed as a disruption from someone's comfort zone, which often proved to be a state of body shame or normative discontent for participants.

The push to move someone from that comfort zone, whether by her own choice or an unplanned event, is what Richardson (2002) calls a "life prompt," which can originate from within a person or outside – new experiences, information, thoughts, or feelings. The HML curriculum and questionnaires were designed with the aim of initiating prompts through new health and body-related information and feelings that can arise from such information. Through analyzing the personal narratives and *testimonios*, it appeared that several participants viewed the Healthy Media Literacy curriculum as an enabling disruption that served to destabilize the painful but unquestioned comfort zone of body shame and self-objectification. These findings demonstrate that the critical

awareness of distorted health ideals and their influence on women's body perceptions that can be developed through Steps 1 and 2 have power to shift someone's worldview of health, thus prompting a disruption that can lead to resilient reintegration. By utilizing a process geared toward critical health and media literacy, such as this HML curriculum, women can choose to experience an enabling disruption and achieve resilient reintegration to improved body image and health. This process can represent the means to "access personal gifts and strengths to grow stronger" (Richardson & Waite, 2002, p. 65).

Additionally, it appeared that for some participants, writing their own versions of body image *testimonios* and sharing them served as an empowering and enabling disruption that increased their self-efficacy to achieve health and resist distorted health ideals. Though my intent with including a discussion of the feminist theory behind the tool of *testimonio* in Step 3 of the HML curriculum was to encourage participants to write their own body-related *testimonio*, I found that the responses took a different turn. As acknowledged previously, few, if any, of the submissions from participants could likely be classified by scholars as *testimonios* in the true definition of the Chicana feminist tool. Instead, most were a recounting of personal experiences with being teased by peers or family members because of appearance, experiencing body shame or the effects of disordered eating, stories of becoming a mother or undergoing major physical changes due to illness or injury, and the highs and lows of living in a female body in a culture rife with objectification of female health. Many of the stories had never been shared before, let alone written down and sent to someone. The submissions received from the Step 3 prompt to write a *testimonio* were something I call body image burden stories. Like *testimonio*, these body image burden stories draw from women's lived experiences as a

basis of authority and knowledge (Fonow & Cook, 2005). The Latina Feminist Group (2001) describes *testimonio* as "a way to create knowledge and theory through personal experiences," and body image burden stories reflect that framework. Also like *testimonio*, these stories document the experiences of oppressed groups and denounce injustices (Huber, 2009), specifically relating to body image and physical health. These writings can "speak truth to power" (Beverley, 1999) by serving as an outlet for shedding light on and resisting distorted health ideals, but they are not necessarily political, as *testimonios* inherently are.

Understanding that race and ethnicity are critical components of the feminist tool of *testimonio* and the theoretical ground from which it was developed, I recognized that race was not overtly discussed or acknowledged in any of the participants' submissions in response to the *testimonio* prompt. As previously acknowledged in this research and discussed throughout the curriculum, race is an innately significant aspect of media literacy, health literacy, and individual body image, and thus is a necessary area of attention for the HML curriculum and future research. However, body image burden stories may differ from *testimonio* in that they do not necessarily privilege race as a central area of attention. Though I did not gather demographic information other than gender, age, and whether or not each participant was a resident of northern Utah, it can be assumed that the majority of the women in this study were Caucasian, based solely on population data for this area. Since Whiteness is often viewed as being without race or "the norm" (Guess, 2006), it is possible that study participants did not identify themselves as part of a racial or ethnic group or speak on behalf of such a community because they do not recognize themselves as part of one.

Unlike *testimonio*, the body image burden stories I received did not insist on the collective identity of the narrator in writing about her experience as a member of a group (Brabeck, 2003). Instead, the writings I received from participants were clearly written on each individual's behalf and not as part of a larger community. It is possible that such individualized stories could have been the result of the HML curriculum being geared toward individuals engaging with it alone, rather than as groups. Future research is needed to determine if body image burden stories from different populations or groups interacting together could represent a more collectivist form of discourse. For example, studies might examine if body image burden stories differ among ethnic groups or other communities in which members feel part of a whole, rather than isolated individuals.

The sharing of burden stories has the potential to reveal to the writers that their experiences are reflective of many others', and that they are not as shameful or as abnormal as they previously perceived. D'Enbeau and Buzzanell (2010) stated, "[W]e view the sharing of realities as a potential means to counteract gender oppressive media representations" (p. 37). Body image burden stories are also founded in this belief in the potential for lived experiences to shed light on the unnaturalness of mediated portrayals of health. Depending on whether the author perceives that her story is reflective of others', it seems possible that a body image burden story could work as a collectivist form of discourse, as Delgado (1999) describes *testimonio.* Whether or not the writings represent the experiences of a group or one individual, I see body image burden stories as aligning with *testimonio* in the ability for such writings to help create alliances and a sense of solidarity among readers who sympathize with the experiences of the writer (Avant-Mier & Hasian, 2008, p. 330). The solidarity that could result from the sharing of

body image burden stories, like *testimonios*, could contribute to feelings of collective identity, or even collective disidentification with distorted health ideals, as more women experience the unifying bond of sharing such vulnerabilities relating to body image.

Similar in some ways to counter-stories, which stem from critical race theory, body image burden stories offer an alternative story that stands in contrast to dominant mass media and social media discourse that privileges profit-driven messages regarding health. Solorzano and Yosso (2002) define counter-storytelling as "a method of telling the stories of those people whose experiences are not often told" (p. 26). In conjunction with a curriculum like HML that includes a health information intervention, women may recognize that their lived experiences with health differ significantly from the experiences represented in media and dominant health discourse. By writing and sharing their own body image burden stories, women could be able to write their own forms of counter-stories specific to body image and health to provide an alternative voice and message to the dominant messages that may not reflect their own experiences. I see body image burden stories as a significant finding that emerged from this particular group of participants and this particular curriculum. These personalized, individual stories of body image and health trials have the potential to serve as a means for sharing previously unvoiced burdens that are needlessly carried alone through inviting social support and invoking solidarity and empathy, as well as countering distorted health discourse in media.

Furthermore, analysis of participants' personal narratives and body image burden stories proved to be a meaningful avenue to gather understanding of women's strategies to resist distorted health discourse and redefine health for themselves. Many of those

strategies for resistance align with traits and skills that researchers have identified as being key to resilience, including characteristics and skills specific to body image resilience. These characteristics and skills include the following:

Health and Media Literacy: an online curriculum for teaching critical media literacy and health literacy proved to be a solid foundation for reframing women's perceptions of their bodies and redefining their definitions of health according to internal, ability-focused indicators rather than objectified, appearance-focused indicators. Health and media literacy can be summed up as the skills to gain access to, understand, analyze, and use information to promote and maintain positive body image and good health. Because objectifying media and distorted health discourse are so prevalent, the skills for health and media literacy must be learned and relearned, in conjunction with continuous critical questioning of media and health discourse.

Critical Self-Reflection: this was implemented as an integral component of the HML curriculum and proved to be an important means for recognizing distorted ideals and redefining health in more accurate ways. Whether prompted by the questionnaires, some stimulating aspect of the curriculum, or the opportunity to write a body image burden story, participants who were critical of their health perceptions and body image feelings proved to be more likely to experience and demonstrate body image resilience. Choate (2007) identified critical thinking skills as a buffer to thin ideals and body dissatisfaction in her research on body image resilience, and participants also identified this skill as crucial to developing and maintaining a positive body image.

Spirituality: participants described this characteristic in a variety of ways, including a "spiritual connection" and knowledge of being "more than just a body."

Spirituality is well documented as a key to resilience (Choate, 2007), as contemporary resiliency research incorporates a focus on spiritual dimensions of internal motivation and power.

Sports and Exercise as a Means to Develop Positive Physical Self-Concepts: participants described this strategy through overwhelmingly positive statements regarding their experiences with physical activity, which are reflective of research that shows physical activity promotes positive body image in girls and women by helping them develop an appreciation of what their bodies can do, rather than how they appear to others. This study indicates that engaging with a curriculum that emphasizes health in terms of how women feel and what they do, rather than how they look, is a meaningful way to reduce self-objectification and increase self-efficacy to achieve health.

Receiving Social Support: research shows one of the major factors that contribute to body satisfaction is receiving social support (Choate, 2007), and the writings of participants in this study echo that finding. S's words, among others, provided a clear example of one way a body image burden story could invite solidarity, empathy, and both peer and family support. By confiding in or bonding with other women, participants described overcoming obstacles that prevented them from making healthy choices. Several participants also mentioned loving husbands, mothers, and sisters who did not speak negatively of their own or others' bodies, friends who embraced their own "imperfect" bodies, and coaches and teammates who kept the emphasis off of how bodies looked and more on how they functioned or what they accomplished.

Giving Social Support: many participants described desires to become advocates for accurate understandings of health and fitness and positive body image among their

families, peers, students, and colleagues. Self-efficacy to not only achieve health for oneself, but also to be an advocate through promoting understanding of health among one's friends and family, is a crucial component of the fight against widespread body hatred and unhealthy behaviors among women. The desire to promote positive body image and dispel health myths or other health-related information that can benefit others proved to be an outcome of participating in the HML curriculum for many participants.

