The importance of being thin

Örebro Studies in Medicine 41

Sanna Aila Gustafsson

The importance of being thin

– Perceived expectations from self and others and the effect on self-evaluation in girls with disordered eating

Title: The importance of being thin – Perceived expectations from self and others and the effect on self-evaluation in girls with disordered eating

Publisher: Örebro University 2010
www.publications.oru.se

Editor: Heinz Merten
heinz.merten@oru.se

Printer: intellecta infolog, Kållered 02/2010

ISSN 1652-4063
ISBN 978-91-7668-717-8

Abstract

Sanna Aila Gustafsson (2010) The importance of being thin – Perceived expectations from self and others and the effect on self-evaluation in girls with disordered eating.

The overall aims of this thesis were to examine personal standards, self-evaluation and attitudes to eating and weight in the development of disturbed eating in adolescent girls, and to examine how adolescent girls with a clinical eating disorder reflect upon and deal with perceived expectations in daily life.

Studies I and II were quantitative studies, conducted in a population-based longitudinal study. Studies III and IV were qualitative interview studies of girls who were suffering from eating disorders and the data were analysed using a phenomenographic approach.

Study I showed that high personal standards expressed in a competitive way were specific for the girls with disturbed eating. These girls also reported a negative physical self-evaluation and often believed that thinness would make them more popular. In study II variables concerning attitudes to eating and weight and physical self-evaluation emerged as risk factors for disturbed eating, whereas personal standards or self-evaluation in general did not. Protective factors were a low BMI, healthy eating attitudes, an accepting attitude towards body size and a positive self-evaluation. Three categories of perceived expectations were described in study III: expectations from others, self-imposed expectations and conflicting expectations. Many informants had problems identifying expectations that were not explicit and they interpreted them as self-imposed. In study IV the various ways in which the informants reflected on dealing with these expectations were summarized into three qualitatively different conceptions: being oneself, adapting to different situations and presenting oneself in a positive light. These conceptions were expressed in five patterns of action, which could have various functions for different individuals and in different situations.

The results suggest that in order to prevent and treat eating disorders and related problems it is essential to integrate both intrapersonal and contextual factors that contribute to the development and maintenance of these conditions.

Keywords: Eating disorders, risk factors, protective factors, sociocultural factors, gender, perfectionism, personal standards, competitiveness, phenomenography.

List of PAPERS

This thesis is based on the following original papers, which will be referred to in the text by their Roman numerals:

I. Gustafsson SA, Edlund B, Kjellin L, Norring C. Personal standards, self-evaluation and perceived benefits of thinness in girls and young women with disturbed eating *European Eating Disorder Review*. 2008:16(6):463-471.

II. Gustafsson SA, Edlund B, Kjellin L, Norring C. Risk and protective factors for disturbed eating in adolescent girls – Aspects of perfectionism and attitudes to eating and weight. *European Eating Disorder Review* 2009:17(5):380-389.

III. Gustafsson SA, Edlund B, Davén J, Kjellin L, Norring C. Perceived expectations in daily life among adolescent girls suffering from eating disorders – a phenomenographic study. *Eating Disorders- The Journal of treatment and prevention* 2010:18:1, 25-42.

IV. Gustafsson SA, Edlund B, Davén J, Kjellin L, Norring C. How to deal with perceived expectations in daily life. – Reflections of adolescent girls suffering from eating disorders (submitted)

LIST OF ABBREVIATIONS

AN	Anorexia Nervosa
ANOVA	Analysis of Variance
BED	Binge Eating Disorder
BMI	Body Mass Index
BN	Bulimia Nervosa
CBCL	Child Behaviour Check List
ChEAT	Children's Eating Attitude Test
DE-group	Disturbed Eating group
DEMO	Demographic and dieting questionnaire
DSM-IV	Diagnostic and Statistical Manual- Fourth Edition
EDI-C	Eating Disorder Inventory- Child version
EDNOS	Eating Disorder Not Otherwise Specified
HE-group	Healthy Eating-group
IDA	Identification of Dieting in Adolescent girls.
IE-group	Intermediate Eating concern-group
NICE	National Institute for Health and Clinical Excellence
PS-group	Psychosocial problems-group
SF-group	Symptom Free-group
SOP	Self-Oriented Perfectionism
WHO	World Health Organisation

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INTRODUCTION

> "There is a huge gap at present between what is taught in therapy and what is taught in mass media and the culture at large"[117](p.381).

My interest in writing about eating disorders among teenage girls was prompted after working clinically for several years with teenagers and young adults who were suffering from this kind of problem. As a social worker I was accustomed to viewing psychosocial problems in their social context so I was surprised to find such a strong emphasis on individual and family factors in the treatment regimes. This is so despite the fact researchers agree that social factors contribute significantly to the onset of the disorder. A primary focus of treatment is often the mapping and alteration of the patient's dysfunctional thinking patterns. At the same time, my patients often described a collision between the messages they received in therapy and that they received from the mass media, friends and society at large. So I started thinking; is it really so dysfunctional to believe that weight loss would lead to greater appreciation by others? Or was the disordered eating initially a functional way of dealing with the social context in which girls and young women are living? And what messages do we send to these girls and women when we attribute these thoughts and behaviours to individual personality traits like perfectionism and negative self-evaluation? It was these thoughts that ignited my interest in how girls experience themselves in relation to their environment and to explore whether or not these factors might contribute to the development of eating disorders. I therefore became interested in the way in which girls who suffer from eating disorders reflect upon and manage the expectations they perceive from those around them.

BACKGROUND

Eating disorders used to be considered a western phenomenon, but with increasing cultural globalization they have spread to all parts of the world and are now found in all social and cultural contexts[86]. Eating disorders are highly gendered and girls and women are greatly overrepresented among sufferers[114]. However, several recent studies have shown an increased rate of eating disorder symptoms in males[22,31,142] and have hypothesized that this may be due to increasing social and media emphasis on male ideal body shape and appearance[22,103]. Eating disorders have been associated with adolescence, but research on eating disturbances and body dissatisfaction in children reveals that both are found well before the onset of adolescence[47]. It also seems that greater attention is now being paid to eating disorders among adult women[74]. This development appears to be the result of an increasingly uniform female ideal, with young girls being forced into prematurely playing adult roles[75], although society has simultaneously become increasingly youth-oriented[74]. Hesse-Biber, Leavy, Quinn, & Zoino[52], claim that eating disorders are a social disease, which needs to be understood within the sociocultural context that affects us all, regardless of gender, class, ethnicity or age. Nevertheless, eating disorders continue to affect adolescent girls disproportionately and Smolak & Murnen[114] point out that it is therefore surprising that so little attention has been paid to the lived experiences of adolescent girls.

When does disordered eating become an eating disorder?

Fairburn & Walsh[26] suggested a definition of eating disorders as follows: "A persistent disturbance of eating behavior or behavior intended to control weight, which significantly impairs physical health or psychosocial functioning" (p.171).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)[3], diagnoses of eating disorders can be divided into three main categories; Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS). A subcategory of EDNOS is Binge Eating Disorder (BED), which is considered a provisional diagnosis in DSM-IV. The criteria for the DSM-IV eating disorder diagnoses are presented in Appendix A.

The characteristic behaviour of a person with AN is a restrictive eating pattern and significant weight loss, while the characteristic behaviour of a person with BN involves regular episodes of binge eating with a sense of lack of control followed by compensatory behaviour. EDNOS represents

eating disorders of clinical severity that do not meet the diagnostic criteria for AN or BN[28] while BED represents a pattern of episodes of binge eating without the subsequent compensatory behaviour. The psychopathology of EDNOS is of comparable severity to that of AN and BN, and many patients oscillate between the diagnoses[28]. Despite this, EDNOS have been neglected by researchers. Recently there has been debate about the usability of the diagnostic classifications for eating disorders, and alterations to the diagnostic classifications have been suggested[29]. Applying the strict diagnostic criteria to children and adolescents poses certain problems. For example, many adolescents who are severely underweight do not express concern about their body shape or weight and consequently they fail to meet the criteria for AN. The weight criteria also pose certain problems in diagnosing children and adolescents since adolescents' weight should be assessed in relation to their individual growth charts. Furthermore, the menarche criteria of AN is difficult to apply in prepubertal cases. Adolescents may also find it difficult to describe their thoughts or behaviour or they may be reluctant to do so, and this can make it difficult to reach a diagnosis[36].

The notion of body image problems refers to problematic attitudes towards body size, weight or shape. While the sociocultural "ideal" body is becoming thinner we are witnessing a worldwide increase in body weight and obesity[140]. Body image problems may, however, affect people of all sizes and they often present as significant clinical problems that cause high levels of distress and are associated with some degree of disturbed eating[15].

Disordered eating that does not meet the diagnostic criteria for an eating disorder are often labelled disordered eating, disturbed eating, sub-clinical eating disturbances or symptomatic eating. There are no clear definitions of these concepts, and they can be measured in different ways. The common denominator is that they include some degree of disturbed eating behaviour, such as restrictive eating, binging or purging. The narrow definition of eating disorders in the DSM-IV has been criticized for not being applicable to a considerable number of individuals who are suffering from clinically significant symptoms related to eating, body shape and weight[127].

How common are eating disorders and related problems?

The lifetime prevalence for AN is estimated to be 0.9% in females and 0.3% in males[55]. The incidence rate is estimated to be 8 new cases per 100.000 of the population per year[54] with girls aged 15-19 years constituting approximately 40% of all new cases. The incidence of AN in Europe

has been stable since the 1970s[54] although one recent study has reported an increase among girls aged 15-19 years[139].

The lifetime prevalence of BN is estimated to be 1.5% and 0.5% for females and males respectively[55] and the incidence rate is estimated to be 12 new cases per 100.000 of the population per year, with the highest risk in females in the age range 20-24 years[54]. While one study[55] found an increase of BN with successive birth cohorts, another study found a decline in BN rates[65]. These contradictory findings may reflect methodological shortcomings, lack of data, and the taboo surrounding BN[54].

EDNOS are more commonly encountered than either AN or BN, but since there is no clear definition of them it is difficult to estimate how common these conditions are[28] or to distinguish a clinical eating disorder from disordered eating behaviour. As a result few studies have investigated the prevalence of EDNOS in community samples. One of the few studies that has included both sexes found a lifetime prevalence for EDNOS of 14.6% in girls and 5.0% in boys[68], though this study used self-reported data and these results may be an overestimation. Data suggest that the prevalence of EDNOS (including BED) is increasing in both men and women[50]. For BED the lifetime prevalence has been estimated as 3.5% in women and 2.0% in men, with an increase with successive birth cohorts[55].

Disordered eating behaviours are relatively common in adolescents and young adults. Among high school students in the USA abnormal eating and weight strategies in the month prior to the interview were reported by over 26% of the girls and 10% of the boys[30]. In a sample of men and women between the ages of 18 and 35 years it was found that although more men (26%) than women (18%) reported overeating, women more often reported losing control over their eating than did men (29.6% versus 20.0%). Women also more frequently reported vomiting (3.7% versus 1.5%) fasting (6.3% versus 4.0%) and body checking (22.5% versus 8.9%)[130].

