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Coaching Interventions for Body Dissatisfaction: Preventing Eating Disorder Symptoms

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Abstract

Body dissatisfaction is a mental health struggle that impacts many individuals on a long-term basis. A major concern around the issue of body dissatisfaction is its propensity to perpetuate negative outcomes, such as eating disorder symptoms. Researchers have identified specific variables that may protect those struggling with body dissatisfaction from engaging in eating disorder symptoms. These protective variables are well-positioned for preventive efforts from coaches and for inclusion in coach training.

Keywords: mental health, eating disorders, body image, anorexia

Introduction

Body dissatisfaction is a pervasive and persistent mental health concern (Fiske et al., 2014; Wang et al., 2019). Researchers have documented alarmingly high rates of body dissatisfaction among adult participants, adolescent boy participants, and adolescent girl participants (McLean et al., 2022; Mintem et al., 2015). Authors have also discussed the negative effects of body dissatisfaction—for example, consistently highlighting the ways in which dissatisfaction with one's body can lead to eating disorder symptomatology (Stice, 2002). Body dissatisfaction has been found to be a risk factor for disordered eating, in that this variable predicted the development of or increase in eating disorder symptoms (Stice, 2002; Foster et al., 2024; Stice & Van Ryzin, 2019). Authors have summarized research linking eating disorders with a host of serious negative physical and mental health effects, such as osteoporosis, heart damage, tooth enamel loss, depression, anxiety, and substance use (Klump et al. 2009; Giel et al., 2022). Jenkins and colleagues (2011) also underscored findings on decreased subjective quality of life among those facing eating disorders. To highlight the seriousness of this issue, Bucchianeri and Neumark-Stzainer (2014) termed body dissatisfaction a "public health concern" and advocated for additional resources to address it (p. 84).

Yet, not everyone who struggles with body dissatisfaction will develop an eating disorder as evidenced by the discrepancy in prevalence rates for body dissatisfaction and eating disorder symptomatology (Tylka, 2004). As Polivy and Herman (2002) asserted: "the majority of individuals who are dissatisfied with their bodies will never go on to develop an eating disorder" (p. 205). This suggests that there are variables that alter the body dissatisfaction and eating disorder relationship (Tylka, 2004). Researchers term such variables to be moderating variables—factors that either increase or decrease the impact of a risk factor (Frazier et al., 2004). In the extant scholarship in this area, several moderating

variables have been documented—those that either attenuate or heighten the impact of body dissatisfaction (e.g., Brannan & Petrie, 2008; 2011; Tylka, 2004; Buser & Gibson, 2018). The attenuating, or buffering, factors are of particular interest, due to their potential ability to prevent someone who struggles with body dissatisfaction from engaging in physically and emotionally harmful eating disorder behaviors, such as self-induced vomiting, overexercising, and extreme dieting.

It is important to note that coaches are not engaging in therapy; they do not work with clients who have diagnosable mental health disorders and thus need to be trained in how to identify diagnosable and/or more serious mental health issues and refer when appropriate (Cavanagh & Buckley, 2024). However, coaches may work with clients who do not display diagnosable and/or more serious mental health issues—yet struggle with body dissatisfaction. Moreover, a focus on prevention strategies is important in coaching (Moore & Jackson, 2024). Given the high rates of body dissatisfaction, this appears to be a variable poised for preventive efforts by coaches. Coach awareness of the factors that protect individuals from the harmful impact of body dissatisfaction could be critical—in terms of helping coaches design targeted preventive interventions that focus on these moderating variables. Moreover, coach trainees can be instructed in the potentially powerful impact of these protective variables as a core element of their education, so that they bring this knowledge to future client care.

Definitions and Prevalence

Fiske and colleagues (2014) noted that body dissatisfaction has been assessed in various ways across research studies, such as the level of displeasure with specific body parts, general appearance, muscularity, and/or weight. These authors asserted that, as body dissatisfaction has not been measured uniformly, it can be difficult to identify accurate prevalence rates across studies. However, they summarized that, in studies where participants were asked to rate their satisfaction with their weight, 46-66% of women and 35-52% of men reported dissatisfaction.

Grabe and Hyde (2006) concluded that body dissatisfaction is a struggle faced by individuals of diverse backgrounds, i.e., Asian American, Black, Hispanic, and White female participants. Moreover, there is evidence that body dissatisfaction is persistent over time. Wang and colleagues (2019) reported that, among participants who were surveyed over a span of 15 years (starting in middle school), 44.5% of females and 18.9% of males reported high levels of body dissatisfaction that remained generally stable over time.

Eating disorder symptomatology can be clinical or subclinical in nature (American Psychiatric Association [APA], 2022; Tylka & Subich, 1999). Clinical eating disorders include diagnoses of anorexia nervosa, which is characterized by self-starvation behaviors, bulimia nervosa, which is characterized by binge eating, followed by compensatory behaviors such as self-induced vomiting, and binge eating, which is characterized by binge eating without the subsequent compensatory actions (APA, 2022). Rates of clinical eating disorders range from .05-1.2% (APA, 2022).