By reframing health in terms of what women's bodies do and how they feel instead of how they look, women can increase their self-efficacy to achieve health and fitness and identify and remove their barriers to healthy behaviors. Women who do not determine their feelings toward their bodies or their health according to their appearance are more likely to feel positively about their bodies and feel more capable of making healthy choices. A curriculum like Healthy Media Literacy can serve as a tool to teach critical media and health literacy in an accessible and practical manner to individuals or groups, which can encourage critical reflexivity about body perceptions, health goals, media consumption, and strategies to redefine health in ways that promote realistic, achievable health instead of self-objectification or the appearance of health. The HML curriculum can also serve as an enabling disruption for women who are in a state of normative discontent or maintaining poor health choices. A health intervention like the one in Step 2: Redefine, which illuminates effective ways to define and measure health and fitness, paired with opportunities for critical self-reflection and discussion of ways to actively resist distorted health discourse personally and publicly, can equip women with the knowledge, skills, and strategies they need to remove barriers to fitness and more

effectively navigate a world of distorted health discourse and redefine health in achievable ways.

By opening up and sharing personal body image experiences in conjunction with learning critical media and health literacy, through writing and sharing body image burden stories, women can break the silence surrounding body shame and unite with other women to collectively disidentify with harmful body ideals and promote accurate understandings of health and fitness. Accordingly, by engaging with an online curriculum like Healthy Media Literacy and sharing the information or their own stories online, women can act as both consumers and producers of media that cultivate positive body image and accurate health understandings among their own circles of influence. Additionally, this study indicates that promoting the writing and sharing of body image burden stories in conjunction with a curriculum like HML can help break the silence that surrounds body shame and related behaviors, invoke empathy and solidarity with others, provide alternative voices to those found in mediated health discourse, and serve as an enabling disruption to start women along the path to resilient reintegration and improved body image. The findings of this study suggest additional future research to expand the idea of women bearing witness to their own body image experiences through body image burden stories, and to refine it further through application in different populations and group settings.

Though this study specifically included women from age 18 to 35, the HML curriculum is applicable to a much wider age range. The media, health, and feminist resistance information included in this curriculum is appropriate for ages 12 and up, and is relevant to women much older than 35, due to the fact that distorted health discourse

has been widely accessible through mass media for decades and has certainly played a role in shaping older women's perceptions of their own bodies and health. This curriculum, or variations of it that consider media literacy, health literacy, and resistance to distorted health ideals, may be tailored for use in a variety of settings to reach more people, including public schools, youth groups, religious congregations, community organizations, and corporate trainings. Due to the pervasive nature of profit-driven health ideals and the ubiquity of media representations of women's idealized bodies, the need for education and resources to help females recognize distorted ideals, redefine health for themselves, and continuously resist harmful body-related messages is crucial. As demonstrated through this study, women have the potential to improve their media literacy, health literacy, body image, and self-efficacy to achieve health, and cultivate a variety of integral strategies to resist harmful health ideals by engaging with an online curriculum like Healthy Media Literacy.

Limitations

Limitations to this study include the ever-present possibility that participants may have given socially desirable answers, or responded in ways they imagined the researcher wanted to hear. I tried to control for this possibility by continuously urging participants to answer as openly and honestly as possible. Because I did not ask for any demographic information other than gender and age, I did not obtain information on the homogeneity of this group. It is necessary to note that this study was conducted in Utah, which has a predominant religion—the Church of Jesus Christ of Latter-day Saints—and relatively little racial and ethnic diversity. Because of this, these findings are not generalizable for

some populations that may differ in terms of socioeconomic status, education level, race or ethnicity, religion, or other factors. Future research with different populations is needed to enhance understanding of how a Healthy Media Literacy curriculum can address the needs of broader groups of women. I acknowledge that some participants could have possibly had prior interest in body image research, simply by the fact that they volunteered to participate in this study. As mentioned in the study implementation section, I did my best to control for these limitations by reaching out to various groups and connections across different races, religions, socioeconomic statuses, and so forth.

APPENDIX A

WEEK 1 QUESTIONNAIRE

1. How do you feel about your body?
2. What factors influence the way you feel about your body?
3. What does it mean to be a healthy and fit woman?
4. From what sources did you learn what it means to be a healthy and fit woman?
5. Do you consider yourself to be healthy or fit? Please describe why or why not.
6. Do you believe it is possible for you to achieve health and fitness?
7. What, if any, behaviors do you currently engage in to maintain or improve your health and fitness?
8. What, if anything, has previously prevented you or currently prevents you from engaging in healthy behaviors?
9. Please describe any changes you intend to make to your health and fitness status, for example, increasing or decreasing the frequency of a behavior.
10. If you do intend to make any changes to your health-related behaviors, please describe why. If you do not intend to make any changes, please describe why.
11. What does your media usage look like in a typical week? As much as you can, please indicate what you watch, read, and listen to (titles of magazines and TV

shows, genres of movies and websites (including social networking), approximate number of hours spent with each).

APPENDIX B

WEEK 2 QUESTIONNAIRE

1. Step 2: "Redefine" of the Healthy Media Literacy curriculum discussed the Body Mass Index (BMI), which is our national standard for judging healthy body weight. Had you ever heard of BMI before this unit?
2. If you have ever calculated your own BMI, how did you feel about your weight classification? Did you feel it is an accurate assessment of your health or fitness?
3. Research shows BMI was never intended to judge an individual's weight, and that it is not an accurate predictor of healthy body weight. The clinical director of Britain's National Obesity Forum said, "It is now widely accepted that the BMI is useless for assessing the healthy weight of individuals." What do you think about that?
4. Step 2 of the HML curriculum also shows that weight and appearance-based measures are very bad measures of health or fitness. Studies show that activity level is a much more accurate indicator of health than body weight, since active people who are considered overweight are actually healthier than people who are thin and sedentary. What do you think about that?
5. Does this information change the way you think about your own health? How might you reconsider the ways you measure and define health?

6. Do you believe it is possible for you to achieve health and fitness?
7. Please describe any changes you intend to make to your health and fitness status, for example, increasing or decreasing the frequency of a behavior.
8. If you do intend to make any changes to your health-related behaviors, please describe why. If you do not intend to make any changes, please describe why.

APPENDIX C

WEEK 5 QUESTIONNAIRE

1. How do you feel about your body?
2. What factors influence the way you feel about your body?
3. What does it mean to be a healthy and fit woman?
4. From what sources did you learn what it means to be a healthy and fit woman?
5. Do you consider yourself to be healthy or fit? Please describe why or why not.
6. Do you believe it is possible for you to achieve health and fitness?
7. What, if any, behaviors or activities do you currently engage in to maintain or improve your health and fitness?
8. What, if anything, has previously prevented you or currently prevents you from engaging in healthy behaviors or activities?
9. Please describe any changes you intend to make to your health and fitness status, i.e., increase or decrease the frequency of a behavior.
10. If you do intend to make any changes to your health-related behaviors, please describe why. If you do not intend to make any changes, please describe why.
11. What does your media usage look like in a typical week? As much as you can, indicate what you watch, read, and listen to (titles of magazines and TV shows,

genres of movies and websites (including social networking), approximate number of hours spent with each).

12. Do you help yourself differentiate appropriate health and fitness messages and beliefs from distorted, profit-driven messages and beliefs? If so, please describe how.
13. Have your beliefs or perceptions of health and fitness changed since you began participating in this curriculum? If so, how, and what prompted the change?
14. Have your health behaviors changed since you began participating in this curriculum? If so, how, and what prompted the change?

APPENDIX D

CODING SAMPLE

To demonstrate the data coding process, I have included two unedited examples of responses I have received after posting my body image and health research online in the form of blog posts at BeautyRedefined.net. I have then identified themes present in those responses, using the same codes I used for this study. Both examples were sent to me in the form of unsolicited e-mails in response to a blog post I wrote on the BMI, which research was also used in Step 2: Redefine of the HML curriculum.

Example A

"I am sitting here overcome with emotion at your article. I am a recovered bulimic. For 17 years I battled this disease. I was bulimic through some of my pregnancies even. For years I despised myself and even with a loving husband and loving Father in Heaven, I couldn't see my value past what I weighed. Your research on BMIs has lifted a burden from my shoulders like you can't imagine. Even as I have grown in acceptance of myself, I had geared myself up to believe that I would have to love myself in spite of what BMI charts said I should be. Knowing that I can disregard them is a freedom I didn't know I could have. I appreciate your website, your research, your obvious passion for reclaiming self acceptance as women in general. I feel like I have

taken a deep long breath after breathing through a straw for too long. Thank you, thank you, thank you!"

Example B

"Since my freshman year of college, I always hovered around 140 lbs. I exercised regularly, and never thought a thing of my size 8 self. Shortly after having my first baby, I started to panic, realizing that other women were so much skinnier than I was. Suddenly a size 8 was disgusting to me, and I was going to be one of those women who 'let themselves go' after having a baby. I began obsessively comparing my body to every woman I saw, and starving myself. If I ate, I would run so long and hard that I got sick, just to make sure the calories didn't stay. I got down to my goal, 117, and shortly thereafter got pregnant with baby #2. Shortly after he was born, I started obsessing again. Within a month after his birth I'd starved myself back down to 117, but this time it wasn't good enough. So I dropped to 113. Of course, next I needed it to be 110. But I noticed that I could no longer run more than 2 or 3 miles at a time, because I was so weak. I couldn't enjoy social functions because I felt like everyone was watching what I ate. I didn't have the energy to keep up with my kids. The only time I didn't feel disgusting was when I was hungry; I WANTED to be hungry. It was about this time that I realized I needed help. I began reading literature about body image, including Beauty Redefined, and found a good support system. I set a new goal to run a 10K, and have been focusing on being healthy enough to train for that. Even though it is still hard for me to weigh more than I want to, I am focused on health and strength now. I HAD to weigh more to be strong enough to run, which is what I love to do. I also find that it's important

to focus on what I can offer the world, which is a lot more than a number on a scale, or a dress size. I have a lot to offer! So thank you for all the work you do to help women change the way they think about their bodies and define beauty. I hope my story will help another woman realize her potential is being hindered by her obsession with weight, and find the courage to begin to change."