In a sample of university undergraduates 84% of females and 78% of males reported a desire to weigh less, and 59% of the females and 34% of the males reported attempting to lose weight in the past year[87]. A study conducted in collaboration with the World Health Organisation (WHO) compared various health behaviours among adolescents in 42 countries. In the Swedish sample 48% of 15 year old girls thought they were too fat, while only 9% actually were overweight. The mean value in all 42 countries was 28% of girls feeling that they were too fat, and 10% actually being overweight. However, this negative attitude to body size was not strongly associated with weight reduction behaviour. Of the Swedish girls,

15% of 15 year olds reported actively trying to reduce weight, which compares with 23% in the whole sample[20].

In conclusion, although AN and BN are relatively uncommon, there is a considerable number of adolescents and young adults – especially girls and women – who are affected by EDNOS or sub-clinical problems related to eating, weight and shape.

Why are girls more affected than boys?

Adolescence is a time of physical change and weight gain, and many girls experience tension between the cultural ideals of female beauty and the physical reality of their own body[127]. Body image is an important aspect of adolescent girls' self-evaluation[72] and girls more often discuss appearance with their peers than do boys. These discussions form the everyday context that adolescent girls have to deal with, participate in and interpret and this may lead to concerns about appearance[61]. It is generally agreed that this is because appearance is a more important competetive domain for girls than it is for boys[52]. The mass media provide a significant source of sociocultural pressure regarding appearance and thinness, and girls are more affected than boys by these media messages[45]. The impact of media images is particularly powerful upon girls who place great importance upon their appearance[40,45]. The mass media generate messages designed for large, heterogenous and anonymous audiences, and today's photographic techniques blur the boundaries between fiction and reality[134]. Many girls may find it difficult to understand that the images of slender models with a "perfect appearance" do not represent reality. Through fashion magazines, internet sites and chat rooms insecure adolescents are able to access advice about how they should be or act. However, such advice is often provided by people who are more interested in promoting products and images than in enhancing a positive self-evaluation[75]. The mass media often portray women as sexual objects and it has been suggested that adolescent girls may internalize this objectification of their body (i.e. self-objectification)[66]. Experiences of sexual objectification by others, and internalization of the objectifying gaze have both been associated with disordered eating patterns[84,100] and with clinical eating disorders[13].

It has been suggested that girls with eating disorders are more likely than their peers to make social comparisons, make negative self-appraisals[18] and they tend to attach more importance to being attractive while simultaneously feeling relatively unable to do so[67]. A girl's peer group functions as a subculture that may either strengthen or weaken concerns about eating, weight and body shape[143]. Experiences of peer influence and peer pressure

often contribute to dieting behaviour in adolescent girls[59]. Competition with and pressure from peers to diet are strongly associated with increased dieting behaviour[57]. Adolescent girls are socialized to be interpersonally oriented, and to be considerate towards the feelings, needs and interests of others. This combination of gender prescriptions (i.e. to be interpersonally oriented and to define themselves by their physical appearance) makes girls more susceptible than boys to the opinions of others[116] and more likely to internalize ideals of thinness[21].

Girls also seem to be more affected than boys by comments made by parents about thinness[108,113] as well as to more subtle messages, feedback and role-modelling by parents. The role played by mothers has been subject to more investigation than that played by fathers but both parents have been found to affect their children's, especially daughters', fears of fatness, body dissatisfaction and efforts to lose weight[108]. For example, mothers are more likely to encourage their daughters than their sons to be thin[99]. These patterns have been found even among preschool children[82], and previous research has suggested that parents are increasingly likely to criticize their children's appearance as the children get older[129]. Daughters are also more susceptible to this kind of parental pressure[108,113], and they are more likely to diet in response to their mothers' encouragement and role-modelling[144]. An association has also been found between mothers' internalizations of media ideals of thinness and eating pathology in their daughters[17].

In the last forty years there has been a rapid and substantial change in the feminine gender role, e.g. women nowadays have a greater independence socially and professionally[114]. However, it has been suggested that the dominant feminine role model for today's girls and women is the "superwoman", who is able to maintain a good career, a happy marriage, healthy children, an active social life and be good looking[114,116]. Research suggests that girls and women who internalize these perfectionist ideals have a higher rate of eating problems[48,116]. Adolescent girls experience many gender stereotypical and often contradictory messages that may be difficult to decode and relate to. For example, although women can now enjoy new opportunities in society, there are still sociocultural forces that discourage women from pursuing some options and promote others[114]. Many young women feel they have fewer chances than men of achieving. While girls are told to be enterprising and to achieve academically, contradicting messages tells girls and women that appearance is the proper arena for female competition and success in appearance is more important than academic success. For example, the most recognizable women are often those who are known more for their looks than for their skills or competence[75]. At the same time, women who are seen as sexy and attractive are often also con-

sidered to be relatively incompetent and unknowledgeable. Young women may thus choose the pursuit of attractiveness as their most viable path to success and their choice to try and achieve a thin body may therefore be rational[81].

Risk factors, protective factors, maintaining factors and symptoms

A risk or protective factor is a measurable factor that precedes an outcome and which can be used to divide the population into a high-risk and a low-risk group. The term risk factor is used for factors associated with an adverse outcome, whereas the term protective factor refers to factors that decrease the likelihood of an undesirable outcome[70].

Many risk and protective factors are common to a number of disorders, and identifying general risk or protective factors may guide the development of broad preventive and health promoting interventions[19]. However, in order to design targeted programmes for high-risk individuals, it is also important to identify specific risk and protective factors for the development of healthy versus disturbed eating[19]. In the last two decades research on the risk factors for eating disorders has grown rapidly[60], while research on the factors that protect against developing disordered eating has attracted less interest[19].

A factor that predicts the persistence of disordered eating in individuals already suffering from an eating disorders is called a maintaining factor. It is important to distinguish between risk factors and maintaining factors, since the identification of maintaining factors is crucial for designing effective treatment interventions. A particular factor may initially function as a risk factor and then, when the eating disorder has become established, it may help perpetuate the disorder[125].

Some researchers have postulated that the increasing interest in investigating causal factors in the development of eating disorders has resulted in an overemphasis on risk factors. For example Polivy & Herman[102] note that features that were formally considered to be symptoms of an eating disorder, such as perfectionism, need for control and self evaluation concerns, have recently been relabelled as risk factors. These authors warn that there is a risk with this approach that treatment will become overly focused on behavioural alteration with regard to eating and weight since the psychological factors associated with eating disorders are no longer considered central.

Researchers have noted the difficulty of identifying the debut of an eating disorder. Clinical syndromes may be preceded by long periods of symptomatology and it is therefore difficult to say when a disordered eating pattern shifted into an eating disorder[60]. In fact, it is likely that the disordered eating and the psychological factors reinforce one another[83,123]. It is therefore difficult to decide which factors preceded the eating disorder[60].

Thus, subsequent research emphasize the importance of both intrapersonal and contextual factors in the aetiology and maintenance of eating disorders. Various factors function in the development and perpetuation of disordered versus healthy eating: risk factors, protective factors, maintaining factors and symptoms of disordered eating. Below, I shall present some of the central concepts that will be used in this thesis. This presentation makes no claim to be exhaustive but it describes a selection of existing research and is designed to place the concepts and this thesis into context.

Perfectionism and personal standards

Eating disorders have been described as the expression of a perfectionist attitude in the area of eating, body shape, and weight and Shafran, Cooper & Fairburn[109] propose that perfectionism is a key maintaining factor for eating disorders. It has been suggested that perfectionism is a predisposing personality trait that increases the risk of developing eating disorders[73]. However, longitudinal study has not found evidence for perfectionism as a risk factor for eating disorders in general[60]. Pearson & Gleaves[98] suggest that one reason for this may be that perfectionism is a multidimensional trait, and that different aspects of perfectionism may be associated with eating disorders in different ways and that in order to study this we need to investigate specific and clearly defined traits that maintain the disordered eating. Self-oriented perfectionism (i.e high personal standards) is an aspect of perfectionism that has been especially associated with eating disorders[14].

Shafran et al.[109] argue that the pursuit of excellence *per se* is of little clinical relevance, and that this should not be confused with the dysfunctional perfectionism that is seen in clinical samples. They define clinical perfectionism as: "the overdependence of self-evaluation on the determined pursue of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences"(p. 778). However, this definition has been criticized by Hewitt, Flett, Besser, Sherry & McGee[53] for failing to take account of the social context. Dunkley, Blankstein, Masheb & Grilo[23] respond to the work of both Shafran et al.[109] and Hewitt et al.[53] by suggesting that there are two higher order dimensions of perfectionism that reflect personal standards and self-critical evaluation

concerns. They contend that high personal standards are not in themselves maladaptive, while self-critical evaluation concerns are. They underline the need to take interpersonal processes into account in order to explain and understand the maintenance of perfectionism.

Competitiveness

Competitiveness has been called the number one obsession of many western societies that leaves no corner of our lives unaffected by the compulsion to rank ourselves against one another[69]. Perfectionism and competitiveness are closely related, but while perfectionism involves trying to live up to standards set by oneself, competitiveness involves pursuing a standard based on the performance of others. While perfectionism has been the object of interest in much research on eating disorders, competitiveness has attracted very little attention.

Researchers have suggested that there is an important distinction to be made between two kinds of competitive attitude. *Hypercompetetiveness* is described as the need to be successful at all costs in order to feel good about oneself, while *personal development competitiveness* does not focus on winning, but rather on self-improvement and task mastery[104,105]. Hypercompetitiveness has been found to be associated with disordered eating[128], especially when it concerns physical appearance[11].

However, it has been hypothesized that personal development competitiveness may be associated with optimal psychological health. More particularly, it has been suggested that since individuals with this type of competitive orientation are not interested in comparing themselves to others but are focused on personal development, they may be more resistant than most to societal pressures to be thin. It is therefore hypothesized that different kinds of competitiveness may act as either risk or protective factors in the development of disordered eating, although these hypotheses have not been tested in longitudinal research[128].

Self-evaluation

The term self-evaluation refers to ways in which individuals assess their self-worth[49], and the concepts of self-concept, self-scheme and self-esteem are closely related to this.

Several longitudinal studies have discussed negative self-concept, although each defines and measures this in different ways, which may explain why the results are inconclusive. However, Jacobi, Hayward, de Zwaan, Kraemer & Agras[60] conclude that there is a slight preponderance

of studies that have found a negative self-concept, low self-esteem or ineffectiveness to pre-exist the development of eating disorders, although these factors are not specific to eating disorders. Self-esteem and positive self-evaluation are also the factors most consistently associated with resilience to eating disorders[127].

An individual's self-evaluation is multidimensional, and it varies across the different domains in life[49] as well as according to the individual's appraisal of a situation. Thus low perceived competence has a stronger negative impact on psychological well-being if it concerns an area of great importance to the individual[67]. Appearance and weight are often very important to adolescent girls, and it has been suggested that weight-related self-evaluation (i.e. the impact that body image has on self-evaluation) plays a role in the transition from dieting to disordered eating and in the maintenance of disordered eating patterns[83]. For example, negative self-schemes have been found to be predictive of disordered eating behaviour 6 and 12 month later, but only in subjects who initially had a negative body image[115]. A negative self-evaluation with regard to weight and body shape is also a symptom often found in individuals who are suffering from an eating disorder, and a factor that maintains disordered eating[27].

