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Relationships among Coping, Weight Preoccupation, and Body Image in College Undergraduates

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Abstract

Weight preoccupation is a significant predictor of eating disordered behavior. Previous research has shown that coping style and body mass index relate to weight preoccupation. A significant limitation of previous studies was exclusion of body image, also a predictor of disordered eating. Purpose of this study was to investigate influence of coping style and body image on weight preoccupation in young adult college females. Results indicate body image dissatisfaction is a stronger predictor of weight preoccupation than is coping style. Implications of this study suggest that therapeutic interventions need to focus on self-efficacy and dissonance in addition to coping strategies.

Review of Related Literature

The question of eating and weight preoccupation continues to be one of central importance to the preservation of well-being and prevention of eating disorders, particularly in young women. For more than a decade now, researchers have been exploring the salience of body dissatisfaction, weight preoccupation and eating patterns or disorders in college students (Adams & Rini, 2007; Barker, Williams & Galambos, 2006; Denisoff & Endler, 2000; Klemchuk, Hutchinson & Frank, 1990; VanBoven & Espelage, 2006). In light of these concerns, it is important to remember that deterring disordered eating before it begins requires understanding of predictors of eating disorders in nonclinical populations. Accordingly, there is a broad base of related research with college students that includes the study of possible predictive factors such as binge eating (Barker, Williams & Galambos, 2006), BMI changes over a college year (Adams & Rini, 2007), and the relationship between stress and eating (Kandiah, Yake, Jones & Meyer, 2006). Although there is a natural relationship between consumption changes and changes in weight and body size, most studies have emphasized stress's relationship with eating in the context of coping, or as a trigger for disordered eating. VanBoven and Espelage (2006) summarize this by stating that "theorists and researchers have long hypothesized an association between maladaptive coping strategies and eating disorder symptoms" (p. 345).

In order to understand the hypothesized relationship between coping and eating behaviors, we need to first understand the sometimes elusive concept called coping, which we define here as the way that a person carries out responses to perceived threats, both external and internal (Carver, Scheier and Weintraub, 1989; Lazarus & Folkman, 1984). Since the 1940s, when practitioners began using the concept of coping clinically, researchers have proposed many models of coping. With the evolution of the study of coping came an increased focus on coping styles or ways of coping. In theory, these coping styles categorize the ways in which people manage stress and permit development of general predictions in order to classify people as to how they cope with stressful encounters. One model that has been dominant in the literature is the cognitive coping model (Lazarus & Folkman, 1984). This model emphasized the process of cognitive appraisal, where on the basis of one's appraisal a person chooses a strategy to implement in order to deal with whatever particular stressor he/she is facing. Lazarus and Folkman suggested (1984) that coping strategies fall into one of two categories, either problem-focused or emotion-focused, and these have provided the framework for abundant research on coping in a wide variety of contexts. At the same time, research on specific styles and strategies has also continued.

Some investigators have proposed distinctions at the level of whether coping involves situation-specific coping strategies or dispositional styles of individuals (Hudek-Knezevic & Kardum, 2000), and others have suggested a variety of other classifications including approach versus avoidant coping, cognitive versus behavioral coping, and functional versus maladaptive coping (Moos & Shaefer, 1993). In reality, however, "little consensus can be found about how to conceptualize or measure the central constructs in the field, namely, ways of coping" (Skinner, Edge, Altman & Sherwood, 2003, p. 217). Despite the complexity of the conceptualization of coping as well as its measurement, many investigators continue to use the dichotomy of emotion-focused and problem-focused coping styles to understand various reactions to stressful situations, including disordered eating and body image.

Denisoff and Endler (2000), for example, found that stress led to an increased level of weight preoccupation in young women. In addition, however, they also found that when controlling for level of stress the relationship between emotion-based coping and weight preoccupation remained significant. They concluded that "it is not the mere presence of stress that may be related to weight preoccupation, but more importantly, how one copes with the stress that eventually impacts health" (p. 101). This suggested that coping strategies are a stronger predictor of weight preoccupation than is a person's experience of stress and appears consistent with VanBoven and Espelage's (2006) argument that proposes an association between maladaptive coping strategies and symptoms of eating disorders. Despite this contribution, one of the limitations of the Denisoff and Endler (2000) study was lack of use of a measure of body dissatisfaction, a concept that has been related to disordered eating (Johnson & Wardle, 2006; Vaz, Penas & Ramos, 1999). Given the established link between weight preoccupation and disordered eating as well as body dissatisfaction and disordered eating, study of these variables together is essential if we are to draw any conclusions about the complex relationship between weight preoccupation and other constructs.