I have segmented the above submissions into several codes I identified while critically analyzing the texts. The following list represents a completed identification of codes, meaning both *a priori* codes, or those I identified prior to analyzing the texts, and inductive codes, or those I identified and added while analyzing the texts. Codes are identified and highlighted in a color that coordinates with the places that code is found within the texts. Along with visually highlighting them, I also listed examples of each code to keep track of specific instances where the code appeared.

Appearance-Oriented Views of Body or Health

- Weight-specific goals: 117, 113, 110
- BMI as health ideal, always out of reach
- Disordered eating to achieve weight-related goal
- Weight loss as health "success"
- Running to make herself sick and keep calories off

Positive Physical Self-Concept

- Exercised regularly, didn't pay much attention to size or weight

Interpersonal Experiences that Inform Self-Concepts

- Self-comparison to others' appearance
- Fears of others' judgment about weight
- Disregard for others' approval

- Desire to influence others for good
- Appreciating others' passion and research on body image

Knowledge as a Means for Empowerment

- "Your research on BMIs has lifted a burden from my shoulders like you can't imagine."
- She can offer the world more than her dress size or # on a scale
- Began reading about body image

Strategies for Redefining Health and Resisting Distorted Health Ideals

- Focus on what she can do, how she feels
- She loves to run, so she runs to stay focused on ability and not weight
- Found a support system
- Started reading about body image
- Set a goal to run a 10K to focus on strength and ability, not weight
- Focused on what she can offer the world, not just a # on a scale

Disruptions to Previously-Held Beliefs about One's Body or Health

- Having a baby
- Fears of looking like she "let herself go" after having a baby
- Too weak to run
- Couldn't keep up with kids
- Couldn't enjoy social functions, too anxious about others' judgments on food
- Read research debunking BMI, no longer holds that as her goal

APPENDIX E

HML CURRICULUM EXCERPT, UNIT 1, PHOTOSHOPPING

II. Photoshopping Phoniness

Photoshopping, digital alteration, image manipulation, blah blah blah. Everyone talks about the fact that so many images of women are "perfected" with the help of technology, but do we really understand how serious this issue is? Like exactly HOW MUCH these photos are manipulated and changed to fit some seriously un-human and unrealistic ideals that we view over and over again? And do we understand that it isn't just fashion magazine covers that feature Photoshopped images? It's everywhere.

While the vast majority of images of women are being digitally altered, so are our perceptions of normal, healthy, beautiful and attainable.

One of the main strategies used to reinforce and normalize a distorted idea of "average" is media's representation of women as abnormally thin (meaning much thinner than the actual population or what is physically possible for the vast majority of women) – either by consistent use of models and actresses that are underweight or close to it, or by making the models and actresses fit their idea of ideal thinness and beauty through digital manipulation. Essentially, "the feminine ideal is tanned, healthy slenderness, with no unsightly bumps, bulges or cellulite, and bodily and facial perfection that results from hours of labor: exercise, makeup and hair care" (Coward, 1985) – and 20 years later, plastic surgery and Photoshopping. This unrealistic form is consistently represented across almost all media forms, along with blemish-free, wrinkle-free, and even pore-free skin, thanks to the wonders of digital manipulation as an "industry standard" that is openly endorsed and defended by magazine editors like Lucy Danziger of *Self*.

Though we hear about Photoshopping controversies all the time, media executives and producers continue to use it to an unbelievable extent and they vehemently defend it as a perfectly acceptable thing to do. Here are a couple interesting (and appalling) case studies from popular magazines to showcase this very issue:

Due to copyright restrictions, I have not included this image in this dissertation. The image shows Kelly Clarkson performing on "Good Morning America" in September 2009 and a dramatically slimmed-down version of herself on the September 2009 cover of *Self* magazine.

When superstar singer **Kelly Clarkson** was digitally slimmed down almost beyond recognition on *Self*'s September 2009 cover, people noticed. Her appearance on "Good Morning America" within just days of the cover shoot proved that her body did not look anything like the very thin one that appeared on the cover. In a shockingly ironic twist, the issue she appeared on was titled "The Body Confidence Issue" and featured an interview inside where she explained how comfortable she felt with her body:

"My happy weight changes," Clarkson says in the September issue of SELF. "Sometimes I eat more; sometimes I play more. I'll be different sizes all the time. When people talk about my weight, I'm like, 'You seem to have a problem with it; I don't. I'm fine!' I've never felt uncomfortable on the red carpet or anything."

Rather than apologizing for the seriously unethical and extreme Photoshopping snafu, *Self* editor Lucy Danziger tried to defend her magazine's work to the death:

"Yes, of course we do post-production corrections on our images. Photoshopping is an industry standard," she stated. "Kelly Clarkson exudes confidence, and is a great role model for women of all sizes and stages of their life. She works out and is strong and healthy, and our picture shows her confidence and beauty. She literally glows from within. That is the feeling we'd all want to have. We love this cover and we love Kelly Clarkson."

Interestingly, Danziger wasn't satisfied with that statement and felt inspired to take to her personal blog to further rationalize away the Photoshopping hack job:

"Did we alter her appearance? Only to make her look her personal best…But in the sense that Kelly is the picture of confidence, and she truly is, then I think this photo is the truest we have ever put out there on the newsstand."

It's hard to believe anyone's "personal best" is a fake representation of herself. They'll plaster "body confidence!" all over the magazine and quote Kelly talking about her own real body confidence, but they refuse to show us her actual body.

This is just **one example** that happened to generate enough media coverage that people were able to find out about the scary distortion of an active, 27-year-old superstar's body in media. Unfortunately, this case study is pretty representative of thousands more that appear in magazines, on billboards, in advertisements, in stores and everywhere else you can think of every single day. At Beauty Redefined, we've termed this phenomenon "the normalization of abnormal." Since we'll see millions more images of women in media than we'll ever see face-to-face, those images form a new standard for not just "beautiful," but also "average" and "healthy" in our minds. *When women compare themselves to a standard of beautiful, average and healthy that simply doesn't exist in real life, the battle for healthy body image is already lost.*

In 2011, the American Medical Association (AMA) announced they've adopted a policy against "false advertising:"

The AMA adopted a new policy to encourage advertising associations to work with public and private sector organizations concerned with child and adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image.

Dr. Barbara L. McAneny of the AMA stated, "*We must stop exposing impressionable children and teenagers to advertisements portraying models with body types only attainable with the help of photo editing software*." And yet, in the last year, Photoshopping has reached an all-time high. It is inescapable.

Women's Health Losses and Media Powerholder Gains

From lost self-esteem, lost money and time spent fixing "flaws" and a well-documented preoccupation with losing weight for women, the effects of these unreal ideals hurt everyone. We know that advertising – especially for fashion or beauty products – depends on people believing they can achieve physical ideals by using certain products or services. That means those beauty ideals have to look totally attainable and normal, while making real women feel abnormal and anxious about their bodies. We need to understand that ALL media (with very few exceptions) depend on advertising dollars to operate. Because of that, the entertainment media or editorial content has to uphold those same ideals (thin ideals, White ideals, etc.) or else advertisers aren't happy.

Due to copyright restrictions, I have not included this image in this dissertation. The image shows the same model in two different ads for Ralph Lauren clothing, though one image has been digitally slimmed to an extreme extent.

Same model, differing degrees of Photoshopping on REAL printed ads, Oct. 2009. Ralph Lauren responded: "After further investigation, we have learned that we are responsible for the poor imaging and retouching that resulted in a very distorted image of a woman's body. We have addressed the problem and going forward will take every precaution to ensure that the caliber of our artwork represents our brand appropriately."

From media outlets like *Self*, *Redbook*, Ann Taylor and *GQ* (illustrated below) that go to great lengths to make unrealistic and unattainable beauty ideals look normal and within reach, to the diet and weight loss industry raking in an estimated $68 billion on Americans' quest for thinness in 2012 (Marketdata Enterprises, 2012), those with financial interests at stake in our beliefs about women's bodies are **thriving** unlike ever before. Simultaneously, women and families are losing. Losing self-esteem. Losing time and money spent on items, services and products meant to fix our never-ending list of "flaws." Losing real understandings of healthy, average and attainable. Sometimes even losing weight they didn't need to lose in order to measure up (or down) to photoshopped ideals we see every day as "normal."

While representations of women's bodies across the media spectrum have shrunk dramatically in the last three decades, rates of eating disorders have skyrocketed – tripling for college-age women from the late '80s to 1993 and rising since then to 4% suffering with bulimia (National Eating Disorder Association, 2010). Perhaps even more startling is the 119% increase in the number of children under age 12 hospitalized due to an eating disorder between 1999 and 2006, the vast majority of whom were girls (American Academy of Pediatrics, 2010). Though the U.S. Department of Health and Human Services (2000) reports that "no exact cause of eating disorders have yet been found," they do admit that some characteristics have been shown to influence the development of the illnesses, which include low self-esteem, fear of becoming fat and being in an environment where weight and thinness were emphasized – all of which are shown to be related to media depictions of idealized bodies, which is all but inescapable. Scholars have proposed that eating disorders such as anorexia nervosa and bulimia are due, in part, to *an extreme commitment to attaining the cultural body ideal as portrayed in media.*

Photoshopping has taken these unreal ideals to a scary new level.

Henry Farid, a Dartmouth professor of computer science who specializes in digital forensics and photo manipulation, agrees. “The more and more we use this editing, the higher and higher the bar goes. They’re creating things that are physically impossible,” he told ABC News in August 2009. “We’re seeing really radical digital plastic surgery. It’s moving towards the Barbie doll model of what a woman should look like — big breasts, tiny waist, ridiculously long legs, elongated neck. All the body fat is removed, all the wrinkles are removed, the skin is smoothed out.”