Sociocultural pressures

The sociocultural model of eating pathology[118-120] hypothesizes that social pressures to be thin from multiple sources (i.e. mass media, family and peers) encourages social comparisons, internalization of a thinness ideal, over-emphasis on the importance of appearance and body dissatisfaction, which in turn increases the risk for eating disorders[125]. Sociocultural pressures from mass media, family and peers have been shown to have a cumulative effect[24]. Prospective and experimental findings support this conclusion and also suggest that the negative effects of social comparisons and sociocultural pressures to be thin are more pronounced for individuals who already experience body dissatisfaction[41,125].

Huon and Strong[56] propose that separate forms of social influence from family, peers and mass media (i.e. modelling, competitiveness, conformity and compliance) are important precursors of dieting behaviour among adolescent girls. Although this model finds some support[56,58] further study of these relationships is required. For example, the above-mentioned sociocultural pressures have only been studied with regard to dieting and appearance, while areas other than appearance have not been examined using this model. Sociocultural pressures in other areas than appearance have been neglected in research on eating disorders, although there has

been a recent tendency to broaden the scope of inquiry to include the internalization of social discourses[100].

Experimental research suggests that sociocultural pressures to be thin play a more important role in fostering eating pathology than in maintaining it[125]. However, in a study of media usage based on interviews with 28 women who were suffering from anorexia, the following vicious cycle was evident; the more advanced the anorexia, the more dependent the women became on the media as a source of advice. This suggests that the media may play a role in both fostering and maintaining an eating disorder[146].

However, there are also factors that serve a protective role against these sociocultural pressures. For example, it has been suggested that support from family and peers and the ability to resist stereotypes may protect against the development of eating disorders[127,143].

Body dissatisfaction

A number of longitudinal studies have addressed weight concern, body dissatisfaction and negative body image and found these to be significant risk factors for the development of eating disorders[60]. It has also been suggested that an accepting attitude towards body size and shape is protective[16] and that these factors play a pivotal role in maintaining an established eating disorder[27]. Actual body mass has not been found to directly increase the risk of developing an eating disorder[60,125] but it does appear to increase the likelihood of body dissatisfaction, a perception of pressures from others to be thin and poor self-esteem. It thus seems to play an important role in promoting risk factors for the development of an eating disorder[125].

The belief that thinness will improve popularity among friends has been associated with dieting and weight concern[35,107], and it has also been suggested as a risk factor for the development of both anorectic[133] and bulimic[124] psychopathology. One study found that for girls at age 11, a larger perceived body size, and a smaller idealised body size were predictive of higher eating disorder scores three years later[32]. This is in line with research that has suggested that perceived body size and perceived pressures to be thin have a greater impact on disordered eating patterns than actual body size[41,123].

Eating attitudes and dieting

The association between dieting and eating disorders is often quoted in theories of the aetiology of eating disorders. In one oft-quoted study it was

shown that adolescent girls who dieted were at eight times greater risk of developing disordered eating than those who did not[95] and in a more recent study, the same author noted that severe dieters ran an even higher risk (18 times) of developing an eating disorder than initial non-dieters[96]. Thus, dieting might seem to be an important precursor of eating disorders[60]. However, results from experimental studies using calorie deprivation do not support the conclusion that dieting is a risk factor for eating disorders[125]. It would therefore seem that it is rather self-reported dieting together with problematic eating attitudes or weight concerns that is associated with eating disorders[60,125]. Clearly, once an eating disorder has developed, these attitudes tend to perpetuate the problem[27].

In summary

Although there is consensus that both intrapersonal and contextual factors play important roles in the development and maintenance of healthy as well as disordered eating, few studies have investigated these factors in longitudinal studies, and even fewer have investigated them from the point of view of adolescent girls who are struggling with them. It has been shown that distressing experiences and conditions in daily life affect psychological health more negatively than do adverse life events, and the more these daily experiences become internalized within the individual's value system, the more they influence psychological wellbeing[71]. In order to enhance treatment we need to understand how those who suffer from eating disorders make sense of their world, and how they are affected by and try to deal with specific situations in daily life[79].

AIMS

This thesis has two major objectives. Firstly, it aims to examine personal standards, self-evaluation and attitudes to eating and weight in the development of disturbed eating in adolescent girls. Secondly, it aims to examine how adolescent girls with a clinical eating disorder reflect upon and deal with perceived expectations in daily life.

These overall aims were expressed in four specific aims:

- To examine possible differences in personal standards, self-evaluation and perceived benefits of thinness among three groups of Swedish females aged 14-21 years: one group with disturbed eating, one group with other psychosocial problems and one symptom free group. (Study I)

- To longitudinally examine the role of personal standards, self-evaluation, perceived benefits of thinness and attitudes to eating and weight in the development of healthy versus disturbed eating in adolescent girls. (Study II)

- To describe the variation of perceived expectations in daily life of adolescent girls who suffer from eating disorders. (Study III)

- To investigate how adolescent girls with eating disorders reflect upon various ways of dealing with perceived expectations in daily life. (Study IV)

METHODS

This thesis includes four papers. Studies I and II are quantitative and are based on data from a population-based longitudinal study, while studies III and IV are derived from qualitative interviews. Studies I and II are linked to each other as are studies III and IV. Therefore, the presentation of methodology below is organized into two sections: studies I & II and studies III & IV.

Studies I & II

Participants

The IDA project

Studies I and II form part of a prospective longitudinal study of risk and protective factors in the development of eating disturbances in girls (Identification of Dieting in Adolescent girls: the IDA-project). The study employs an accelerated multicohort design[64] and data are derived from simultaneous assessments of five age groups (7, 9, 11, 13 and 15 years at inclusion). The sample was selected by a stratified random sampling procedure based on all school classes in Uppsala county (pop. 289.062) in central Sweden. A total of 39 schools, which were selected to reflect the national pattern of living conditions, were randomly sampled and approved for participation. Letters with information about the purpose and procedure of the study were sent to the girls, their parents, teachers and school nurses, and informed consent was requested from both the girls and their parents before the girl was included. Recruitment was terminated when the number of girls who had accepted the invitation had reached at least 250/age group. In the two oldest age groups it was expected that there would be a higher percentage of dropouts at the follow-up in year 2000, since these girls would not still be in school. Therefore a larger number of girls was invited and included in these two age groups. The younger girls (below age 10) and a few older girls who had reading and writing difficulties participated in an interview based on the questionnaires, while the remaining girls completed questionnaires during regular class time. After the girls had completed the assessment, they were asked to bring home an envelope containing questionnaires to their parents, who where asked to return the completed forms by post. In year 1, the total number of participants in was 1.279 (231 aged 7, 212 aged 9, 263 aged 11, 304 aged 13 and 282 aged 15). The following years all of the girls who had participated were invited

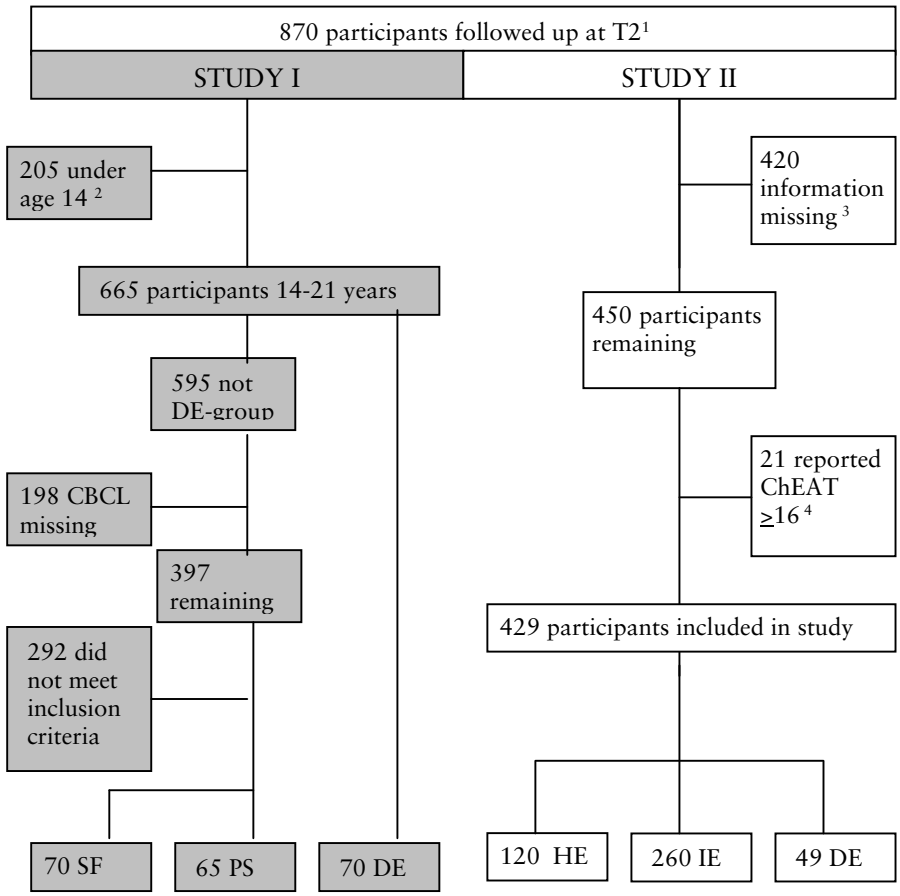
again and at the follow-up five years later, 870 (68%) of those who took part in 1995 participated. The design and methods of the IDA-project have been described elsewhere[42]. The Research Ethics Committee at the Faculty of Medicine, Uppsala University, granted ethical approval for this study.

Sample in studies I and II

Studies I and II are based on data from participants who took part in the assessment five years after inclusion. These data come from assessments made in 1995/1996 (referred to as T1) and 2000 (referred to as T2). In order to compare T2 data with an earlier assessment (study II) we used data from 1995 for participants in the two oldest age groups (13 and 15 years at inclusion). One of the instruments, EDI-C (all instruments will be described in the next section) was not given to the 11-year-olds in 1995 and data from 1996 were therefore used for this age group. Participants in the youngest age group were not included in the studies, since they had not been given the EDI-C instrument at any time, and participants in the following age group (9 years at inclusion) were not included in study II, since they had not been given the EDI-C in either 1995 or 1996. The participants included in studies I an II are shown in flow-chart (figure 1).

At T2, 70 of the girls (8.5%) reported disturbed eating patterns that exceeded the limit that had been set using the Childrens Eating Attitude Test (ChEAT). Of these participants 37 (52.9%) reported repeated attempts to eat less than 500 kcal/ day, 39 (55.7%) reported vomiting in order to control weight, 34 (48.6%) reported losing control over their eating, 30 (42.9%) reported excessive exercise, 7 (10%) reported taking diuretics, 5 (7.1%) reported taking diet pills and 4 (5.8%) reported taking laxatives in the past year. All of them reported experiencing at least one of these symptoms in the past year. In study I these participants were all included in the Disturbed Eating-group (DE). In order to control for pre-existing eating disturbances, the 21 participants who scored over the cut-off limit on the shortened ChEAT at T1 were excluded from the DE-group in study II.

Figure 1. *Overview of the inclusion of participants: study I in grey boxes to the left, and study II to the right.*



[1] 870 of the 1279 participants included in 1995 responded to the follow-up in 2000.

[2] Participants in the youngest age group were excluded since EDI-C was not given to them at T1.

[3] Participants in the two youngest age groups (n=395) were excluded, since EDI-C was not given to them at T1. An additional 25 participants were excluded due to missing data at T1 or T2.