"Body image dissatisfaction among adolescent and adult groups has been found to be so predominant for women that it is considered to be a normative component of their living within modern Western society (Kostanski, Fisher & Gullone, 2004, p. 1317). The conceptualization of body image is complex, including affective and cognitive-behavioral elements (Kostanski, Fisher & Gullone, 2004; Vaz, Penas & Ramos, 1999); studies have, however, provided support for the associations between body image and/or body dissatisfaction and disordered eating symptoms as well as body mass. Specifically, research in clinical populations has indicated that body image has an effect on development of disordered eating, especially among young women (Vaz, Penas, & Ramos, 1999). Furthermore, Johnson and Wardle (2006) stated that "A body image-specific dimension of negative affect (i.e., *body dissatisfaction*) has been demonstrated in a wide range of studies to be associated with the development of disordered eating" (p 120). Finally, Afifi-Soweid, Rema, Kteily, and Shediac-Rizkallah (2002) found that preoccupation with weight is related to development of disordered eating in entering college students. Influencing this relationship, though, was weight of participants. Those students that had high body mass index (BMI) scores had high levels of weight preoccupation.

The purpose of this study was to investigate the influence of coping style and body dissatisfaction on weight preoccupation in young adult college females. We hypothesized that body dissatisfaction plays a more significant role in weight preoccupation than do coping strategies.

Methods

Participants

The subject population was a non-clinical sample of undergraduate female students recruited via classrooms. Participants included 36 women with an average age of 22.47 years (SD=6.76). Of these, 25% (n=9) were freshman, 16.7% (n=6) were sophomores, 33.3% (n=12) were juniors, and 25% (n=9) were seniors. Twenty-seven of the participants (72.2%) were Caucasian, six (16.67%) were Black/African American, one (2.8%) was Asian/Asian American, and two (5.6%) identified as multiracial/other.

Measures

Students completed a version of the original Body Image Assessment (Williamson, Davis, Bennett, Goreczny, & Gleaves, 1989), the Body Image Assessment for Obesity (BIA-0: Williamson, Womble,

Zucker, Reas, White, Blouin & Greenway, 2000), The Eating Disorder Inventory-2 (EDI-2; Garner, 1991), and COPE Inventory (Carver, Scheier & Weintraub, 1989). In addition, we obtained height and weight in order to calculate body mass index (BMI).

Body Image Assessment. The BIA-O is a version of the Body Image Assessment developed to include greater variance in size of silhouettes for the purpose of providing appropriate range of choice for participants of various body sizes. It is a set of 18 black and white silhouettes of female bodies with body size variation from very small to very large. A research assistant shuffled the cards and presented the entire set randomly in a way that allowed participants to see all of the cards at one time. The participant first selected the silhouette that best represents her current body size (CBS). The research assistant then reshuffled the cards, presented them in a new random order, and asked the participant to select the silhouette that best represents her ideal body size (IBS). The research assistant repeated this process one more time and asked the participant to select the card that best represents the body size that is realistic for her to maintain over a long period of time (RBS). The cards, numbered on the backs from 1-18, allow the administrator to record each participant's CBS, IBS, and RBS numerically. This allows for computation of difference scores and provides indices of body dissatisfaction (CBS-IBS and CBS-RBS). Specifically, scores for each index (CBS, IBS and RBS) range from 1-18, the value of the card chosen for each index respectively. Body dissatisfaction is the value of CBS minus the value of IBS (CBS-IBS) and also the value of CBS minus the value of RBS (CBS-RBS). Possible scores for each index of body dissatisfaction therefore range from -17 to 17. A score of 0 indicates no discrepancy in body sizes, and a score of 17 indicates the maximum body discrepancy. Directionality is not of relevance to this study because it is the size discrepancy, not actual perceived or desired sizes that provide a measure of body size dissatisfaction. Reliability coefficients for the original BIA remain high over a one to two week time interval (Williamson et al., 1989). The BIA-O has similarly high test-retest statistics. Specifically, two week test-retest correlation coefficients were .93 for CBS, .77 for IBS, and .85 for RBS (Williamson et al., 2000). In addition, results from Williamson et al. (2000) provided support for validity of the discrepancy scores as a measure of body dissatisfaction as indicated by positive correlations with the Body Shape Questionnaire (Cooper, Taylor, Cooper & Fairburn, 1987).