Individuals may also engage in disordered behaviors that may not rise to a clinical level of an eating disorder diagnosis (Tylka & Subich, 1999). Rates of subclinical symptoms are higher than clinical eating disorders; for example, Sanlier et al. (2017) reported that 19.4% of adult males and 19.3% of adult women reported disordered eating patterns and attitudes. Neumark-Stzainer et al. (2011) reported that 54.4% of young adult females and 29.9% of

young adult males reported unhealthy behaviors related to weight control, such as fasting or skipping meals. Moreover, 20.6% of young adult females and 7.3% of young adult males reported extreme behaviors to control weight, such as using diet pills or self-induced vomiting. Authors have noted that disordered eating practices are prevalent among study participants from diverse ethnic/racial backgrounds, such as Black/African American men and women, White men and women, and Hispanic/Latino men and women (Simone et al., 2022). In the sections below, the term *eating disorder symptoms* will refer to clinical and subclinical manifestations, unless otherwise indicated.

Moderating Factors

As noted previously, rates of body dissatisfaction have been reported to be higher than rates of clinical and subclinical eating disorders (APA, 2022; Neumark-Stzainer et al., 2011; Sanlier et al., 2017). Highlighting this discrepancy, researchers have examined variables that may intervene in the link between body dissatisfaction and eating disorder symptoms—potentially protecting body dissatisfied individuals from engaging in harmful behaviors (e.g., Buser et al., 2016; Buser & Gibson, 2018; Brannan & Petrie, 2008; 2011; Tylka, 2004). While augmenting moderators have been identified—that is, variables that increase the link between body dissatisfaction and eating disorder symptoms—the following sections will focus on buffering moderators.

To create a coaching practice and training model that focuses on ways to prevent the adverse impact of body dissatisfaction in its relationship with eating disorder symptoms, only variables underscored as protective will be reviewed. This model will focus on three main categories of variables that can be applied to client care and coach training—factors that can be used to develop preventive strategies for those who struggle with body dissatisfaction and may thus be at risk of developing eating disorder symptoms.

A Self that is Trusted and Important

In the research on protective moderators, variables related to one's sense of self emerge as pivotal in the link between body dissatisfaction and eating disorder symptoms. For example, authors have found that high levels of self-esteem weakened the association between body dissatisfaction and eating disorder symptoms among adult females (Twamley & Davis, 1999; Brannan & Petrie, 2011; Dakanlis et al., 2013), adult males (Dakanalis et al., 2015), and female college athletes (Brannan et al., 2009). The constructs of "I position" (Buser & Gibson, 2018), compassionate self-responding (Bicaker & Altan-Atalay, 2020), and self-determination (Brannan & Petrie, 2011) were also found to attenuate the association between body dissatisfaction and eating disorder symptoms among adult female participants.

The constructs of self-esteem, "I" position, self-compassion, and self-determination all relate to one's sense of self—particularly a sense of *trust* in oneself and a sense that oneself is *important*—worthy of love, respect, and care. Self-esteem has been understood as "the overall affective evaluation of one's own worth, value, or importance" (Blascovich & Tomaka, 1991, p. 115). Abdel-Khalek (2016) summarized scholarly definitions of self-esteem, such as the seminal work of Rosenberg (1965), noting that self-esteem refers to a sense of self-respect and self-worth. The Rosenberg Self-Esteem scale measures this construct via items that inquire as to an individual's belief in their positive qualities, respect for the self, and satisfaction with the self (Rosenberg, 1979). In addition, a belief in one's abilities and self-efficacy is an aspect of self-esteem (Abdel-Khalek, 2016; Branden, 1969/2001). This self-efficacy belief involves a sense of: "confidence in one's mind—in its

reliability as a tool of cognition. . . . It is the conviction that one is competent to think, to judge, to know (and to correct one's errors) . . ." (Branden, 1969/2001, p. 112).

An individual with a high "I" position is secure in their sense of self; they respect and value their own opinions and beliefs such that they are not excessively affected by external viewpoints (Skowron & Schmitt, 2003). Similarly, Brannan and Perie (2011) summarized conceptualizations of self-determination and underscored that individuals with high self-determination are intrinsically motivated. Intrinsic motivation refers to being internally driven to action out of personal pleasure versus being motivated for action due to a potential for external reward (Ryan & Deci, 2002). Finally, the construct of compassionate self-responding includes care and support for the self when feeling upset and in relation to one's faults, a sense of collective humanity wherein one's mistakes are understood as a common human experience, and the ability to keep adverse cognition and emotions in perspective and separate from one's sense of self (Neff, 2003, 2016).

A core similarity among these three variables seems to be an underlying *trust* in oneself. Individuals with high self-esteem, "I" position, self-determination, and compassionate self-responding appear to have a depth of trust in themselves, such that they believe they can address challenges they may face, follow their own beliefs in the face of external pressures, act based on internal motivation, and maintain a distance from overwhelming or negative emotions. Moreover, another core similarity seems to be an underlying sense that oneself is *important*. Individuals with high self-esteem, "I" position, self-determination, and compassionate self-responding appear to respect themselves, value their own personal views, follow an internal guide to determine action, and care for themselves when experiencing difficult emotions. Authors have surmised that individuals who score high on some of these variables, such as "I' position and self-esteem, may be able to avoid the societal pressures around thinness that can contribute to eating disorder risk (Buser & Gibson, 2018; Brannan & Peterie, 2011).