[4] Since we were interested in studying predictors for disturbed eating during the follow-up period, participants with ChEAT-scores at T1 at or above the cut-off were excluded.

Study I consisted of 205 girls/young women who were divided into three predefined groups:

- DE-group (n=70): participants who scored ≥ 16 on the shortened ChEAT were selected for the Disturbed Eating-group.
- PS-group (n=65): participants with scores ≥ 18 on the revised CBCL and ChEAT-scores < 16 were selected for the Psychosocial problems-group.
- SF-group (n=70): participants with ChEAT-scores = 0 and who had CBCL-scores below the median (≤ 7) were selected for the Symptom-free group.

Participants were aged between 14 and 21 years, with a mean age of 16.8 years at T2. The mean BMI was 21.1, with a range of 15.8-41.5. There were no significant differences between the groups in age or BMI. Four out of five of the subjects had at some point wished they were thinner, and all in the DE-group had wished they were thinner.

Study II used a longitudinal design where data from T1 were analysed to find predictors that might constitute risk and protective factors for the development of disturbed eating. The subjects (n=429) were divided into three groups according to eating concerns at T2.

- DE-group (n=49): participants with scores ≥16 at T2 but not at T1 were selected for the DE-group; these participants had developed disturbed eating patterns during the follow-up period.
- IE-group (n=260): participants with ChEAT-scores 1-15 at T2 were defined as the Intermediate Eating concern group.
- HE-group (n=120): all participants with ChEAT-scores = 0 at T2 were selected for the Healthy Eating attitudes group.

The mean age of the participants at T1 was 13.5 (range 12-16) and the mean BMI was 19.6 (range 13.4-32.0) with a significantly lower BMI in the HE-group than in the other two groups.

Measures

Children´s Eating Attitude Test: ChEAT (studies I & II)

A Swedish version[25] of the Children´s Eating Attitude Test[76] was used to assess attitudes and behaviour associated with eating disorders. ChEAT includes three subscales; "Dieting", "Bulimia" and "Oral control". The

instrument consists of 26 items, but items 13, 19 and 25 have been reported to have low item-total correlations[111] and were therefore excluded, leaving a 23-item instrument. Chronbach´s alpha of .89 has been reported for the 23-item scale. A score of 20 or more on the ChEAT has previously been suggested as a cut-off point for the development of clinical eating disorders[111]. Since we excluded three items, a new cut-off score of ≥ 16 was used for this study. Each item is formulated as a statement, and the response format uses six categories from "never" to "always", and the most dysfunctional attitude is ranked 3, followed by 2 and then 1. The three most functional attitudes are not ranked. Thus higher ChEAT-scores indicate more eating and weight concerns.

Child Behaviour Checklist: CBCL (study I)

The CBCL[2] is an instrument for measuring social competence and behavioural or emotional problems in children and adolescents. It is based on the parents' evaluation. It consists of questions about competence and problem items but only the problem items were used in this study. Items 2 and 4 (asthma and allergy) are not included in the total problem score. In this study we also excluded item 56, which measures the presence of physiological symptoms that have no known medical cause. The measured psychosocial problems include: withdrawal, anxiety, depression, social problems, thought problems, attention problems, delinquent behaviour and aggressive behaviour. Chronbach´s alpha of .96 has been reported for the CBCL problem scales. The 82nd to 90th percentile on CBCL has been suggested as a cut-off point[2] and in line with this scores over the 82nd percentile (≥ 18) for the total sample were selected as cut-off.

Demographic and dieting questionnaire: DEMO (study I & II)

A Swedish extended version[25] of the Demographic and Dieting Questionnaire[76] was employed. The questionnaire contains questions concerning demographics, self-reported weight and height, wish to be thinner, reasons for wishing to be thinner, dieting, disturbed eating behaviours and body image. Questions about age, weight and height were used to calculate Body Mass Index (BMI= kg/m^2). Since normal weight ranges differs according to age, age-adjusted BMI-percentiles were used for children and adolescents. For participants of 18 years or older the reference values for 18 years were used[51]. For details of the questions about demographics and dieting that were used see appendix B.

Eating Disorder Inventory for Children EDI-C (study I & II)

The EDI-C[33] Swedish version[136], includes 11 subscales, and in this study three of the items from the perfectionism subscale were used. For the adult version it has been suggested that the perfectionism subscale is best represented by three items that measure self-oriented perfectionism and three items that measure socially prescribed perfectionism[110]. This is likely to be true even for the EDI-C, since the items concern the same aspect and the psychometric properties of EDI-C are comparable to the properties of the EDI-2[135]. The three items concerning self-oriented aspects of perfectionism (SOP) all concern personal standards, and we therefore selected these three items from the original six perfectionism items in order to assess personal standards. Responses are given on a 6-point scale ranging from "never" to "always", where the most dysfunctional attitude is ranked 3, followed by 2 and then 1. The three most functional attitudes are not ranked; thus, the higher the value, the greater the dysfunctional attitude. Chronbach´s alpha of .74 has been reported for the three SOP-items of the perfectionism subscale[110].

I Think I Am (study I & II)

I Think I Am[93] is a Swedish instrument including five subscales measuring different domains of self-evaluation in children and adolescents. Responses are given on a 4-point scale ranging from "not at all true" to "certainly true". Higher values indicate a more positive self-evaluation. Chronbach's alphas for the relation between the subscales and the total scale between .71 and .82 have been reported. I Think I Am was used to measure Self-evaluation. It consists of the following five domains:

Physical traits (14 items) contains questions about body functioning (e.g., "I am generally healthy") appearance (e.g., "I feel ugly") and evaluation of body size (e.g., "I am neither too fat nor too thin").

Competence and skills (14 items) includes questions about self-evaluation of competence (e.g., "Others do things better than me") and related skills (e.g., "I remember easily").

Psychological traits (16 items) contains questions about personality traits (e.g., "I have a bad temper") coping abilities (e.g., "I give up easily") and behavioural conduct (e.g., "I seldom make trouble").

Family relations and support (14 items) contains questions about the perceptions of being seen and heard (e.g., "Nobody pays attention to me at home") or appreciated (e.g., "Mostly, my parents are pleased with me") by family members, as well as the perception of family support (e.g., "My family would always help me").

Social relations (14 items) contains items about the perception of being accepted and liked by people outside the family (e.g., "I have no close friends", "My teachers are nice to me")[93].

Statistical analyses

Categorical variables were analysed with Chi-square test and Fisher's exact test specially assigned for more than two groups when appropriate. To control for the effect of weight we performed separate chi-square analyses for participants with a BMI $\geq$ 75th age-adjusted percentile.

Data from ChEAT, EDI-C and I Think I Am were analysed using one-way analysis of variance (ANOVA) with Scheffe´s posthoc test. Two-way ANOVA's were conducted to control for the possible influence of BMI (study II) and three-way ANOVA´S were conducted to control for age and BMI (study I and II). BMI was entered as a dichotomous fixed factor with a breakpoint at the 75th age adjusted BMI-percentile[51]. Age was entered as a fixed factor with four values based on year of birth. In study II a variable was considered a risk factor if the DE-group differed significantly from both other groups, and correspondingly, a variable was considered a protective factor if the HE-group differed significantly from both other groups. P-values <0.05 were considered statistically significant.

Studies III & IV

Participants

Data for this study were obtained from interviews with girls in the age range of 15-19 years who were suffering from a clinical eating disorder according to DSM-IV and who had recently been accepted for treatment at a specialized eating disorder service in central Sweden. Of those girls who met the inclusion criteria a purposive selection was made to ensure a variation of diagnoses, ages, living conditions, school backgrounds and interests.

A total of 31 girls were asked to participate in the study, and 18 of them accepted. Eight of the informants had a restrictive pathology (5 AN, 3 EDNOS type 1 or 2). Six informants reported bingeing (1 BN, 5 EDNOS type 3) The remaining four informants were normal weight girls who frequently purged after eating normal amounts of food as a means of weight control (EDNOS type 4). The majority of the girls were living with one or both of their parents, while one was living with an older sister and two were living with their boyfriends. Four of the girls were still in high school,

and the remaining girls were studying at institutions from a wide range of higher education.

Data collection

At assessment a staff member gave verbal and written information about the study. If the girl was under the age of 18 her parents were also informed about the study and they had to give their written consent for their daughter to take part. If the girl agreed to take part in the study I contacted her to make an appointment. Seventeen of the interviews took place at the eating disorder unit and one in the girl's home. I conducted all the interviews. During the interviews I used a checklist to ensure that important topics were covered, but the informants were encouraged to speak freely about each topic. The checklist included questioning about which expectations they felt were communicated by the mass media, by their families, their schools and peers, and how they were affected by these expectations (see Appendix C). I used probes and follow-up questions to encourage informants to clarify and elaborate upon their responses and I used summarizing transitions to address possible misunderstandings[97]. However, when they described their perceptions of these expectations and how they were affected by them, the girls spontaneously began to reflect upon various ways of dealing with them and these reflections were in focus in study IV.

The interviews lasted for 35-65 minutes, and they were tape-recorded and transcribed verbatim. In order to enhance credibility and confirmability the informants' were invited to read their transcripts. The inclusion period lasted from November 2006 to March 2008. The Research Ethics Committee at the Faculty of Medicine, Uppsala University, granted ethical approval for the studies.

Data analyses

A phenomenographic research approach was used. Phenomenography is a context-related approach in which the differences between people's ways of experiencing and perceiving their worlds are brought into focus of awareness. Thus the results of a phenomenographic study lie in the variation of people's experiences. Focus is then upon the way in which the studied phenomenon is perceived (i.e. second order perspective) and the results are described in the outcome space. The purpose of a phenomenographic study is to describe the critical aspects of a person's way of experiencing the world that enables them to handle it more or less effectively[80]. There are

two major analytical frameworks in phenomenography. One is based on understandings of awareness, and the other is based on understandings of intentionality. Phenomenographic research commonly uses one or the other of these analytical frameworks, although they may also be used concurrently[46]. In study III we used the awareness framework, and the analysis contains a structural aspect (i.e. how the outcome is arranged) and a referential aspect (i.e. what the outcome is about)[80]. Study IV was analysed within an intentionality framework. Understandings of intentionality mean that all psychological phenomena are directed towards an object, and thus each conception has a "what" aspect and a "how" aspect[80]. In study IV the what aspect refers to the meaning that the informants attributed to dealing with perceived everyday expectations, and the how aspect refers to how they went about dealing with them. The data analysis was conducted in four steps in accordance with Marton & Beaty[79]. The steps of the analysis may sound straightforward, but in practice the analysis moves back and forth between these steps, and each step may entail a revision of the previous step.

- The first step consisted of listening to the interviews and reading the transcripts several times. In study IV this coding was performed in QSR N´Vivo, version 8.
- The second step consisted of identifying distinct ways of understanding by comparing differences, similarities and complementaries in the informants' statements. These statements were grouped into preliminary conceptions. In study III this was carried out by myself alone, but in study IV, both I and another author (JD) read the statements and grouped them independently of each other.
- In the third step these preliminary conceptions were discussed and compared with each other by me and another of the authors (JD) in a process of negotiated consensus[138]. This resulted in a preliminary map of the outcome space.
- In the final step each statement was discussed and grouped in relation to the preliminary outcome space. This process resulted in descriptions of the unique character of each conception and the relations between them.