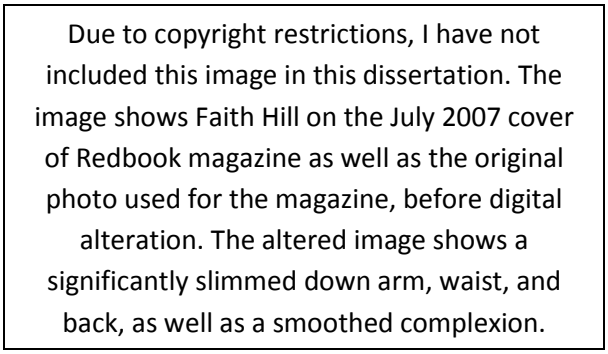
What we see in media, and what we may be internalizing as normal or beautiful, is *anything but* normal or beautiful. It’s fake. It’s a profit-driven idea of normal and beautiful that women will spend their lives trying to achieve and men will spend their lives trying to find. But until we all learn to recognize and reject these harmful messages about what it means to look like a woman, we all lose. And I don’t want to lose.

Due to copyright restrictions, I have not included this image in this dissertation. The image shows the before and after of a model on Ann Taylor’s website, with the “after” image being noticeably slimmed through the ribs, waist, and hips.

Ann Taylor’s online Photoshopping ad disaster, August 2010

This scary display of digital manipulation in action was caught on popular clothing store Ann Taylor’s website in August 2010, when the women behind the feminist website Jezebel discovered the “before” image (on the left, obviously) being displayed while the startlingly narrower ”after” the image loaded. The already stunning model’s hips and thighs were shrunk to strikingly thin proportions, but her waist simply looks ridiculous.

After the website Jezebel reported the glitch (and thank goodness for that!), Ann Taylor fixed it and sent an apology their way, saying, “We want to support and celebrate the natural beauty of women, and we apologize if, in the process of retouching, that was lost. We agree, we may have been overzealous on some retouching but [going] forward we’ll make sure to feature more real, beautiful images.” Unfortunately, Ann Taylor is a notorious repeat offender.



Faith Hill retouched to oblivion on the July 2007 cover of Redbook

Right arm? Suddenly appeared on the cover. Left arm? Cut down by at least 1/3 of its original size. Wrinkles, normal complexion or any other signs of life on her face? Erased. Back? Sliced out almost entirely. Enough said.

Kate Winslet slimmed beyond recognition on the Jan. '03 GQ cover

Acclaimed actress Kate Winslet is notoriously beautiful and curvaceous, so it's not surprising men's magazine GQ would want to include her on their cover. What IS surprising is that they removed her curves entirely, leaving extremely thin legs that bear no resemblance to her own and a rightfully upset actress.

She told Britain's GMTV, "I don't want people to think I was a hypocrite and had suddenly gone and lost 30 pounds, which is something I would never do, and more importantly, I don't want to look like that! … They made my legs look quite a bit thinner. They also made me look about 6 feet tall, which I'm not – I'm 5 foot, 6 inches."

APPENDIX F

HML CURRICULUM EXCERPT, UNIT 2,

HEALTH INFORMATION

Unit 2, Part 1: REDEFINE

As a body image researcher, I learned several years ago that our culture's definition of beauty and our definition of health are very much intertwined. They are almost indistinguishable from each other when you see or hear media or just regular people discussing health and fitness. **Most often, women's health and fitness are described, depicted, defined and discussed in terms of *appearance:*** weight, dress size, measurements, whether a body looks "toned," "firm" or "sleek," etc. Even when media or individuals are talking about fitness activities, like running races or exercise trends, the goals and effects are centered in appearance terms — toning up, losing weight, lifting, tightening, flattening, etc. This focus on looking fit and healthy rather than being fit and healthy is so pervasive that it shows up in major health campaigns for both adults and children. From unfortunate fat-shaming in Georgia's "Strong4Life" campaign (see image below) to kids being graded on their weight in public schools all across the country via their BMI score on their report cards, we see well-meaning people using harmful and ineffective strategies like crazy to try and counteract the much-publicized obesity crisis. This overwhelming focus on body size has stolen the spotlight in mass media and scholarly research since the mid-'90s, all citing an urgent need to end an obesity crisis that has been championed by the federal health agencies.

Due to copyright restrictions, I have not included this image in this dissertation. The image shows a young girl in an ad for Georgia's "Strong4Life" campaign with the text "It's hard to be a little girl when you're not."

With the health and fitness of the nation as the key justification for calling high levels of obesity a "crisis," it is important to understand how bodily health is defined in research. *How is health measured? What defines a healthy or physically fit body?* **In a country where both obesity and eating disorders have skyrocketed simultaneously, it is crucial to understand how physical health has been and is being understood, tested and promoted.** I dedicated a couple of years of my own PhD research to this question and was amazed by what I found.

Scholars are concerned that very little evidence has been produced regarding the question of exactly how body fat is supposed to cause disease (*1*). With the exception of osteoarthritis, where increased body mass contributes to wear on joints, and a few cancers where estrogen originating in adipose tissue may contribute, causal links between body fat and disease remain hypothetical. Researchers are asking health professionals and policy makers to consider whether it makes sense to treat body weight as a barometer of public health. **Despite this shaky foundation for defining physical health in terms of body fatness, much of current health and communication research measures health through simple measures of a person's body fat, and that may be doing more harm than good for the health status of this country.**

Defining Health: Body Fat = Body Health?

Researchers measuring health in terms of body fat generally rely on the American Council on Exercise's guidelines to determine which percentages are healthy, with anything below 10% and above 31% in women (or below 2% and above 24% in men) considered a health risk. Direct measures of body composition estimate a person's total body fat mass and fat-free or lean mass through MRI, underwater weighing, CAT scan, and other methods. Power, Lake & Cole (1997) said, "*an ideal measure of body fat should be accurate in its estimation of body fat; precise, with small measurement error; accessible, in terms of simplicity, cost and ease of use; acceptable to the subject; and well-documented, with published reference values.*" They go on to state that "*no existing measure satisfies all these criteria.*" Since these methods are expensive and invasive, they are rarely used in research. Because of this, scholars are much more likely to rely on indirect measures of body composition, including the most popular of them all: **Body Mass Index (BMI).**

Indirect techniques for measuring fat include all the most common ones: waist and hip measurements, skinfold thickness, and indexes of measured height and weight such as BMI. **These measurements are only a surrogate measure of body fatness, yet they are commonly used to represent not only levels of body fat but also *health and fitness* in research and media discussion about healthy bodies.** The life and health insurance industry, medical practitioners, researchers, health specialists and seemingly everyone else on the planet uses the BMI to measure people's health. That's because it is

the international standard for judging healthy weight, as upheld and promoted by the CDC, NIH and WHO. **This is bad.**

Here are 10 quick reasons why the BMI is a *shockingly terrible* measure of both body fat and health:

1) The equation used to calculate BMI (the ratio of an individual's weight to height squared) was developed in the 19th century by Adolphe Quetelet, a French scientist who warned the calculation was only meant to be used for large diagnostic studies on general populations and was **not accurate for individuals**.

2) The BMI's height and weight tables used to tell you what your score means came from the **life insurance industry**. Yep. A standardized table of average weights and heights was developed first in 1908, when life insurance companies began looking for ways to charge **higher premiums** to applicants based on screening by their own medical examiners. By setting the thresholds for "ideal weight" and "overweight" lower than what mortality data showed as the *actual* healthy weight ranges, they were able to collect more money for those they deemed "overweight." In 1985, the NIH began defining obesity according to BMI, which defined the 85th percentile for each sex as the official cutoff for what constitutes "obese," **based on the standards for underweight, average, overweight and obese that were set by the 1983 Metropolitan Life Insurance Company mortality tables** (Williamson, 1993).

3) The NIH implemented the BMI standard under the theory that it would **simply be used by doctors to warn patients who were at especially high risk for obesity-related problems** (*2*). It was never meant for individuals to calculate their BMI and accept it as a diagnosis of whether or not their weight is healthy, yet that is EXACTLY how it is used today. Individuals are encouraged to easily diagnose their own BMI status through the NIH website-hosted BMI calculator.

4) Those weight tables are based on the *unfounded idea* that **any weight gain after age 25 is unhealthy**. Though weight tables before the mid-1900s allowed for increasing weight with age (which naturally occurs), the Metropolitan Life insurance Company became the first to deem an increase in weight after age 25 as undesirable and unhealthy – again, to collect **higher premiums**. Also, the BMI is advised to be used only for people older than 20, due to the changes young bodies undergo before that age, yet it is very often used to diagnose adolescents and teens. Researchers admit that it is **unclear** at what level of body fat health risks begin to rise for children (Denney-Wilson et al., 2003), so **trying to define a standard of what constitutes overweight and obese for children is incredibly difficult**.

5) Those weight tables also did **not** take into account body frame or build, unlike previous tables, which included "small," "medium" or "large frame" due to demands from physicians who rightfully wanted to avoid **serious miscalculations** of body fat (Cziernawski, 2007).

6) Those same 1983 tables (and now our BMI) also failed to take **gender** into account, despite healthy levels of fat and weight distribution **differing greatly** between males and females (*3*).

7) BMI is based on a **Caucasian standard**. It is proven to be *highly inaccurate* for other races and ethnicities. In particular, in some Asian populations, a specific BMI reflects a **higher percentage** of body fat than in White or European Populations (James, 2002). Some Pacific populations and African Americans in general also have a **lower percentage** of body fat at a given BMI than do White or European populations (Stevens, 2002). Even the WHO has acknowledged the extensive evidence that "the associations between BMI, percentage of body fat, and body fat distribution differ across populations" (WHO, 2004).