Eating Disorder Inventory. The EDI-2 is a 91-item self-report questionnaire that requires participants to respond to items on a 6-point forced choice scale ranging from "Always" to "Never." It provides a measure of eating attitudes and behaviors within 11 subscales, including the eight scales of the EDI (Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears) and three provisional scales (Asceticism, Impulse Regulation, and Social Insecurity). Research has validated use of the EDI with both clinical and non-clinical populations. Research has shown the EDI-2 subscales to have high internal consistency, ranging from .83 to .92 (Garner, 1991). Subsequent studies have shown it to have good discriminant validity, being able to distinguish between individuals with symptoms of an eating disorder versus normal controls (Nevonen, & Broberg, 2001) as well as outpatients with general psychiatric conditions and those with bulimia nervosa (Schoemaker, Verbraak, Breteler, & van der Staak, 1997). Because of its excellent psychometric properties, the EDI-2 has become one of the most widely used tests in the assessment of eating disorders. Recent research (e.g., Denisoff & Endler, 2000) has used a composite score of 3 subscales, drive for thinness, bulimia, and body dissatisfaction, as a measure of weight preoccupation for non-clinical populations. Anchors for the Likert scale items were 0=Never and 5=Always. We summed scores for the first three subscales to obtain a measure of weight preoccupation.

COPE Inventory. The COPE Inventory is a 60-item questionnaire that uses a 4-point forced choice scale, with anchors for the scale being 1=I usually don't do this at all and 4=I usually do this a lot, to provide a measure of 15 different styles of coping, each scale composed of 4 questions. These include positive reinterpretation and growth, mental disengagement, focus on and venting of emotions, use of instrumental social support, active coping, denial, religious coping, humor, behavioral disengagement, restraint, use of emotional social support, substance use, acceptance, planning and suppression of competing activities. There is not an overall score for the COPE. Rather, each scale gets analyzed separately in relation to other variables. Scoring consists of summing responses to each of the four questions within each scale so that the range of scores on each scale is from 4 to 16, with highest scores indicating most frequent use of the respective coping style. The measure was the product of work

developed on two theoretical models, the Lazarus model of stress and a model of behavioral self-regulation (Carver, Scheier & Weintraub, 1989). Developers of the scale reported evidence of convergent and discriminant validity for the scale (Carver, Scheier & Weintraub, 1989). They also reported internal consistency coefficients from .45 to .92 and test–retest reliability coefficients from .46 to .86. Although users can phrase the COPE instructions in order to measure situation coping (ask the participant to consider how they cope with a specific situation or stressor) or dispositional coping (ask the participant to consider how they cope in general), in this study we worded it to measure dispositional coping.

Body mass index. A research assistant recorded height and weight for each participant, and we calculated BMI using the equation BMI=Weight (inches)/Height (pounds)^2 * 703.

Procedure

Research assistants gave a brief presentation to classes about the project and asked students to participate in a study about the ways that they cope, satisfaction with their body, and how much thought they give to their weight. Those who agreed initially read and signed an informed consent form and then completed the two written surveys (EDI and COPE) in a classroom. After each finished the written surveys, she went alone to a separate private room to complete the BIA in order to obtain a measure of body dissatisfaction. Consistent with standardized administration procedures described above, participants chose the one silhouette (from among the group of 18, shuffled and presented in random order) that they perceived to depict their current body size. They then picked (after reshuffling) the silhouette that depicted the body size they would most prefer and subsequently (again after reshuffling) the body size they believed is realistic for them to maintain over a long period of time. After completing the BIA, participants went to another private room to have their height and weight taken by a research assistant.

Results

We computed a composite score of the first three scales of the EDI (Drive for Thinness, Bulimia, and Body Dissatisfaction) to produce an index of weight preoccupation and also computed measures of body dissatisfaction by subtracting subjects' ratings of their Current Body Size from their Ideal Body Size (CBS-IBS) and from their Realistic Body Size (CBS-RBS) respectively (possible range -17 to 17 with 0 indicating no discrepancy), as per their choices on the BIA and according to standardized instructions. We obtained COPE scale scores for each participant using the sum of responses to the 4 respective questions on each of the 15 coping styles. Specifically, the possible scores for each style of coping ranged from 4-16, with higher scores indicating greater prevalence of the use of that particular style of coping.

As seen in Table 1, correlations revealed positive significant relationships between weight preoccupation and body image dissatisfaction (measured by both CBS-RBS, CBS-IBS), active coping, and behavioral disengagement. It is also interesting to note that only one of the two indices of body dissatisfaction (CBS-RBS) revealed a positive significant correlation with coping, particularly Behavioral Disengagement ($r=.350$, $p=.046$) and Mental Disengagement ($r=.404$, $p=.020$). In addition, BMI significantly positively correlated with both measures of body dissatisfaction but not with weight preoccupation (see Table 1).