RESULTS

Study I

In study I girls with disturbed eating (DE-group) were compared to symptom free girls (SF-group) and girls with other psychosocial problems (PS-group) on measures of personal standards, self-evaluation and perceived benefits of thinness.

Significantly more subjects in the DE-group (15.7%) than in the other two groups (1.5% in the PS-group and none in the SF-group) believed that their friends would like them better if they were thinner. Subjects from the DE-group reported as motivations for wanting to be thinner a desire to feel better about themselves, be more popular among boys and be better accepted by other girls significantly more frequently than subjects from both of the other groups.

The DE-group expressed significantly higher personal standards than did the PS-group (see table 1). By comparison with the SF-group, the DE-group expressed a more dichotomous and competitive pursuit of high personal standards, while there was no difference in terms of a more adaptive aspect of personal standards. All five self-evaluation domains showed significantly lower values in the DE-group than in the SF-group. This indicates that the subjects in the DE-group evaluated themselves more critically than did the subjects in the SF-group. On physical self-evaluation the DE-group also reported significantly more negative self-evaluation than the PS-group, while these groups did not show any significant difference on the remaining four self-evaluation domains.

Table 1. *Comparisons by one way analyses of ANOVA among the three groups.*

Construct[1]	Item/subscale	Mean values / SD			Sign [2]	Post hoc Scheffe
		DE	PS	SF		
Personal standards	I hate being less than best at things.	0.9 1.14	0.3 0.80	0.3 0.66	***	SF=PS<DE
	I feel I must be best, or not do anything at all.	0.6 0.95	0.2 0.62	0.1 0.37	**	SF=PS<DE
	I want to do very well at things.	1.8 1.14	1.1 1.05	1.4 1.04	**	PS<DE
Self-evaluation	Physical traits	3.0 8.79	8.3 9.47	17.1 6.25	***	SF>PS>DE
	Competence and skills.	7.5 8.41	8.5 7.35	13.1 5.61	***	SF>PS=DE
	Psychological traits.	1.7 10.00	6.0 10.66	17.5 8.07	***	SF>PS=DE
	Family relations	8.7 9.78	10.9 8.35	18.3 5.40	***	SF>PS=DE
	Social relations	11.8 6.84	11.8 8.44	16.9 5.80	***	SF>PS=DE
Perceived benefits of thinness [3]	Number of motives to be thinner	2.7 1.50	2.0 1.31	1.5 0.82	***	SF=PS<DE

[1] For "personal standards" and "number of motives to be thin" high values are more pathological, for "self-evaluation" higher values are more functional.

[2] ** p< 0.01 *** p<.001

[3] The remaining items in the construct "perceived benefits of thinness" were analysed with Chi-square test and are not included in the table.

Study II

In study II girls with disturbed eating at T2 (DE-group) were compared to girls with intermediate concerns about eating and weight (IE-group) and girls with healthy eating attitudes (HE-group). Comparison was made on personal standards, self-evaluation, perceived benefits of thinness and attitudes to eating and weight 4-5 years previously. There were no significant differences between any groups on the measurement of personal standards at T1. Nor did self-evaluation regarding social relations, family relations and competence and skills differ between any of the three groups at T1.

However, already at T1 the girls in the DE-group reported significantly more eating and weight concerns and more negative physical self-evaluation. They were also more likely than the subjects in both of the other groups to believe that being thinner would make them more popular with their friends. Consequently eating and weight-related variables and negative physical self-evaluation emerged as early risk factors (see table 2).

The HE-group deviated from both of the other groups on the following variables: lower BMI, healthy eating attitudes, an accepting attitude towards body size and a positive self-evaluation, particularly with regard to physical and psychological characteristics. Thus, these factors emerged as early protective factors.

Table 2. *Overview of variables that emerged as Risk and/or Protective factors.*

Variables measured at T1	Risk factor	Protective factor
Eating attitudes and behaviours measured by ChEAT	X	X
Body mass index (BMI)[1]		X
Ever having had a wish to be thinner[2]		X
Number of motives to be thinner[3]		X
Belief that thinness would make one more popular	X	
Self-evaluation of physical traits	X	X
Self-evaluation of psychological traits		X
Global self-evaluation		X

[1] Low BMI was found to be a protective factor.

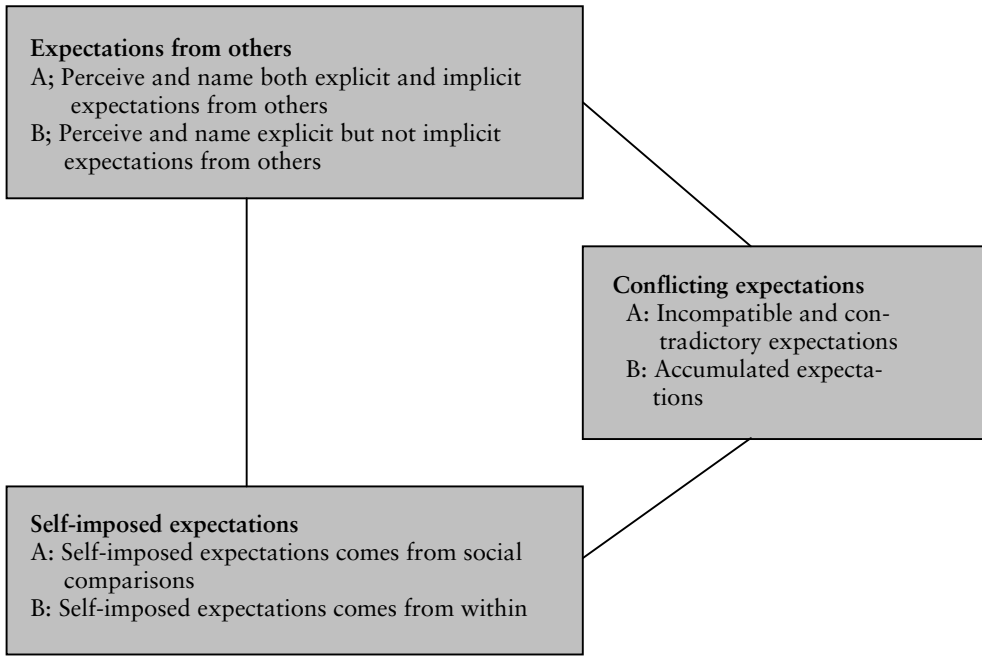
[2] Answering no to the question "have you ever wanted to be thinner" was associated with lower risk.

[3] Among those who reported having wanted to be thinner, the fewer motives they had, the less their risk of developing an eating disorder.

Study III

In study III girls with a clinical eating disorder were interviewed about perceived expectations in daily life, and how they were affected by these expectations. Three categories emerged: expectations from others, self-imposed expectations and conflicting expectations. These categories could be further subdivided into conceptions. The categories, the conceptions and the relationships between them are described in the outcome space (see figure 2).

Figure 2. *Illustration of the outcome space. The categories "expectations from others" and "self-imposed expectations" influenced each other. Conflicting expectations emerged when several expectations from others or self-imposed expectations separately or in combination came in conflict with each other.*



Expectations from others were perceived to be both explicit and implicit. Explicit expectations were described as other people communicating that particular characteristics or behaviours were desirable and how often they thought a particular form of behaviour should be performed. The informants described implicit expectations as being communicated by the way in which others responded to various characteristics or behaviours. Many informants had problems identifying expectations that were not explicit. The informants internalized these expectations and interpreted them as self-imposed.

Self-imposed expectations were those that informants described as integrated into their own value system. These were understood by informants in two qualitatively different ways: most informants perceived self-imposed expectations to arise mainly from social comparisons while some considered them to come mainly from within themselves. Self-imposed expecta-

tions contributed to a competitive attitude that created negative stress for the informants.

All of the informants described how ackumulated expectations from different areas could be conflicting and distressing. However, half of the informants also commented on a further dimension of conflicting expectations; contradictory and incompatible expectations, which were felt to be particularly distressing since the girls found it impossible to balance them. These contradictory expectations often had to do with gender stereotyping.

Study IV

Study IV took the results of study III a step further. The same informants reflected upon their efforts to deal with perceived expectations in daily life. All of the informants described having difficulty with this and all but two of them said that these difficulties had contributed to the eating disorder. The informants described two different aspects of dealing with perceived expectations, "Purposes of dealing with expectations" and "Patterns of action". The outcome space is described in table 3.

Purposes of dealing with perceived expectations was subdivided into three conceptions. "Being oneself" (conception A) was described as the most desirable way to deal with these expectations, but also the hardest. "Adapting to various situations" (conception B) was used without much reflection, as long as it worked. When this way of dealing with expectations was unsuccessful it was evaluated negatively by the informants, while "presenting oneself in a positive light" (conception C) was described negatively even when it was successful.

Patterns of action comprises five ways of dealing with perceived expectations in daily life: voicing feelings, changing one's way of thinking and planning, trying harder, doing something else and avoiding situations that involve negative affect. All of these were described as working well in certain situations. However, informants also explained that if they relied on the same pattern of action, without adjusting it to the demands of the situation, this had negative consequences. For instance, several informants said that "working harder" might work initially but if one continued with the same strategy this could lead to a competitive need to reach an ever higher level in the future. When it proved impossible to live up to these high personal standards, this could result in a sense of failure and fear of trying again. Several informants described having a competitive attitude which meant that they either made excessive demands of themselves or they did not try at all so as to avoid failing.

Table 3. *Illustration of the outcome space. Each pattern of action could be expressed in a number of ways depending on the informant's objective.*

PATTERNS OF ACTION	PURPOSES OF DEALING WITH PERCEIVED EXPECTATIONS		
	Being oneself (15 informants)	**Adapting to various situations** (17 informants)	**Presenting oneself in a positive light** (18 informants)
Voicing feelings	Talking about feelings in an open and honest manner, without self-censorship because of consideration of others and without fear of being seen wrongly or in a negative light.	Talking about feelings but with attention to how others may receive this and adapting the information in order to avoid to hurt someone or being seen negatively.	
Changing one's way of thinking and planning	Accepting oneself and feeling that one is good enough as one is. Planning in ways that consider one's strengths as well as weaknesses.	Trying to weigh up both one's own and others' perspectives in order to plan as effectively as possible.	Thinking and planning in a way that presents one's persona in the most positive light possible.
Trying harder	Trying to optimize the outcome, given one's conditions and trying to develop further.	Trying harder within a particular field so as to avoid negative consequences for others or to avoid attracting negative attention.	Trying harder in order to present oneself in a more advantageous light.
Doing something else	Concentrating on an activity that dispels anxiety in situations that one feels one cannot influence.	When one risks disappointing someone else, doing something that would be seen as positive instead.	Distracting oneself with another activity so as not to show what one really feels or thinks.
Avoiding situations that involve negative affect	Avoiding situations because one believes that participation will result in more negative than positive consequences for oneself.	Avoiding situations so as not to create conflict or hurt someone.	Avoiding situations so as not to appear in a disadvantageous light.