8) **In 1998, millions of people considered of "normal" weight were suddenly re-classified as "overweight" the next day** when the NIH lowered the threshold for "overweight" and "obese" by 10 lbs. They based this change on the vague claim that studies linking extra weight to health problems warranted the changes (Cohen & McDermott, 1998). On June 16, 1998, the "average" woman was 5 feet, 4 inches tall and weighed 155 pounds. On June 17, a woman of that same height and weight became "overweight." The requirement for "average" dropped 10 pounds to 145, and a person of the same height who weighed 175 pounds was considered "obese."

9) **Experts say it's "useless."** Dr. David Haslam, the clinical director of Britain's National Obesity Forum, said, "*It is now widely accepted that the BMI is useless for assessing the healthy weight of individuals*" (*4*). Despite extensive evidence proving the BMI lacks accuracy for calculating an individual's body fat (*4*), A growing pool of evidence suggests that BMI is a "crude tool" for judging individual health that "*fans fears of an obesity epidemic even as it fails as a reliable measure of an individual's health*" (Heimpel, 2009). Even the U.S. Preventive Services Task Force concluded there is **insufficient evidence** to suggest BMI screening can be used to prevent adverse health outcomes (4). Prentice & Jebb (2001) illustrated a wide range of conditions in which "surrogate anthropometric measures, especially BMI, provide **misleading information about body fat content**, including infancy and childhood, aging, racial differences, athletes, military and civil forces personnel, weight loss with and without exercise, physical training and special clinical circumstances."

10) **More and more studies are showing the fact that people in the "overweight" and even "obese" categories of the BMI are at much lower risk of death than those in the "underweight" and even "normal" categories. So why do we keep measuring health based on BMI?**

Despite all the evidence against it, government health agencies defend the BMI as the national standard for judging healthy weight due to the fact that it is **"inexpensive and easy for clinicians and for the general public"** (CDC, 2010). That's exactly why researchers use it so consistently as a stand-in for "health." It might be "useless," but it is cheap and easy.

It is imperative to keep in mind that the much-publicized U.S. obesity crisis has risen to the forefront of national attention only since the late '90s, after the NIH changed the standard for what constitutes overweight and obesity. Using data gathered from 1976-1980 and comparing it to data from 1999-2002, the CDC reported that obesity doubled from 15 to 31% between 1980 and 2002 (CDC, 2007). It is unclear whether the data was compared using the same standard for determining "obesity," since the criteria for fitting into this category changed in 1998 to include *many* more people that were previously considered merely "overweight."

Unfortunately, heart disease, cancers and diabetes remain serious threats to public health, and obesity is considered a risk factor for these chronic illnesses. So if the BMI is worthless, then what do we use to measure or determine bodily health? The No. 1 step is to quit measuring and start exercising. (*That brings us to the incredibly important Part 2 of this "REDEFINE" unit of this curriculum*.) But if you just can't stop measuring, one step in the right direction is just as easy to calculate and much more accurate than BMI: waist circumference (WC). It is a more specific marker of upper body fat accumulation than BMI and is correlated with lipid abnormalities (O'Connor et al., 2008). When the researchers were evaluating a weight management program for overweight and obese adolescents, O'Connor et al. (2008) found a *significant decrease in waist circumference*, but not BMI, in participants. Janssen et al. (2004) evaluated WC in assessing obesity-related health problems and found that waist circumference is more effective than BMI at explaining obesity-related health risk. They found that people who are overweight or obese according to the BMI often have the *same level of health risk as normal weight people with the same WC value*.

Though WC is a step in the right direction and closer to measuring health, it still isn't quite there. The next step is to redefine what this crisis is *really* about. It's about health, not body size. During the time the obesity crisis has been in the forefront of media and federal health agency initiatives, the diet and weight loss industries have *thrived* unlike ever before, raking in $61 billion in 2011 alone — while almost 0% of people who used their products, services and plans lost weight and kept it off. Simultaneously, fat-shaming/thin-ideal-promoting media have also flourished, with

female body image hitting an all-time low. Promoting fitness, rather than thinness, is of crucial importance. Unfortunately, many of the mainstream ways "fitness" is advertised are leading to increased body anxiety and a distorted view of what it means to be a healthy, fit woman.

One of the most prominent ways "fitness" is depicted, promoted and made extremely popular online (especially through social media) is through "fitspiration." There's no doubt you have seen these images just in time for "bikini season" to motivate you to "get fit." They are almost always images of parts of women without heads or faces. They are always very thin, surgically and/or digitally enhanced, tanned, oiled up parts of bodies with text like this: Look good, feel good. Unless you puke, faint, or die, keep going. Girls who are naturally skinny are lucky. Girls who have to fight to be skinny are strong. Skinny girls look good in clothes. Fit girls look good NAKED. While a slogan and image motivating you to get out and move and live and do is a beautiful thing, so many of these "fitspiration" messages floating across the web must be exposed for what they *really are*. Ever heard of a thing called "thinspo" or "thinspiration?" It's an online world of thousands – even millions – of females who share and collect pictures of very thin women as inspiration to keep up their eating disorders. It is a saddening and terrifying world of females banding together to literally get thin at any cost, and thousands of girls and women **die** every year in this pursuit of thinness. I argue that fitspo may be thinspo in a sports bra. Here are a few ways to determine if the fitness inspiration you are viewing is healthy and motivating you toward *real* health goals or keeping you imprisoned in a body that is to be **looked at** above anything else.

1) Pay attention to the advertising so often being done in these "fitness inspiration" messages and you will see what is really being sold here. Is it a message of real health and fitness or a message asking you to commodify yourself by buying sports bras, yoga pants, the latest fitness DVD, etc., to appear a certain way? Advertisers are VERY GOOD at framing their messages as an empowering "You Go Girl!" message with their fists in the air cheering you on. But pay attention to their swift move from using that pumping fist to cheer you on, to punching you in the face for not being enough. If you do not have rock hard chiseled abs, the right workout outfit, etc., you are not good enough until you do. These advertisers will make sure you know that, because their profit depends on your wallet and your beliefs about yourself.

2) Next time you see one of these "fitspiration" messages, please ask yourself how it makes you feel. If these images and texts motivate you to respect your body as something that can do so much good, make and reach fitness goals, and maintain health that will keep you happy and able, then they are appropriate for you. If they motivate you to worry about being looked at or to improve parts of your body to meet a beauty ideal you see in media, you must be aware of this. Objectifying images/messages (or messages that lead you to see yourself as an object or parts to be looked at only) tend to lead many people *away* from exercise and healthy eating choices, rather than toward them, because

they promote body anxiety and shame. Being motivated to exercise or eat healthy because of shame never lasts — and usually ends up in a cycle of bingeing, being sedentary, and then shaming yourself into trying harder again. This is a terribly damaging cycle to your health.

3) Fitness never pits one woman's body against another's. Any motivational statement that has to diss another type of body in order to make you feel good about your body? Not healthy or helpful. You've seen those photos of Marilyn Monroe vs. Nicole Richie with the words: "When did this become hotter than this?" or some variation. Ugh. When we pit female against female, we get nowhere fast. We must work to stop minimizing ourselves and other women to *just* bodies EVERY TIME we judge each others' bodies, comment on them, even compliment each other on only appearance over and over.

With so much evidence showing that our obsession with body fat is missing the mark for health and well-being of all sorts, scholars argue we need to do away with the title "obesity crisis" altogether. This crisis isn't about too many people meeting an arbitrary standard of body fat, this crisis is about poor health due to unhealthy choices defined most prominently by inactivity and poor diet. Measuring health according to activity level is *the most promising step* for getting an accurate gauge of true wellness. But FIRST, we must focus on getting rid of barriers like "feeling too fat to exercise" and not knowing if you can be successful in order to make way for real success!

Unit 2, Part 2: Forget About Fat and Get Fit!

In a world where health successes and failures are too often measured entirely by weight loss or weight gain, we have to seriously reconsider this idea. Fitness researchers prove it: "There is a need to increase knowledge and understanding of the health benefits of exercise, and reduce the emphasis on weight loss. This agrees with the evidence that cardiorespiratory fitness is a more powerful predictor of risk than body weight" (1). How often do we see health advice that promises you will *"Lose 10 lbs. by Friday!"* or *"Shrink your belly bulge!"* if you'll begin some exercise program or make healthier food choices? **Constantly.** This messed-up way of thinking – equating healthy choices with quick weight loss – is seriously hurting our health. It's also making lots of people **LOTS** of money, while our health problems are still killing us. Experts are warning against this profit-driven tendency to focus on *thinness* rather than actual indicators of health and fitness. In a fantastically-titled paper – "Beneficial effects of exercise: shifting the focus from body weight to other markers of health" – King et al. (2009) conclusively demonstrated that "significant and meaningful health benefits can be achieved even in the presence of lower-than-expected exercise-induced weight loss." Sounds crazy, right? It goes against anything most media will every tell you about health, but it's true. **Even when you don't lose as much weight as you think you should (and as money-making media train you to think), you're still likely gaining some serious health benefits.** Doctors know this is true. When people with serious

health issues like Type 2 diabetes, cardiovascular issues and high blood pressure start a meaningful exercise program, their health problems often **disappear** or greatly improve – *regardless of whether or not they remain overweight or obese*.

The Society for Nutrition Education produced a report in 2002 promoting healthy weight in children, which emphasized the need to "set goals for health, not weight, as appropriate for growing children" and says that **it is "unrealistic" to expect all children to be at an ideal weight range**. Instead, this report defines "healthy weight" as "the natural weight the body adopts, given a healthy diet and meaningful level of physical activity," which it later specifies to be one hour of physical activity each day.