Table 1: Correlations Between Weight Preoccupation, Body Dissatisfaction and Coping

	Wt Preoc.	CBS-IBS	CBS-RBS	Active	Beh. Dis.	Mental Dis.	BMI	Mean (SD)
Wt Preoccupation	----	.740**	.572**	-.352*	.469**	.208	.260	12.66 (13.55)
CBS-IBS		----	.741**	-.220	.323	.230	.600**	1.17 (2.18)
CBS-RBS			----	-.262	.350*	.404*	.592**	-.03 (1.54)
Active Coping				----	-.343	-.283	-.236	10.79 (2.07)
Behavioral Disengagement					----	.385*	.170	6.18 (1.88)
Mental Disengagement						----	.147	10.70 (2.46)
BMI							----	25.26 (5.80)

*p < .05 **p < .01

After computation of the correlations, we utilized a stepwise regression analysis to determine predictors of weight preoccupation. Included in the regression analyses were those variables that correlated significantly with weight preoccupation, and we also included BMI in the regression analysis despite the lack of a significant correlation with weight preoccupation because it provided the only physiological measure. A three model regression analysis emerged from the stepwise regression analysis, with CBS-IBS, Active coping, and BMI predicting 65.8% of the variance in weight preoccupation. As seen in Table 2, body dissatisfaction alone, as measured by CBS-IBS, predicted 52.1% of the variance in weight preoccupation. Active coping explained 6.4%, and BMI explained 7.3% of the variance in weight preoccupation. Incremental R2 as well as significance levels for each of the successive models appear in Table 2. Beta coefficients appear in Table 3.

Table 2: Summary of Stepwise Regression Analysis of Body Dissatisfaction, Coping Styles and BMI in Predicting Weight Preoccupation

Model	*R*	R^2	R^2 change	F	df	p
1 – CBS-IBS	.722	.521	.521	32.66	1	.000
2 – CBS-IBS, Active coping	.765	.585	.064	20.44	2	.000
3 – CBS-IBS, Active coping, BMI	.811	.658	.073	17.93	3	.000

Table 3: Beta coefficients of Stepwise Regression Analysis of Body Dissatisfaction, Coping Styles and BMI in Predicting Weight Preoccupation

Predictor	unstandardized B	standardized beta	t	p
1 – CBS-IBS	4.920	.722	5.715	.000
2 – Active coping	-1.483	-.255	-2.112	.043
3 – BMI	-.736	-.314	-2.439	.021

Discussion

The purpose of this study was to investigate the influence of coping style and body dissatisfaction on weight preoccupation in young adult college females. As hypothesized, these data support that body dissatisfaction plays a more significant role in weight preoccupation than do coping styles. This is consistent with the findings of Vaz, Penas and Ramos (1999) in a clinical population and adds to the findings of Denisoff and Endler (2000) given the absence of a measure of body image in their study. In light of the prevalence of body image dissatisfaction in women, this finding certainly has implications for understanding and prevention of disordered eating.

Interestingly, only one of two indices of body image dissatisfaction is a significant predictor of weight preoccupation, although both correlated with weight preoccupation. Specifically, the difference between participants' current body size and ideal body size (CBS-IBS) predicted weight preoccupation, as opposed to the measure of the difference between current body size and realistic body size (CBS-RBS). In other words, being far from a body size that you believe would be ideal is the primary predictor of weight preoccupation, rather than being far from a body size that you believe would be realistic for you to maintain. Based on these findings, although CBS-IBS and CBS-RBS are both measures of body dissatisfaction, there is an apparent difference in what each is measuring. The challenge of understanding the complex issue of body image is not new, and in fact there have been concerns expressed in the literature with respect to the overabundance of instruments available to measure body image and related difficulties of defining the concept and the many variations of conceptualizations that exist (Kostanski, Fisher & Gullone, 2004). There are at least two theoretical explanations for the discrepancies found, one rooted in cognitive dissonance and one in self-efficacy.