Summary of main findings

- Girls with disturbed eating were more likely than others to believe that being thinner would make them feel better about themselves and lead to acceptance and approval from others. (I)

- High personal standards, expressed in a dichotomous and competitive way were particularly pertinent for the girls with disturbed eating, while they didn't differ from symptom free girls in terms of more adaptive aspects of personal standards. (I)

- These competitive personal standards were not evident among the girls with disturbed eating four to five years earlier. (II)

- Concerns about eating and weight, a belief that thinness would lead to popularity, and a negative physical self-evaluation were found to be early risk factors for disturbed eating. (II)

- A low BMI, healthy eating attitudes, an accepting attitude towards body size and a positive self-evaluation, particularly with regard to physical and psychological characteristics, were found to be early protective factors. (II)

- The informants perceived conflicting and unattainable expectations about appearance as well as about social behaviour and performances, and perceived these conflicting and unattainable expectations to be severe stressors in daily life. (III)

- The informants often experienced difficulty identifying expectations that were not explicit, and they internalized these expectations and interpreted them as self-imposed. (III)

- The informants described three conceptions of dealing with perceived expectations; to be oneself, to adapt to various expectations and to present oneself in a positive light. (IV)

- These various conceptions were more or less effective depending on the situation in which they were used. (IV)

- The informants internalized sociocultural values about independence and autonomy, and this sometimes constrained them from using flexible and effective patterns of action to deal with perceived expectations in daily life. (IV)

DISCUSSION

Reflections on main findings

Why is it so important to be thin — so important, indeed, that some adolescent girls make themselves ill trying to achieve it. What other factors increases the risk of developing an eating disorder, and what characterizes those who remain unaffected by these social pressures to be thin? These questions are the focus of this thesis. I will discuss the results by addressing four topics.

Appearance as a primary competitive domain

In studies I and II it was shown that body dissatisfaction, a negative physical self-evaluation and a belief that being thinner would lead to approval and acceptance from others distinguished the girls who developed disturbed eating habits well before these habits became established. All of the informants in study III said that they had high self-imposed expectations regarding appearance, and most of them described these as a result of comparing themselves with others. They also noted that their self-evaluation dropped when they failed to keep up with or surpass those they compared themselves to. The results describe how sociocultural factors may influence the realms within which a competitive attitude in the appearance domain is developed and maintained.

High personal standards, expressed competitively were more pertinent among girls with disturbed eating than they were among girls from both of the other groups in study I. However this hypercompetitive attitude was not seen prior to the disordered eating. It has been suggested that hypercompetetiveness in relation to thinness and appearance may be associated with eating disorders in women and this association is explained by the fact that appearance is a primary competitive domain for girls and women[11,52].

Research on the aetiology of eating disorders has mostly been conducted within a medical framework, and this approach tends to pathologize those who suffer from eating disorders as being pathologically dependent on the portrayed beauty ideals[94]. This description may stigmatize those who suffer from eating disorders as being superficial or vain. Several qualitative studies have provided new insight to the underlying thought patterns and motivations that guide adolescent girls and young women to pursue disordered eating patterns. For example eating disorders have been described as means of achieving a sense of stability and security[91], control and connection[9,10],

inner drive, mastery, identity and self-confidence and of avoiding negative emotions and experiences[91]. Thus, these studies described the pursuit of thinness not as a goal in itself but rather as a mean of reaching particular goals in life. Thinness is often associated with desirable personality traits and social, personal and professional success[8] and it may therefore be seen as the outer manifestation of feeling happy, competent, popular and successful. Malson[77] describes that "Surface image becomes all that matters, because all that matters [...] is signified by the body and, more precisely, be the body as surface image"(p.139). Thus, rather than seeing striving for thinness as a an expression of vanity, we need to view it as an expression of a sociocultural context that is sending unacceptable and contradictory messages to adolescent girls.

The development of healthy versus disordered eating

The results of study II show that although eating concerns and a negative body image were found in the group that later developed disturbed eating, psychological factors such as perfectionism and global self-evaluation did not differ between the groups at this stage. These results suggest that a negative body image and concerns about eating appear earlier in the causal chain than negative global self-evaluation or high personal standards.

The pioneering work that Hilde Bruch conducted in the seventies described eating disorders as self-disorders and anorectic girls' relentless pursuit of thinness as a mean to camouflage their underlying poor self-worth[9]. These thoughts are still influential in the understanding and conceptualisation of eating disorders, although prospective research has failed to convincingly confirm the presence of a premorbid personality type[60,73]. The results of study II suggest that rather than seeing eating disorders as a result of an individual's predisposition for perfectionism and negative self-evaluation we should focus upon how an initial negative body image is extended such that it comes to affect every area of life and leads to these competitive and self-defeating thoughts and behaviours.

The results of study II also indicate that we should distinguish between early risk factors that are present long before disordered eating develops, and factors that occur during the process of development of an eating disorder. For example, although the girls who developed disturbed eating show no signs of this pattern four to five years earlier, this does not rule out the possibility that hypercompetetiveness may have contributed later to in the development of disturbed eating. It may be hypothesized that poor physical self-evaluation and the belief that thinness will lead to increased popularity meant that appearance became an increasingly important factor

in the individual's self-evaluation and that this may, in turn, have led to competitiveness about appearance. When a girl fails to meet her desired standard, negative weight-related self-evaluation may then be extended to other aspects of self-evaluation, as suggested by McFarlane, McCabe, Jarry, Olmsted & Polivy[83]. The increasing focus on appearance combined with a negative self-evaluation may lead to a spiral of increasingly distorted thinking[49] in which competitiveness grows along the way.

Study II also suggests that a protective factor may not always be the opposite of a risk factor. For example, positive self-evaluation emerged as an early protective factor. However, girls who developed an eating disorder four or five years later did not seem to have more negative self-evaluation than the girls who later described intermediate eating concerns. There was one exception to this. The girls who later developed eating disorders distinguished themselves from the others in terms of their physical self-evaluation. What does this mean? I contend that this means that eating problems cannot be dismissed as simply an expression of poor self-esteem or as a symptom of psychological problems. Eating disorders also affect girls who begin with a positive self-evaluation but who view their appearance, body and weight negatively. The girls in the SF-group had significantly lower weight at T1 than those in the other groups and it is possible that girls with low weight are less negatively affected (or maybe even positively affected) by social pressures to be slender since the message they receive is that they are living up to the ideal standard.

Gender stereotypes, do they matter?

In study III almost all of the informants described the mass media and peers as important communicators of gender stereotypes. While teachers were held to communicate gender stereotypes to an extent, none of the informants felt that their parents communicated gender stereotypical expectations. This was a surprising finding since previous research has shown that parents' expectations of their children are permeated with gender stereotypical expectations[12] and that parents exert pressure regarding appearance particularly upon their daughters[6]. However, values and attitudes that are communicated in the family are learnt by children and gender stereotypical expectations that parents communicate may be so strongly internalized into the informant's own value system that they are not noticed until they become difficult to live up to[12]. In one study[85], it was found that eating disorder patients with a short duration of illness were less able to critically examine sociocultural expectations than were members of a control group, while the reverse was true for patients with a long duration

of illness. The informants in our study were all adolescents who were just starting their therapy and who therefore had a relatively short duration of illness. It may therefore be hypothesized that patients from a sample that had a longer duration of illness would be more likely to describe gender stereotypical expectations from parents.

Internalization refers to the incorporation of specific values to the extent that they become guiding principles for the individual[132]. Thus, internalized ideals come to represent personal goals and standards against which one judges oneself and others[131]. Internalization of an appearance ideal is associated with eating disorders, especially for girls[62]. For example, Calogero, Davis & Thomson[13] found that since adolescent girls are socialized to regard attempts to improve their physical appearance as self-chosen, they may internalize the mass media's objectification of their bodies without reflecting on its negative effects. Several researchers have also found that internalization of the so-called "superwoman ideal" has been associated with eating disorders[48,116,137]. Several informants felt that gender stereotypical expectations made of women and girls were a great stressor in their lives. Since various expectations conflicted with each other, any attempt to live up to one expectation inevitably resulted in perceived failure to live up to another and they ended up feeling "trapped". Examples of such conflicting expectations included expectations to be "perfect" yet still be "yourself", ambiguity about appearance and achievement, and expectations that they should be considerate towards others but also stand up for themselves and take space – though not too much, or in the wrong way. It was thus a question of interpreting implicit expectations and finding the right balance between these expectations.

It has previously been shown that as long as the expectations of different agents are in accord with each other, gender development is straightforward, but when there is disparity between the expectations coming from different sources, the development of personal standards of conduct become complicated[12]. There is therefore a need for further studies of the association between internalization of gender stereotypes and eating disorders and of the way in which these gender stereotypes affect girls with an eating disorder.

Dealing with expectations in daily life

Assertiveness and independence are highly valued traits in western societies. While girls are fostered to be interpersonally oriented and sensitive to the needs and feelings of others, this interpersonal manner of handling expectations has been considered less functional than men's more individu-

alistic manner[5,106]. Thus, the informants' favouring of the strategy of being oneself is in harmony with societal values. However, it has been suggested that this way of viewing autonomy and independence as ideals does not pay enough attention to the value of relationships and respect for the needs of others[106]. In study III several informants described having problem behaving assertively and independently since they did not know how to combine this with the need to be considerate of others' needs and wishes. Their feelings of failing to do this contributed to a negative self-evaluation.

Saukko[106] argues that eating disorder therapies often become trapped in the same conundrum as patients and they often promote norms, such as autonomy and independence. She argues that instead of condemning one discursive position (e.g. seeking approval from others) it may be more therapeutic to teach the patients to critically explore these discursive positions and to recognize that they are contradictory. In this way the patient may be able to see both the empowering and the disempowering dimensions of social discourses, such as striving for perfection and success. Several of the informants in studies III and IV attributed their eating disorder partly to an inability to set limits and deal effectively with the expectations they perceived from others. They explained how their eating disorder contributed in the short term to reducing anxiety and giving a feeling of control, and it is therefore important to teach other ways to deal with sociocultural expectations.

Previous research[38,39] has found that girls with eating disorders often internalize appearance ideals about thinness. The results of study IV highlights that the girls internalized not only ideals of attractiveness and thinness but also ideals about appearance, performance and behaviour. These kinds of internalized cultural values, which prescribe or proscribe certain types of actions or feelings, may prevent girls and women from dealing with sociocultural expectations assertively[34,63].

I argue that adolescent girls in general, and adolescent girls with eating disorders in particular, need help and guidance to evaluate and judge a situation, the needs and wishes of themselves and others and the probable consequences of various behaviours in order to consciously decide on strategies for dealing with the situation. Thus may efforts to be oneself, adapt to various situations and present oneself in a positive light complement one another in a functional and flexible way.

Methodological and ethical considerations

The presuppositions of the researcher influence every instance of the research process: study design, choice of methods, interpretation and presen-

tation of data. One way for the researcher to deal with this is by giving an account for these pre-understandings, and of how they may have influenced the study. This is common practice in qualitative research but is often overlooked in quantitative studies[92]. My own interest in this topic was prompted by my experiences as a social worker and of working with the treatment of eating disorders. It was also influenced by the fact that I am a woman with an interest in highlighting gender issues. These factors have coloured the studies here and influenced the choice of research variables in studies I and II. They have also influenced the design of studies III and IV and the interpretation of the data in all of the studies. Awareness of one's own preconceptions is essential for critically evaluating one's own work, for ensuring that the results are adequately substantiated and the interpretations take consideration of earlier research. I believe that the results presented in this thesis are well substantiated and theoretically grounded. In the following sections I shall discuss other factors that require methodological and ethical consideration.