The U.S. Department of Health and Human Services stated that poor nutrition and physical inactivity are the second leading causes of preventable morbidity and mortality, and are among the top priorities of Healthy People 2010. Notice there is no mention of obesity or overweight in this statement. Along with this imperative, scholars, health educators and medical experts have begun a push toward a "health at any size" movement that encourages people to switch their focus away from weight loss and toward healthy behaviors that can increase physical and emotional health at any weight – even at weights currently considered medically compromising (2). This shift in health objectives toward *activity* rather than *fat* is founded upon a huge body of research that shows **health and fitness often has very little correlation to body weight or even an individual's BMI**. There's one impressive meta-analysis of medical studies since the 1970s that concluded overweight and active people may be healthier than those who are thin and sedentary (3). **Understanding that activity level – rather than body weight – is a reliable indicator of a person's health, is a key to dismantling an unhealthy ideology that defines health according to appearance-based measures.**

A promising example of promoting physical activity without emphasizing weight loss as the measure of success is from one 2011 study (4) that tested the effectiveness of an exergame (like a Wii or Kinect exercise-promoting video game) to promote **exercise self-efficacy**. Self-efficacy is the confidence in one's ability to achieve a goal or complete a task. That study, and many others, shows that even when people know what they need to do to be healthy, **that knowledge only turns into healthful habits through the mediator of self-efficacy** (4). That means people have to believe they can exercise – in the right ways, consistently, effectively, without hurting themselves, embarrassing themselves, or whatever else might hold them back – in order to do it and stick with it. That makes exercise self-efficacy a hugely vital goal for anyone who cares about improving their own health or others'. **In order for exercise-promoting campaigns to be effective, people need to be able to identify and remove barriers to physical activity in their lives – any excuses, real or imagined, that are holding them back from exercise.** One of those barriers is feelings of previous **failure** at exercising – and this one is especially true for *women.* Health studies show women tend to associate **weight loss** with **"success,"** while many *men* who **gained weight** during a

study period still considered themselves to have been **successful** at controlling their weight or managing their health (5). The researchers rightfully warned, "It is possible that women's perceived lack of success in weight control when no changes in weight ensue may prompt the adoption of aggressive and possibly harmful weight-loss methods, and exacerbate negative body image and weight pre-occupation." Yep, that's exactly what happens.

Interestingly, researchers have identified **body dissatisfaction** as one of the major barriers to regular exercise for women. One study found that one of the most significant barriers to exercise for obese people was their body image perception, with ***"feeling too fat to exercise"*** showing up as one of the most common stumbling blocks, particularly for females (6). Recent studies have found that body size satisfaction had a significant effect on whether a person performed regular physical activity, regardless of the individual's actual weight (7). **That is, those who were satisfied with their body – regardless of their size – were more likely to engage in physical activity regularly than those who were less satisfied.**

This is scary, considering studies show women tend to overestimate their body weight and size, while men tend to underestimate their body weight and size (8). In one telling example, researchers found that 61% of *normal weight* women perceived themselves as *overweight*, while 92% of *underweight* women perceived themselves to be *average or overweight*. **As media images of women's bodies across advertising and entertainment of all genres have shrunk to extremely thin proportions over the past several decades, women's perceptions of their own bodies has become just as distorted.**

In a country where 50% of women say their bodies "disgust" them and a whopping 90% of women are dissatisfied with their appearances (9), **body shame needs to be viewed as a huge barrier to health and physical activity for women, and one that must be addressed in meaningful ways – *NOW*.** This rampant self-loathing, which can be partially attributed to women's self-comparisons to unrealistic and unattainable body ideals in mass media, may very well encourage women to give up on achieving healthy body weights altogether due to the perception that "healthy" or "average" is unreachable. Studies help to confirm this idea. A 5-year study on a group of teen girls (10) found that girls who were more comfortable with their bodies — *regardless of their weight or size* — were actually **healthier** over time. They were more likely to be physically active and pay more attention to what they ate. Meanwhile, the girls who were the most dissatisfied with their size tended to become **more sedentary** over time and paid less attention to maintaining a healthy diet. This makes sense. When you are ashamed of your body, how likely are you to go to the gym or go outside and be active? How much more likely are you to shut yourself inside with the TV and food that will do you no good?

Promoting positive body image is crucial to promoting health. Increasing positive feelings about our bodies and being able to see them as more than objects to be measured, judged and looked at are key to helping people make healthy choices – especially increasing their physical activity. **There is so much at stake in turning this health crisis around.** The current obsession with women's bodies, from the obesity crisis to unattainable appearance-focused fitness ideals, can be viewed as a reflection of the *economic interests* of many: the insurance industry, the diet and weight loss industry, federal health agencies, the beauty product industry and mass media (especially women's magazines) that uphold the beauty ideals their paying advertisers depend on, among others. With so many power holders with serious financial interests at stake in maintaining a stake in women's beliefs about their bodies, it is unlikely that media distorting women's health will change anytime soon.

But *we can* change.

Dismantling and revealing harmful ideas about health must become the responsibility of everyone who recognizes their existence: **health educators and practitioners** who know the difference between thin beauty ideals and indicators of physical fitness; **parents, teachers, friends** and other influential individuals who see signs of low self-esteem, distorted body perceptions and disordered eating in girls; **media consumers** who recognize negative feelings about their own or others' bodies after reading or viewing media that represents ideals as normal or "healthy;" **media decision makers** who can disrupt the steady stream of idealized bodies with positive representations of more normative shapes and sizes, and place the emphasis on activity rather than appearance; and **activists** who are willing to visibly resist messages that repackage women's health in power-laden terms in any way possible, whether through volunteering to speak out against harmful ideals for any audience who will listen, or by attracting attention toward the dangerous link between beauty ideals, low self-esteem and serious health consequences.

How to REDEFINE health for yourself and your family:

While profit-driven media would have us believe the "Weigh Less, Smile More!!" and "Perfect Your Parts, Perfect Your Life!!" headlines plastered across the globe, those messages rake in billions and get us nowhere closer to body-loving happiness. What research and real-life experience make very clear is that when we can begin to see ourselves for more than our parts and simply feel OK about our bodies, we get much closer to health, fitness and happiness.

Ending body hatred is a major key to achieving real health and fitness, rather than temporary and often unsatisfying appearance-related goals. Here are a few strategies to consider when working to REDEFINE health for yourself and spread the wealth to those around you.

Set a true fitness goal: When it comes to our bodies, women often come up with goals that have *a lot* to do with how we look and *little* to do with getting on to real health and happiness. My goals used to revolve around clothing sizes, measurements or numbers on the scale, and I don't think I'm alone in realizing that even if the number got smaller, it had little to do with my actual health or happiness. I can look back in old journals and see that sometimes I resorted to extremes in eating and exercising to get to that random number I thought would bring with it all the joy I could imagine: "*If I can just lose this much weight, I'll be SO happy*!" or "*I'll love myself if I can just lose this many inches*." But personal experience and academic research have taught me something very different: an arbitrary number is never the key to happiness, confidence or even health and fitness. If you've held yourself back from running, biking, swimming, etc., because you felt self-conscious about what to wear, how much your stomach or thighs "jiggle," how red your face gets from the workout, sweating in public, (the list goes on), it's time to set a goal and fight to achieve it! Make this goal about your abilities and you'll be much less inclined to care about what you look like doing it. Run a certain distance without stopping. Swim 10 laps faster than ever before. Do a certain number of crunches, push-ups, pull-ups, new dance classes each week – any fitness achievement measured in actions and not numbers on a scale, measuring tape or clothing tag.

Forget your number: If you tend to fixate on your weight, measurements or clothing sizes, pledging to leave those numbers behind is your key to freedom! Make a goal to stop weighing or measuring yourself. It turns out that when we fixate on arbitrary numbers, that often gets in the way of our health. Start judging your health through your activity level by setting a fitness goal (see No. 1) instead of a meaningless number, and you'll get somewhere great!

Shut down negative thoughts and talk: Too many girls and women have a constant script of mean thoughts about themselves running through their minds. Recent studies show us that girls who don't like their bodies become more sedentary over time and pay less attention to having a healthy diet. If you think you're gross and worthless, why would you take care of yourself? Set a goal to stop saying negative things about yourself. Start with a day, a week, a month, whatever you can do, and make it a permanent practice! On the flipside of the last study, research has found that girls who feel OK about their bodies — regardless of what they look like – are more likely to be physically active and eat healthy. They are less likely to engage in disordered eating like binging, purging or starving, and more likely to exercise regularly. Since what we THINK about our bodies has a strong connection to how we TREAT our bodies, set a goal to shut out negative thoughts as they come and replace them with positive truths!

Leave your keys at home: If you drive or take public transportation to work, school, or elsewhere when you could be walking or biking instead, why not give it a try? Increasing activity is a beautiful way to release endorphins to feel happier, get your heart pumping and enjoy the outside world!

Try out the latest cleanse: Whether it's health and fitness magazines featuring airbrushed celebrities in bikinis with the latest strategies to get "sleek and sexy" in 3 days without ever moving an inch, or fitspiration models with exposed buttocks, breasts and oiled-up abs all over Instagram and Facebook — you've likely got a pretty specific image in your mind of what it means to be a "fit" and "healthy" woman. This is a trending *beauty* ideal that is parading as a *fitness* ideal. But what about the vast majority of women who will never, ever have six-pack abs, jutting hip bones, cellulite-free thighs that don't touch, and every other appearance ideal that is held up as a sure indicator of fitness — regardless of how many squats they do, how "clean" they eat, how many marathons they run, etc.? This image of what it looks like to be a fit woman is so common and unquestioned that it has become natural and invisible. THIS cleanse will start to rid you of that numbness.