Initially, Festinger's theory of cognitive dissonance purported that if a person holds two cognitions that are psychologically inconsistent, that person would feel motivated to attempt to reduce the dissonance (Aronson, 1992). Aronson later proposed an elaboration that stated "dissonance is greatest and clearest when it involves not just two cognitions, but, rather, a cognition about the self and a piece of our behavior that violates that self-concept" (Aronson, 1992, p. 305). Participants in the current study selected a body size that they believed they were currently, one that is ideal, and one they believe to be realistic for them to maintain over a long period of time. Based on these data, it appears that when one feels as though her current body size is not what it could be realistically, she experiences cognitive dissonance. The cognition held by participants about themselves is that of their maintainable body size. The behavior that violates that self-concept is that which has prevented them from actually attaining and maintaining such a realistic goal. In contrast, when one is far from what she believes to be an ideal body size, she does not experience cognitive dissonance because her ideal weight is not necessarily attainable so it does not involve a violation of one's self-concept (Aronson, 1992).

Support for this explanation is evident in the correlations between indices of body dissatisfaction and coping strategies, particularly mental and behavioral disengagement. Although CBS-IBS was the primary predictor of weight preoccupation, with active coping the second predictor, CBS-RBS was the only index of body dissatisfaction that positively correlated with any coping style, and did so with both mental and behavioral disengagement. In other words, the difference between participants' current and realistic body

size correlated with their use of disengagement styles of coping. Dissonance is psychologically uncomfortable, therefore it "prompts the implementation of a dissonance-reduction strategy" (Elliot & Devine, 1994). Participants who experience cognitive dissonance would thereby feel motivated to reduce the dissonance. Reduction of dissonance could take any number of forms, including a change in cognition about oneself (realistic body size) or a change in the associated discrepant behavior (change in body size). Festinger's original proposition, however, also indicated that there are many things that can occur during the process of dissonance reduction that may increase or decrease the amount of the dissonance one experiences (Galinsky, Stone & Cooper, 2000). In fact, Galinsky et al. state that there is little research exploring circumstances when attempts at reducing dissonance could fall short.

> "…it is worth while to emphasize that…the presence of pressures to reduce dissonance, or even activity directed toward such reduction, does not guarantee that the dissonance will be reduced…In fact, it is quite conceivable that in the process of trying to reduce dissonance, it might even be increased. This will depend upon what the person encounters while attempting to reduce the dissonance. (Festinger, 1957 as cited in Galinsky et al., 2000, p. 124).

Furthermore, Case, Andrews, Johnson, and Allard. (2005) suggested that "much research has also noted that sometimes people *avoid* information, if paying attention to it will cause mental discomfort or dissonance" (p. 354). While changing their cognition about their realistic body size, or actually changing their body size would be two possibilities for reduction of dissonance, these results indicate that participants of this study were instead using the coping mechanisms of behavioral and mental disengagement as a means of dissonance reduction. This was only true of those with greater discrepancy between current body size and realistic body size, not those farther from their identified ideal body size. Consistent with this explanation, other research has found a relationship between disordered eating, or ED risk-factors, and the use of escape-avoidant coping strategies (Engler, Crowther, Dalton & Sanftner, 2006; Ghaderi, 2003; VanBoven & Espelage, 2006). Such coping styles appear to be maladaptive and present when one has inadequate or poor coping skills available (Engler et al., 2006; Shatford & Evans, 1986; Soukup, Beiler & Terrell, 1990). From this perspective, prevention and intervention might focus on improvement of coping skills. The rationale would be that an increase in adaptive coping skills would help avoid or overcome eating disordered behavior and/or reduce the number of risk factors one carries for an ED. On the contrary, having knowledge of or even a capacity for adaptive coping strategies does not necessarily mean that one will use them in every circumstance. From the perspective of dissonance theory, clinicians need to redirect focus of prevention and intervention efforts so that the reduction of dissonance is the target for change rather than coping styles. Stice, Chase, Stomer and Appel (2001), in fact, developed a dissonance-induced model of intervention for eating disorders as an alternative to psychoeducational interventions that present information about eating disorders or coping and found evidence that such a model can influence attitudes of those with disordered eating patterns through dissonance reduction efforts. Despite positive results, other evidence still exists to suggest that excessive discomfort resulting from dissonance frequently results in avoidance of the dissonance and related stressors. Elkin and Leippe (1986), for example, stated that people may deal with inner conflict of dissonance by not thinking about the dissonance. They stated "Perhaps the dissonance-plagued person would prefer that you "don't remind me"" (p. 63). Given that dissonance can reach levels of discomfort that are unmanageable, it is important to realize that the more distance there is between ones realistic body size and the body size they believe themselves to be, the greater the cognitive dissonance that individuals may be experiencing. If individuals have made previous attempts to reduce dissonance, in this case attempts to reduce the discrepancy between current and realistic body size, as stated by Festinger (1957 as cited in Galinsky et al., 2000), dissonance could even increase.