Study I and II

Longitudinal population based studies are essential for drawing conclusions about the risk and protective factors for a particular condition. Long follow-up periods are required to enable distinctions to be made between causal risk factors and factors that occur in the development of an eating disorder[112].

In longitudinal studies it is important that the same data are gathered from the same participants at different times. Self-reporting questionnaires are therefore an appropriate instrument that offer particular advantages. They make it possible to follow a relatively large population sample over time and see how they respond to the questions at different times[112]. In the IDA-project, it was important to find reliable, appropriate and ethically justifiable instruments for studying children, adolescents and young adults. For example, the instrument EDI-C was not considered appropriate for children under the age of 13 since it contains questions about disordered eating that might provoke unpleasant thoughts in young children. For this reason, some of the age groups did not fill in this questionnaire at the early assessments. By contrast, the instrument I Think I Am is not designed to be used with adults so participants who at the final assessment were already young adults may have found the questions inappropriate to their age. Furthermore, this is a Swedish instrument, which means there are no reference values from other countries.

Another problem in longitudinal projects with a long follow-up period is the dropout rate. After five years 68% of the original participants took part in the follow-up, and it is impossible to know whether the drop-outs differed in some particular regard. However, a dropout analysis of earlier measurements of demographic data or eating concerns revealed no significant differences between dropouts and completers. The dropout rate did, though, differ markedly between age groups; dropout was more common among older participants. The dropout rate in the age-group that was 9 years at inclusion was 8.5% in five years, compared to 34.8% in the oldest age-group. This was foreseen when the study was designed, since the younger children were still in school five years later, and the instruments were administered to the school and were filled in during school hours, while the older participants had left school and were sent the instrument by post. For this reason, a larger number of participants was initially included for the two oldest age-groups.

The use of self-reporting questionnaires entails particular methodological and ethical considerations. Questionnaires with predesigned response options force the participant to give simple answers to complex questions. This may cause problems for informants who want to give well-reasoned answers and who do not find answers that correspond to what they want to say. These questionnaires also fail to capture the unexpected, since there is a limited number of possible answers and these are based on the designer's way of thinking about a phenomenon. The results are typically presented in digits, with means and standard deviations that tell us very little about the participants' different motivations for taking one or the other stance[44]. One ethical consideration is that the questionnaire was filled in during class time and this means that some students may have felt pressurized to participate so as not to stick out or have to explain why they did not want to participate. These limitations notwithstanding, the strengths of these studies are that they are based on a large population-based representative sample, they have a long follow-up period, they employ well-tested instruments and they span the transition period from childhood to womanhood.

Studies III and IV

Qualitative studies may provide important in-depth understanding of people's underlying thoughts and motivations, and there is a need for qualitative studies in the field of eating disorders that will yield reliable, clinically relevant findings about the sufferers' point of view[7]. The phenomenographic research approach offers potential for healthcare research, since

recognition of the qualitatively different ways that people perceive and experience their worlds may have important implications for healthcare and clinical practice[4].

In the qualitative studies (III and IV) several measures have been taken to ensure trustworthiness. We used a purposive sampling method to gather rich and varied material. We ensured that we had achieved saturation in our material. The informants were encouraged to speak openly and a checklist was used to ensure that the various topics had been covered. Follow-up questions and summaries were used to gain rich data and to make sure the informants had understood the information correctly. The informants were then allowed to read their own interviews. We tried to show sensitivity to the data by not establishing any categories in advance, and two researchers have gone through the material and collaboratively designed the final categories and relationships between them. Repeated comparisons between categories and the printed out interviews were made to ensure that the results were well grounded in the empirical data and quotations have been used to clarify and exemplify. However, a qualitative study cannot show that the informants are representative of all adolescent girls who suffer from eating disorders. The girls who agreed to participate may be influenced by a common motivation that was not shared by those who declined.

In a phenomenographic interview the researcher is supposed to put his or her own presuppositions in "brackets"[80]. This is necessary in order for the interviewer to maintain an open attitude to that which the informant says and to obtain rich descriptions. I found this difficult to achieve during the initial interviews. After ten years experience of talking to youngsters with eating disorders, it was easy to start out by acknowledging what they said so that they felt that I understood what they meant but then they did not clarify what they were trying to convey. After a couple of interviews, I began to appreciate the importance of bracketing my knowledge and experience and showing greater curiosity about their narratives. This attitude encouraged fuller descriptions, deeper reflection and enabled me to gather a number of unexpected and interesting ideas and stories. Laying aside one's own presuppositions is also important so that one does not pose leading questions or unconsciously influence the informant. The informants appeared to speak openly and freely about their thoughts and I did not feel that they were trying to please or to tell me what they thought I wanted to hear. This is interesting since, as a group, teenage girls with eating disorders are often described as being eager to please. It is possible that this was because of my long experience of working with such girls and the fact that I explained to them that I wanted to know what they thought

and to capture different ideas and that there was no right or wrong. Perhaps they also felt familiar with the interview situation since they had recently been through assessment discussions at the clinic, or perhaps the informants felt comfortable being interviewed since the questions were about their everyday experience, and they were the authorities on this topic and were probably used to discussing and reflecting upon it.

A checklist was used during the interviews and this included questions about perceived expectations from the mass media, family, school, romantic partners and peers. Apart from asking about these social agents I avoided posing leading questions so that I would not steer the statements the informants gave. When the informants said they did not experience expectations from a particular area or from a particular person this may have been because they did not perceive any expectations or it may be that they simply did not find these expectations problematic, or that they did not remember them at that moment. For example, only a few of the informants mentioned expectations from their sibling or other relatives. It is a limitation of this study that I did not ask more specifically about this.

The outcome of a phenomenographic study consists of qualitatively different conceptions as well as the relationships between them. Although the contents of expectations may differ according to situation, the conceptions and the relations between them may be transferable to other contexts[78]. For example, the three conceptions of dealing with perceived expectations in daily life, as described in study IV, are likely to have relevance also for adolescent girls who are not suffering from an eating disorder. In order to assess the transferability to other contexts, the importance of the similarities and differences between contexts needs to be considered in each instance[101].

Implications for treatment and prevention

Although several treatment interventions for adolescents with eating disorders have been investigated, the NICE guidelines[1] conclude that there is insufficient evidence to suggest that any particular specialist psychotherapy is superior to others. Thus, several factors, such as the adolescent's age, duration of the illness, diagnosis, patient acceptability and family climate, need to be taken into account when choosing a therapeutic approach[141]. Eating disorder therapies have been criticized for adopting a medical model, for focusing too much on symptoms and for paying too little attention to the context of the entire sociocultural experience, thereby failing to address the contradictions and pressures experienced by contemporary women as an underlying problem[106,117].

For example, although family-based treatment is an effective and well established treatment for adolescents with eating disorders, a study by Halvorsen & Heyerdahl[43] has shown that patients are only moderately satisfied with the treatment. Although the patients rated items about therapeutic alliance highly, they were more critical with regard to whether their therapist had understood their problem and been able to help them[43]. Cognitive behavioural therapy has been criticized for lacking a sociocultural perspective on the development and maintenance of eating disorders and for thereby disregarding the fact that disordered eating may be an adaptive response to the demands made of girls and young women in today's society[37].

In this thesis I have shown that girls who developed disordered eating did not pursue higher personal standards or have a more self-critical global self-evaluation four to five years earlier than those with only moderate eating concerns. However, they had more eating concerns, greater body dissatisfaction and they believed that thinness would lead to more social benefits. I have argued that instead of viewing eating disorders as a result of certain premorbid personality traits, we need to understand how intrapersonal and contextual factors work together in the development of these conditions. Thus, therapeutic interventions need to address the functions that these disorders fulfill for adolescent girls. We need to be ready to explore and discuss these functions and help the individuals find other, less harmful, patterns of action. To accomplish this I suggest that a joint exploration of the patients' personal values and goals alongside ways to achieve them are important tools in therapy.

In the last two decades several programmes have been designed to prevent eating disorders and related problems. Critical processing of sociocultural messages are important components of these interventions. Cognitive dissonance programmes[121,122], where participants are encouraged to act and speak against the thin ideal has given good results for degrees of internalization of thinness ideals, body dissatisfaction, dietary restraint, eating pathology and negative affect[126].

A recent study[145] found that in a universal sample of both genders media literacy reduced concerns about body shape and weight, dieting, body dissatisfaction, feelings of inadequacy and depression.

Concurrently with the increasing problem of weight control, healthcare services also focus on the importance of exercise and low fat food. Unfortunately, these messages are often counterproductive and not health-related and they stigmatize overweight[88,90]. It has been suggested that we need to take a broader spectrum of eating and weight related problems into account when designing preventive interventions. Otherwise there is a risk

that while addressing one problem (i.e. obesity) we inadvertently increase the risk for another problem (i.e. eating disorders) and send contradictory messages to adolescents. Furthermore, being overweight and having an eating disorder often occur together and therefore need to be addressed simultaneously[89].

On the basis of the results of this study I would like to stress that prevention interventions should not be restricted to critical processing of appearance ideals but should take a broader spectrum of sociocultural values into account. I also suggest that these interventions should avoid falling into dichotomies that simply risk further contributing to conflicting expectations. Instead these prevention interventions should help adolescents to critically explore different discursive positions so that they become aware of both the empowering and the disempowering dimensions of social discourses and are able to make conscious choices about how to deal with sociocultural pressures in everyday life.

Future research

The results of this thesis point to several issues that should be addressed in future research in order to increase our understanding of eating disorders and enhance treatment and prevention of these conditions.

- Future research needs to further investigate the distinction between hypercompetetiveness and personal development in relation to personal standards in those with eating disorders.

- Longitudinal research that distinguish between risk and protective factors for the development of eating disorder in women compared to men are scarce. Given the different sociocultural pressures exerted upon boys and girls, men and women, exploration is required of these aspects of these conditions in the male population.

- More longitudinal research, as well as qualitative research is needed to understand how factors such as eating concerns, perceived benefits of thinness, negative physical self-evaluation, global self-evaluation and competitiveness work together to increase the risk of developing an eating disorder.

- Future research needs to investigate treatment interventions that use a social-psychological perspective and that try to teach adolescent girls to deal with sociocultural expectations by encouraging them to try to reach their goals without competing with others. These treatment interventions need to be investigated not only in randomised controlled studies, but also by capturing the patients' point of view.

- Future research needs to investigate the whole range of sociocultural pressures, and the way in which internalization of sociocultural attitudes in different areas of life are associated with eating disorders.

SUMMARY IN SWEDISH

Det fanns två huvudsakliga syften med denna avhandling: att undersöka högt ställda krav på sig själv, självvärdering och attityder till ätande och vikt för uppkomst och vidmakthållande av ätstörningssymtom hos tonårsflickor, och att undersöka hur tonårsflickor med en klinisk ätstörningsdiagnos uppfattar och reflekterar kring upplevda förväntningar i det dagliga livet.

Studie I och II genomfördes inom ramen för ett longitudinellt projekt med en uppföljningstid på 5 år. Studie III och IV var kvalitativa studier baserade på intervjuer med 18 flickor i åldrarna 15-19 med en ätstörningsdiagnos. Data analyserades utifrån en fenomenografisk ansats.