It's called the **media fast**. Rather than cutting out food, you cut out media. You cleanse your mind in order to cleanse your body. Choose a time period — 3 days, a week, a month, or more — and avoid media as much as humanly possible. All of it. No Twitter/Instagram/Facebook, TV, Netflix, movies, blogs, radio, any advertising you can avoid. Without this never-ending stream of biased, $-driven, idealized, Photoshopped, self-promoting messages and images (even well-meaning ones from friends and family and people trying to encourage their version/depiction of health), you give your mind the opportunity to become more sensitive to the messages that don't look like or feel like the truths you experience in real life, face to face, with real fit people and your own health choices. Without those messages, you can see how your life is different and how your feelings toward your own body are affected. When you return to viewing and reading popular media, you will be more sensitive to the messages that hurt you, that hurt your self-perception and those that are unrealistic for you. Then you can make personalized, critical, well-informed media choices for yourself and your household that will uplift and inspire, and promote health rather than objectification and unattainable appearance ideals that may shame you into poor health choices.

In conclusion, research tells us a lot about the ways media objectifies females and asks us to view ourselves (to self-objectify) as parts to be ogled by those around us, perfected and shaped by surgeons, judged by each other, and constantly in need of repair with the help of makeup, waxing, tanning, bleaching, plucking, new fashions and posing. Watch a Blockbuster movie or your favorite TV shows and see how the camera pans up and down the females' bodies, zooming in on their parts. Drive past billboards on I-15 that cut the heads off of women and invite them to give themselves the gift of implants this year – "Do it for YOU!" You get the idea. In a media world more powerful than ever before, girls today grow up viewing themselves as parts to be looked at and we spend our lives perfecting those parts and feeling bad when those parts aren't yet perfect. These beliefs have seeped into the ways we view our own health and fitness, and confuse many people about what it means to be a fit woman. Because of that, our goals and resolutions often reflect our self-objectifying views that often don't get us to real health and don't last too

long (ex: “Fit into my jeans from 2003″ or “Lose 20 lbs.”). Have you ever reached one of those goals and then realized you still weren’t happy with where you were? It’s because the ideals we see in media and set for ourselves are *designed to be unattainable* – we’ll work forever trying to reach them, but since they’re forever out of reach, we’ll spend all our money, time and energy working toward them. **Let’s work to reframe our goals in ways that prioritize health and fitness, rather than appearance or arbitrary numbers and sizes.**

APPENDIX G

HML CURRICULUM EXCERPT, UNIT 3,

PERSONAL NARRATIVE

Unit 3: RESIST

If you've wondered who is behind this study, the curriculum was written by me, Lindsay Kite (pictured left), a 28-year-old woman who is a PhD candidate at the University of Utah in the Department of Communication. I have devoted the last 10 years (since 2003) of my life, along with my twin sister Lexie Kite (pictured right), to studying media and body image, and the last 4 years (since 2009) to running Beauty Redefined, a nonprofit organization working to promote positive body image in order to improve women's mental and physical health. I am dedicated to helping people recognize, reject and RESIST harmful messages about women's bodies.

This unit is focused on ways women can RESIST harmful messages about female bodies and health, and unite to push back in the name of health and happiness. An important part of that resistance is breaking the silence that so often surrounds body shame and anxiety and helping girls and women to feel united by their realities as women in such an objectifying media world that confuses us about what it means to be healthy and beautiful. One powerful way to empower women to embrace their experiences and their

bodies is to share our stories and experiences and remind others that their bodies and experiences are *not* abnormal or shameful — as media so often encourages us to feel in order to convince us to buy products and services to "fix" ourselves.

I'm going to start that story-sharing here! As you read my story, I want you to think about YOUR story. Your experiences, good and bad, that have influenced the way you think about your body and your health. How have your self-perception, body image, health choices, friend choices, fun choices, and all choices been affected by your experiences — how people talked to you and treated you, what you imagined people thought of you, injuries, health problems, pregnancies, attention from romantic interests, media influence, etc.?

Here is my story.

As a swimmer on a competitive and demanding team throughout elementary, middle and part of high school, I practiced intensely on a daily basis. My favorite part was the excited, anxious, heart-racing feeling I'd get on the way to every meet and before every race. *Unfortunately, it didn't take long before that anxious, heart-racing feeling started to stem from the way I thought I looked in my swimming suit, rather than my performance.* I went home from practice one day in third grade and stood in front of a full-length mirror, looking at myself from every angle. I noticed one dimple in the side of my little girl thigh and desperately felt the need to cover up, though I knew that would be impossible every day in my swimming suit. Instead, I vowed to remind myself to keep my left hand covering the dimple on my left thigh at all possible moments.

That is when my appearance started to creep to the forefront of my every thought.

My newly heightened awareness of my looks quickly gave way to a relentless preoccupation with weight loss, starting around age 11. Journals and notebooks filled with weight-loss goals, motivating thoughts and tips, food logs and my most depressing thoughts were still lined up in my home bookshelf, stacked next to piles of *Seventeen, Teen, YM* and *Twist* magazines. I would have literally given ***anything*** to look like the girls on those pages, or like Kelly Kapowski. That's what the happiest, coolest teenage girls looked like. For a long time, my weight defined my days – either successful or a waste. One step closer to happiness or another day of worthless disappointment.

By high school, it consumed me. In a particularly melodramatic mid-puberty journal entry, I wrote: "*I HATE MYSELF. I have gained 4 pounds in the last 2 weeks. Not exaggerated one bit too. I have no idea why this weight is coming on so fast, but it scares me and it's all I think about constantly. I hate this."*

I was active, athletic, pretty, social and smart. No one called me fat. No one treated me like an outsider. I got asked out by boys. And I still felt this way. I wasn't alone. **My**

thin, beautiful friends suffered the same preoccupation and obsession with weight loss, but we suffered alone. Heather, the healthy and beautiful president of the ballroom dance team, could tell you her weight from any given day of the previous years. Popular and sought-after Jennifer* cut out dozens of lingerie models from Victoria's Secret catalogs and stuck them all over the back of her door for "motivation." Jane*, a cheerleader I didn't know that well, bragged to everyone that all she had eaten in the past three days was five Doritos. I wondered how she found the motivation to be so strong. Jessica*, by all accounts a very thin girl, cried when she fit into a size 12 in black LEI pants, even though *everyone* knows LEIs are sized extremely small. We were all middle-class White girls form Idaho, with happy, successful families of all shapes and sizes, but **we all shared deep-seated idea that the only way to attain happiness, success, popularity and love was to be as thin as possible.** *I had no real-life experiences to back this idea up, and I don't believe any of those girls did either.*

What we truly shared, along with everyone else we knew, was easy access to media our entire lives, where Kelly Kapowski was always pursued, everyone pitied the chubby girl Zack agreed to take on a date, Jasmine, Belle, Ariel, Cinderella, Snow White and all the other Disney protagonists were unrealistically thin and so sought-after, while any average-sized or overweight characters were mocked, explicitly labeled as fat and often the antagonists. Male characters were valued for humor, athleticism, intelligence and power, while female characters were overwhelmingly valued for their beauty alone. Commercials and advertisements consistently reflected these differing measures of worth. I recognized it, but never ever thought to question it. *That's just the way things work.*

Not much changed when I got to college. **Freshman year was filled with weight loss ups and downs, but I felt happy and OK about myself, and boys paid attention too, even though I was fully convinced I needed to undergo a major transformation in order for them to like me.** The next summer, I got down to my lowest weight ever.

August 17, 2004: "*Last night I tried on my old pants from Christmas of senior year and they are way too big. I distinctly remember wearing them and feeling pretty good about myself at choir practice, and now I can't imagine ever fitting into them or feeling good. I've gotten more compliments than I can count and it feels so good even though I don't feel so great about myself. I hope that eventually changes*."

The next semester at Utah State University, I took an awesome required journalism class called "Media Smarts" from Brenda Cooper and Ted Pease on critically analyzing the media for its implicit but powerful messages. We looked at race, class, gender and violence in media and I was amazed by all of it, but none resonated with me more than the hugely imbalanced portrayals of gender — particularly the ways media sets the standards for what it means to be successful or worthwhile. **No one in my life ever taught or demonstrated to me that thinness and body "perfection" equals happiness or success.** *TV, magazines and movies do it incessantly – sometimes overtly, sometimes*

implicitly, but always consistently. That creates a false reality that makes real-life bodies seem sub-par. I realized the first step to dispelling these myths and oppressive standards that had held me and all of my friends back for so many years was to point out that ***it's all made up***. Producers, casting directors, advertisers and media executives make specific decisions for specific economic reasons – they don't simply reflect reality, as we sometimes believe.

I knew talking about women's representation in media got my heart beating fast for a reason. The palpable excitement of learning about it reminded me of my swimming days – the anxiety before a meet, the anticipation of putting all of my hard work to use. Media's messages to women enrage me and thrill me, and its implications are too real to accept and just move on. I took my first women's studies class for that reason, and was assistant to the director of the Women and Gender Studies program for the next year and a half. My heartbeat didn't slow down – instead, the work became more and more personal as I identified that passion as the loaded term **"feminism"** and began to reconcile the many facets of feminism with my own conservative religion. With time and studying, they fit together so comfortably, and I felt a strong desire to share my newfound compatibility between spirituality and feminism with anyone and everyone.