A second theoretical explanation for the discrepancy between CBS-RBS and CBS-IBS lies in efficacy theory. Data from the current study show differences in the correlations between coping and the two indices of body dissatisfaction. Specifically, those with large discrepancies between current and realistic body size tended to disengage both mentally and behaviorally and did not utilize active coping. On the other hand, those with large discrepancies between current and ideal body size showed no significant correlation with coping styles. Although many view the use of disengaged coping as maladaptive and reflective of the absence of adaptive coping strategies (Engler et al., 2006), it may be that having knowledge of or even a capacity for adaptive coping strategies does not necessarily mean that one will

use them in every circumstance. One influence on the choice of coping styles, or what effort an individual puts into coping with a stressor, is self-efficacy.

Efficacy research suggests that low efficacy indicates a person's belief that he/she cannot achieve a particular task, and subsequently is not likely to make efforts to do so. "Efficacy expectations determine how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences. The stronger the perceived self-efficacy, the more active the efforts" (Bandura, 1977, p. 194). This would support findings from our study in that those participants who made use of behavioral and mental disengagement may have been those with low weight-related self-efficacy. As a result, they would be unlikely to expend effort on the goal of reducing the discrepancy between their current and realistic body size. Indeed, participants with the most discrepancy between their current and realistic body size disengaged both behaviorally and mentally. On the other hand, those with the most discrepancy between their current and ideal body size did not utilize greater disengaged coping styles. A person's reported ideal body size is not necessarily a size that she believes is attainable. The BIA instructions ask the participant to "select the silhouette that most accurately depicts the body size that you would most prefer." In contrast, a person's identified realistic body size is what "you believe is realistic for you to maintain over a long period of time". CBS-RBS may in fact be a measure of self-efficacy, while CBS-IBS is a measure of body size dissatisfaction. If a person is far from a size that she believes she could physically reach, this is a different experience than if a person is far from a size that she only believes she would like to be, not what she could ever hope to be. Future studies that include specific measures of self-efficacy are necessary to confirm this proposition, but other findings of this study do suggest that self-efficacy could be responsible for the discrepancy between body dissatisfaction indices.

Additional research on the topic more generally is necessary in order to strengthen support of current findings. The Body Image Assessment is a self-report scale that is highly subject to participants' perception and belief about ideal body size as well as their own body size. Although a subjective measure of body size dissatisfaction has value and fit the purpose of this study in understanding participants' discrepancies in their own subjective beliefs and perceptions, future studies need to take such nuances of the measure into account. Furthermore, the small sample size reduces generalizeability of the current findings. In an ongoing effort by so many to understand body dissatisfaction, weight preoccupation and ultimately disordered eating, as well as the relevant and practical implications offered for clinical intervention considerations, additional research with large samples is important for the field. Finally, an obvious but unanticipated limitation is the lack of a measure of self-efficacy. Although this was not a construct included in the original research question, in light of the results of this study, absence of a measure of self-efficacy limits the extent to which one can explain results of the current study. This is a direction for future research.

Conclusion

As predicted, body image dissatisfaction is a primary consideration, more than coping styles, in understanding predictors of weight preoccupation in nonclinical samples of college women. Body image, of course, is complex, and our understanding and measurement of the concept is still developing. Although common measures of body image dissatisfaction include subjective ratings of current, realistic and ideal body sizes, it is clear now that further exploration is necessary in order to identify distinctions between indices of such measures.

Although the difference between ones current and ideal body sizes may predict weight preoccupation, the difference between ones current and realistic body size may be a potential source of cognitive dissonance. These distinctions are important as we attempt to improve prevention and treatment of disordered eating. If the measure of the difference between current body size and realistic body size is indicative of the presence of cognitive dissonance, then traditional interventions that focus on psychoeducation and/or acquisition of adaptive coping styles may not be as appropriate as attempts to reduce dissonance and the accompanying psychological discomfort.

Finally, efforts to reduce dissonance must take into account one's self-efficacy. Low efficacy relates to a person's belief that she cannot achieve a particular task and subsequently she will not put forth effort

toward that task. For those who lack belief in their ability to reduce the stressor of body image dissatisfaction, the issue may not be that they lack adaptive coping ability, but that they do not implement those coping styles that require effort given their low weight related self-efficacy. Additional research that includes a deliberate measure of self-efficacy is necessary in order to understand this possibility.

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