Studie I visade att högt ställda krav på sig själv som kom till uttryck på ett dikotomt och kompetitivt sätt var specifikt för flickorna i gruppen med ätstörningssymtom. Dessa flickor rapporterade också en mer negativ kroppslig självvärdering, mer uppfattade fördelar av att vara smal och trodde oftare att de skulle vara mer populära om de var smalare jämfört med flickor med andra psykosociala besvär och symptomfria flickor. I studie II framträdde negativa attityder till ätande och vikt och negativ kroppslig självvärdering som riskfaktorer för att utveckla ätstörningssymtom 4-5 år senare, medan högt ställda krav på sig själv och global självvärdering inte särskiljde gruppen med stört ätbeteende. Skyddsfaktorer var lågt BMI, hälsosamma attityder till ätande, accepterande attityd till kroppsstorlek och positiv självvärdering, speciellt gällande kroppsliga och psykologiska aspekter. I studie III beskrev informanterna tre kategorier av uppfattade förväntningar: förväntningar från andra, egna förväntningar och motstridiga förväntningar. De flesta av informanterna uppfattade att massmedia förmedlade såväl uttalade som outtalade förväntningar, medan de hade svårigheter att identifiera outtalade förväntningar gällande hur de skulle se ut, prestera eller uppträda från kamrater, föräldrar och lärare. Istället tenderade de att internalisera dessa förväntningar, och uppfatta dem som egna högt ställda krav på sig själva. Motstridiga förväntningar kunde yttra sig på två olika sätt. Alla informanter beskrev att ackumulerade förväntningar inom flera olika områden bidrog till stress i det dagliga livet. Men hälften av informanterna beskrev en ytterligare dimension av motstridiga förväntningar, nämligen förväntningar som var inbördes motsägelsefulla, och därmed uppfattades omöjliga att leva upp till. Dessa inbördes motsägelsefulla förväntningar handlade ofta om genusstereotypa förväntningar på flickor/kvinnor.

I studie IV kunde informanternas olika sätt att hantera upplevda förväntningar sammanfattas i tre kvalitativt åtskiljda uppfattningar; ”vara sig

själv", "anpassa sig till olika situationer" och "framställa sig i en positiv dager". Dessa strategier kom till uttryck i följande fem handlingsalternativ; "ge uttryck för känslor", "omstrukturera tankar och planer", "kämpa hårdare", "göra något annat" och "undvika situationer som väcker jobbiga känslor". Dessa handlingsalternativ kunde vara olika funktionella beroende på situationen, och vad informanten ville uppnå. Informanterna uppfattade strategier som syftade till att vara sig själv som de mest önskvärda. Informanterna använde ofta strategier som syftade till att anpassa sig till olika situationer utan att reflektera över dem, så länge de fungerade. Strategier som syftade till att framställa sig i en positiv dager värderades av informanterna som de minst önskvärda, trots att dessa strategier i flera situationer fungerade bra.

Resultaten av den här avhandlingen belyser betydelsen av att se den sociokulturella kontextens betydelse i utvecklandet och vidmakthållandet av ätstörningar hos tonårsflickor, och indikerar att såväl individuella som sociokulturella faktorer behöver belysas i behandling och prevention av dessa tillstånd. Framförallt bör behandling av tonårsflickor med ätstörning innefatta ett tydligt fokus på att uppmuntra till ett kritiskt förhållningssätt gentemot sociokulturella förväntningar, och att utforska olika sätt att hantera dessa förväntningar på ett flexibelt sätt, samt att uppmuntra patienten att sträva efter sina egna mål, utan att behöva tävla med andra, eller försöka vinna andras gillande.

TACK (Acknowledgements)

Ett stort tack till alla som på olika sätt stöttat mig, trott på mig och funnits till för mig under min doktorandtid.

Ett särskilt tack vill jag rikta till:

Claes Norring, min huvudhandledare, för din tilltro, och för att du alltid tagit dig tid att lyssna på mina idéer och gett mig stor frihet i avhandlingsarbetet. Varje handledningstillfälle har varit utvecklande, givande och roligt, och du har ställt de rätta kritiska frågorna vid rätt tidpunkt, och slutat ställa frågor vid rätt tidpunkt. Du har tvingat mig att själv hitta svaren på många frågor, men när jag har behövt hjälp har jag alltid fått den hjälp jag behöver.

Lasse Kjellin, min handledare, för att du alltid noggrant har satt dig in i mitt arbete. Du har alltid funnits till hands för att svara på såväl praktiska som vetenskapliga frågor, och du är den som fått hjälpa mig med allt som uppstår i det dagliga arbetet. Du har alltid varit lika tillmötesgående, även när jag för tredje gången inom loppet av en timme dyker upp med en ny fråga.

Birgitta Edlund, min handledare, för entusiasm och engagemang såväl i mina forskningsfrågor, som i den fenomenografiska forskningsansatsen. Du har en smittande entusiasm, och ser alltid möjligheter och nya uppslag på vad som kan lyftas fram i studierna.

Josefine Davén, min medförfattare, för att du bidragit med kloka synpunkter och nya perspektiv på de kvalitativa arbetena, och gjort arbetet roligare.

Josefine Westerberg Jacobson, för all hjälp med IDA-data, och för alla roliga möten och stunder. Det är bra mycket roligare att stå i en källare och leta efter data om man gör det tillsammans.

Anette Almqvist för transkribering av intervjuer, och för all tid du lagt ner på att höra även de otydligaste meningar.

Lars-Ove Dahlgren, och alla deltagare på seminarieserien i fenomenografi, för intressanta och lärorika seminarier och diskussioner om vad fenomenografi är, och vad det inte är.

Margareta Landin för all hjälp med referenshanteringen.

Anna Wadefjord för hjälp med allt från att ta vara på mina bortslarvade almanackor och nycklar, till all hjälp med kappan. Och inte minst, för utlåning av hela VÄNNER-serien på DVD.

Alla kollegor på Psykiatriskt forskningscentrum för kritisk granskning av alla delarbeten i avhandlingen, korrekturläsning, konstruktiva synpunkter, uppmuntran och all hjälp med allt stort som smått. Sen har vi ju haft mycket roligt också.

Ingemar Engström, för att jag fått förmånen att ha en doktorandtjänst i den utvecklande och lärande miljön på Psykiatriskt forskningscentrum.

Psykiatriskt forskningscentrum och Forskningskommittén i Örebro läns landsting, som bidrog ekonomiskt till arbetets genomförande.

Anita Ivarsson och Anna Bürger-Sjödin, för att ni på alla sätt visat mig förtroende, och underlättat för mig att kombinera mitt kliniska arbete med doktorandstudierna.

Mina arbetskamrater på Ätstörningsenheten Eriksbergsgården, för ert intresse och för uppmuntran och stöd, och för utbyte av erfarenheter och kunskaper. Det har betytt oerhört mycket att kunna varva avhandlingsarbetet med mitt kliniska arbete, och att tillhöra ett kompetent ätstörningsteam.

Alla flickor och föräldrar i IDA-projektet, som tålmodigt besvarade skattningsformulär.

Alla patienter på Ätstörningsenheten som delat med sig av sina tankar, berättelser och reflektioner. Jag har lärt mig oerhört mycket av er.

Och sist men inte minst:
Till min älskade familj, Mats, Miranda och Sabina, för att ni finns, att ni ger mig perspektiv på livet, och för att ni har sett till att jag inte har grävt ner i mig i mitt avhandlingsarbete.

APPENDICES

Appendix A

DSM-IV Diagnostic Criteria for Eating Disorders

307.1 Anorexia Nervosa (AN)

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one´s body weight or shape is experienced undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current body weight.
D. In post menarcheal females, amenorrhea i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. oestrogen administration.)

Specify type:

Restricting Type: during the current episode of AnorexiaNervosa, the person has not regularly engaged in binge-eating or purching behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purching behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

307.51 Bulimia Nervosa (BN)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both the following:

   1) Eating, in a discreate period of time (e.g. within any 2-hour period) an amount of food that is definetly larger than most people would eat during a similar period of time and under similar circumstances

   2) A sence of lack of control over eating during the episode (e.g. a feeling that one cannot stop what or how much one is eating

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as selfinduced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours occur, on average, at least twice a week for three months.

D. Self evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type:

Purging type: During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
Nonpurging type: During the current episode of bulimia nervosa, the person has used inappropriate compensatory behavior but has not regularly engaged in self-induced vomiting or misused laxatives, diuretics, or enemas.

307.50 Eating Disorde Not Otherwise Specified (EDNOS)

1. For female patients, all of the criteria for anorexia nervosa are met except that the patient has regular menses.
2. All of the criteria for anorexia nervosa are met except that, despite significant weight loss, the patient's current weight is in the normal range.
3. All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than 3 months.
4. The patient has normal body weight and regularly uses inappropriate compensatory behavior after eating small amounts of food (e.g., self-induced vomiting after consuming two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of Bulimia Nervosa.

APPENDIX B

Demographic and dieting questions:

Have you ever wished to be thinner?	Yes/No
Do you currently wish to be thinner?	Yes/No
If you have ever wished to be thinner was it in order to: - Avoid being teased by your friends - Become more popular with boys - Become better accepted by other girls - Dare to go to parties - Maintain good health - Feel less clumsy doing sports - Feel better about yourself	Mark the ones that apply
How much do you weigh? _____	Please specify in kg.
How tall are you? _____	Please specify in cm
Would your friends like you better if you were thinner?	Yes/No
I live together with: - Both of my parents - One of my parents - Other _____	Mark the one that applies. If other, please specify.
Have you, or has anyone in your family immigrated to Sweden? - Me - My mother - My father - Sibling - Grandparents (mother's side) - Grandparents (father's side)	Mark the ones that apply.
How often do you exercise in your free time? - Less than once a month - Once a month - Once a week - 2-3 times a week - 4-6 times a week - Every day	Mark the one that applies best.

Mark the alternative that describes you best. - I feel guilty if I don't exercise. - I worry about my fitness if I miss a training session. - I feel that I need to train even when I'm tired. - If I've eaten a lot I train harder or longer than usual	Always Very often Often Sometimes Seldom Never
In the last year have you used any of the following in order to lose weight? - Dieting pills - Laxatives - Diuretics - Induced vomiting - Eaten limited quanities of food (less than 500 kcal/day)	Never Less than once a month About once a month About once a week Two or more times per week
Have you ever lost control of your eating and over-eaten?	Yes/No
If yes, how often has this happened since the first time?	Never Less than once a month About once a month About once a week Two or more times per week

Appendix C

Interview Guide

1. **What demands/expectations do you experience regarding how you should be from:**

   A, Family
   B, Peers
   C, Romantic partners
   D, Teachers/school
   E, Mass media

   How are these expressed? Can you give examples?
   Do you think these demands/expectations would have been different if you had been a boy?

2. **Do you feel that there are unexpressed demands/expectations about how you should be from:**
   A, Family
   B, Peers
   C, Romantic partners
   D, Teachers/school
   E, Mass media

3. **How important is it for you to live up to the demands/expectations that you feel from:**
   A, Family
   B, Peers
   C, Romantic partners
   D, Teachers/school
   E, Mass media

   How do you feel if you go against what others expect of you or if you fail to live up to their expectations?

4. **To what extent do you feel you succeed in meeting the expectations/demands of:**
   A, Family
   B, Peers
   C, Romantic partners
   D, Teachers/school
   E, Mass media

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