I read "The Feminine Mystique" by Betty Friedan and felt overwhelmingly impressed by its truth, by the oppression imposed upon women by media standards defining the ideal woman by her homemaking and housekeeping skills, which serve to isolate women inside their own homes and families while propelling a thriving economy backed by women consumers seeking fulfillment. I immediately sensed a connection to beauty standards as the "feminine mystique" of today, and was amazed to find a book detailing that very belief – "The Beauty Myth" by Naomi Wolf. **I cried as I underlined entire paragraphs that resonated with my own lifetime of experiences of being stifled by a preoccupation with my appearance that was not a natural part of me.**

"We are in the midst of a violent backlash against feminism that uses images of female beauty as a political weapon against women's advancement." (p. 10)

"Consumer culture is best supported by markets made up of sexual clones: men who want objects and women who want to be objects, and the object desired ever-changing, disposable and dictated by the market." (p. 144)

While the "feminine mystique" produced isolation and unfulfillment, I saw the "beauty myth" as also a force for prompting misery, competition, jealousy, self-obsession and an end to productivity. When I became more worried about the dimple in my thigh than my race time, I stopped excelling as a swimmer. When I am fixated on keeping my clothes in the most flattering position and everything sucked in just right, *I can't think of anything else at all*. I am depressed by the number of activities I could have excelled at, the friendships I could have cultivated, the goals I could have pursued, and

the girls feeling the exact same way I did that I could have helped if I hadn't spent so much of my life preoccupied with the way I looked.

I know media-imposed beauty ideals divide and conquer. They pit one woman against another and make one woman's success the other's failure. The connection between my faith and my feminism became so much stronger as I recognized the potential for fulfillment and unity among women that already existed within my church congregation. With a focus on serving others, taking care of each other and loving God, there is no room for competition and preoccupation with appearance. *That's when the feminine mystique and the beauty myth lose their power: when women unite to step outside themselves and concentrate on bettering the world around them.* I implemented this belief into church meetings and talks, school speeches, papers, newspaper articles and my own writing. I applied for graduate school with this motivation behind me and was thankfully awarded a full fellowship to study media and body image at the University of Utah in 2007.

Soon after moving to Salt Lake City for grad school, I felt overwhelmed with the excitement and potential implications of this work I so wanted to accomplish. On August 19, 2007, I wrote this in my journal (only slightly less melodramatic than previous teenage me):

(*As a side note, most of my journal entries have focused on dating and roommate drama and vacations, not changing the world. This is one of those rare exceptions*.)

Through earning a master's in communication, I hoped to shed light on the powerful, invisible forces behind idealized images of women and the influence they have on all of our lives. **In 2008, during my master's studies, I wrote my lofty intentions in a class paper:**

"I want to help redefine women's values and worth outside the terms of idealized beauty by reaching out to girls who are developing their own ideas of true womanhood and success. I, along with my twin sister Lexie, aim to hold classroom workshops, seminars, conferences, school assemblies, courses and even individual conversations to further this goal. Those mediums can be powerful tools in uncovering oppressive ideologies, questioning ideals and sharing liberating truths that have the potential to expand girls' and women's ideas of what it means to be valuable, successful and desirable – despite media messages that will continue perpetuating even more consistent, coherent, oppressive lies about women."

Despite all my best teenage efforts, that dimple in my left thigh never disappeared, but it hasn't held me back from recognizing my worth and potential as a beautiful, capable, awesome woman — or my potential to spread that truth to women everywhere. **My appearance** (*though it is ironically at the center of discussion in much of the media*

attention we have received for Beauty Redefined — both positive and negative) **does not determine my value, no matter how much the fashion, beauty and diet industries benefit from me believing that message**. I'm unbelievably grateful that the anxiety that came from becoming aware of my body's "flaws" has continuously been replaced by this empowering knowledge about my worth. It has transformed into an anxious, heart-racing desire to share this truth.

Part of my research is on the idea of resilience, or the ability to bounce back and grow in the face of adversity. Sometimes what is needed to help a person become resilient, or at least to prove that she is resilient, is a "disruption" in her life. A disruption can be seen as a prompt to move someone out of their comfort zone. A disruption can be positive or negative, but it requires a response in order for that person to either settle back to their comfort zone or reintegrate even more positively, which opens up an opportunity for a person to demonstrate and exercise resilience. This is the process of "being disrupted by change, opportunities, adversity, stressors or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption," (Richardson & Waite, 2002, p. 65).

In applying the idea of resilience to body image and physical health, I see my Healthy Media Literacy program as a potential "enabling disruption" that can serve to destabilize the painful but unquestioned homeostasis of "normative discontent" in women (Rodin et al., 1985). Research shows that body shame and anxiety is so common in women of all ages that it is the new normal — it is unquestioned and invisible to most of us. By equipping women with the information in this curriculum — from recognizing profit-driven beauty ideals of very thin, young, white, Photoshopped images to redefining what health means in ways that promote real fitness instead of beauty ideals — **I hope to help women recognize that they don't need to accept negative, shameful feelings about their bodies and health. I hope to prompt girls and women to reject harmful ideals that keep them feeling anxious or preoccupied with their appearances, and finally, to encourage women to actively resist harmful body ideals for themselves and for those they have influence over.**

Unrealistic, harmful ideals of female healthy bodies are upheld through their privacy, through the secret shame they invoke by making real women feel sub-par, and the competition they enforce among women trying to attain those ideals. Rather than ignoring or making fun of real bodies that don't fit ideals and accepting the unrealistic representations of women's bodies throughout the media spectrum, **real bodies** need to be emphasized. Real bodies — not the Photoshopped, dehydrated, oiled-up, objectified bodies portrayed as fitness ideals — can be enabling disruptions for people. **Seeing, talking about and just being aware of the multitude of ways real, healthy bodies look can be a major trigger for critical thinking and conversations about real health.** Though we don't often see those enabling disruptions in mass media, they do happen. Women who perform "health" without appearing as the cultural ideal of

"healthy" exist *everywhere.* I know **lots** of women who run marathons, do triathlons, teach Zumba 5 times a week, or otherwise exercise regularly, eat healthy and have excellent health records and do NOT look anything like "fitness" models. I cannot express what a positive influence those women have had on my own body image and perceptions of health. I also know **lots** of women who don't perform or embody "health" but appear "healthy" by mediated and culturally upheld standards. We can all help to expose the unnaturalness of idealized body portrayals that oppresses women, and one of the ways to do that is to BE those women. Work for health and fitness, regardless of what you look like in the process. Stick with it even if your body doesn't look (or weigh) the way we've been taught healthy bodies look (and weigh).

Revealing the unrealistic nature of dominant ideas of "healthy" and their influence on the way girls and women view and treat their bodies is a promising step toward diminishing its power over us. As women recognize their own bodies as *not* merely exceptions to the rules of acceptable female bodies, and *not* as shamefully flawed outliers among a sea of extremely thin, dimple-free and ideally healthy women – but as being representative of *reality* – that's where an enabling disruption can start. When more than one woman recognizes her body isn't shameful or abnormal, no matter what her health status is, that is when we get to something *really* exciting for this body image battle: **collective disidentification**. That's a long term for two, 50, 500, or 5 million women bonding as a group to reject harmful messages and create new ideals that benefit WOMEN, not corporations.

APPENDIX H

HML CURRICULUM EXCERPT, UNIT 3, RESILIENCE

Part of my research is on the idea of resilience, or the ability to bounce back and grow in the face of adversity. Sometimes what is needed to help a person become resilient, or at least to prove that she is resilient, is a "disruption" in her life. A disruption can be seen as a prompt to move someone out of their comfort zone. A disruption can be positive or negative, but it requires a response in order for that person to either settle back to their comfort zone or reintegrate even more positively, which opens up an opportunity for a person to demonstrate and exercise resilience. This is the process of "being disrupted by change, opportunities, adversity, stressors or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption," (Richardson & Waite, 2002).

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bodies portrayed as fitness ideals — can be enabling disruptions for people. **Seeing, talking about and just being aware of the multitude of ways real, healthy bodies look can be a major trigger for critical thinking and conversations about real health.** Though we don't often see those enabling disruptions in mass media, they do happen. Women who perform "health" without appearing as the cultural ideal of "healthy" exist *everywhere.* I know **lots** of women who run marathons, do triathlons, teach Zumba 5 times a week, or otherwise exercise regularly, eat healthy and have excellent health records and do NOT look anything like "fitness" models. I cannot express what a positive influence those women have had on my own body image and perceptions of health. I also know **lots** of women who don't perform or embody "health" but appear "healthy" by mediated and culturally upheld standards. We can all help to expose the unnaturalness of idealized body portrayals that oppresses women, and one of the ways to do that is to BE those women. Work for health and fitness, regardless of what you look like in the process. Stick with it even if your body doesn't look (or weigh) the way we've been taught healthy bodies look (and weigh).

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Susan Bordo (1993) invoked the idea of collective disidentification in the introduction to her book "Unbearable Weight" when she discussed the power of simply sharing a moment of shock and rage with a room full of young girls as she showed them examples of Photoshopping to reveal the unreality of media images – starting with the infamous 1989 *TV Guide* cover featuring Oprah's head pasted onto a young, thin, White actress's body. This experience is reflective of an opportunity for empowerment, which is gained as "individuals develop a shared conception of how they are systematically exploited to benefit another group" (Radford-Hill, 1986, p. 159).

Until engaging with a group of college-age women to openly discuss body image, Rubin et al. (2004) found, "Most group members felt they were alone in their difficulty challenging mainstream beauty ideals" (p. 36). Rubin et al. (2004) said feminist scholars or leaders "can help by sharing their own strategies and struggles in resisting normalized beauty ideals, and by validating young feminists' struggles and celebrating their courage to name and challenge their oppression" (p. 36). Solidarity, unity, understanding and

empathy can arise from these circumstances in the form of collective disidentification as more and more women begin to view themselves as the authorities on their own bodies, on their own health, and their own lived experiences with what it means to be healthy or to simply have an acceptable body.

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