A Body that is More than Appearance

Another category of protective variables in the association between body dissatisfaction and eating disorder symptoms pertain to one's view of the body. For example, Showers and Larson (1999) examined college women who reported elevated body dissatisfaction, but did not report engaging in eating disorder symptoms; they found that these participants reported that physical appearance as an aspect of self was less significant to them—in comparison to the import placed on appearance as an aspect of self that was reported by another group of participants who scored high on measures of body dissatisfaction and reported struggling with eating disorder symptoms. In terms of how the body is viewed, authors have noted that individuals who value a healthy body (versus one that looks a certain way) may be protected from eating disorder symptoms (Buser et al., 2016). Specifically, in a qualitative study with female college students who reported body displeasure but did not engage in eating disorder symptoms, these authors reported a theme wherein many participants reported a core value of being healthy, versus engaging in damaging symptomology to attain a certain appearance. Buser and McLaughlin (2019) reported similar findings in a qualitative study with body-dissatisfied female college students who did not self-report eating disorder symptoms; these participants noted they avoided eating disorder symptoms via a commitment to health versus, for example, being a certain weight.

These findings suggest that a view of the body as *more than* physical appearance is protective in the relationship between body dissatisfaction and eating disorder symptoms.

Specifically, placing a lower value on physical appearance overall may be helpful, in addition to having a value system that runs counter to eating disorder practices. Endorsing a value of taking care of one's body and being healthy may help body-dissatisfied individuals refrain from engaging in the harmful behaviors of eating disorder symptoms such as extreme dieting, binge eating, and purging.

Coping Strategies and Focus

The third category of protective variables pertains to the coping strategies of those struggling with body dissatisfaction. Authors have characterized coping as either problem-focused or emotion-focused (Folkman & Lazarus, 1980). These authors specified that problem-focused styles involve efforts to actively address the stressor/problem and emotion-focused styles center around handling adverse emotions linked to a stressor/problem. Using this conceptualization of coping, Showers and Larson (1999) reported that the use of emotion-focused coping strategies significantly distinguished between two groups of college women participants. In particular, these emotion-focused coping techniques were less common among college women who indicated high body dissatisfaction—but did not report eating disorder symptoms. Conversely, college women who struggled with body pleasure and also struggled with eating disorder symptoms, used emotion-focused coping more frequently.

Researchers have also noted that a support system may be helpful for those struggling with body dissatisfaction. Social supports may offer protection from developing eating disorder symptoms. Specifically, Buser and colleagues (2016) reported that, among body dissatisfied participants, a deterrent to engaging in eating disorder symptoms involved body-supportive and body-positive comments from others in their lives.

Given these findings, it is possible that coping strategies play a role in protecting individuals who face body dissatisfaction from engaging in eating disorder symptoms. It appears that coping styles emphasizing the emotional responses to stressors are not helpful; prioritizing action and directly dealing with an issue may thus be beneficial in the relationship between body-dissatisfaction and eating disorder symptoms. Moreover, securing a support system may also be a buffering factor—specifically a support system that includes body-supportive interactions and comments.

Coaching Practice and Training Implications

The extant research on variables that may protect body-dissatisfied individuals from engaging in eating disorder symptoms have important implications for coaching practice and training. Prevention efforts are valuable in coaching practice (Moore & Jackson, 2024) and these buffering variables can be applied to coaching interventions to potentially prevent the start of eating disorder symptomatology among those who struggle with a dislike of their bodies. Moreover, coach trainees can gain knowledge about these protective variables in their coursework, so that they are well positioned to apply them in client care.

Focus on Client Sense of Self

Research on the body dissatisfaction and eating disorder relationship suggests that an individual's sense of self is critical in potentially protecting someone from engaging in damaging eating disorder behaviors. As the research findings on self-esteem, "I" position, compassionate self-responding, and self-determination suggest, individuals that trust themselves and view themselves as important may be less likely to engage in eating disorder

symptoms, even if they experience body dissatisfaction (Buser & Gibson, 2018; Bicaker & Altan-Atalay, 2020; Brannan et al., 2009; Brannan & Petrie, 2011; Dakanlis et al., 2013; Dakanalis et al., 2015; Twamley & Davis, 1999). A sense of trust in oneself and a belief in the importance of the self are core elements of self-esteem, self-determination, "I" position, and self-compassion. Essentially, these constructs all share a core element of an individual prioritizing their personal views and/or abilities over external pressures, emotions, demands, and doubts. To clinically apply these findings, coaches can find ways to encourage clients to develop a sense of self-trust and a belief in the importance of the self—in contrast to an individual who is guided by external forces and places little value on their own personal opinions, views, and goals.

One way that coaches could encourage this development of a self that is trusted and important would be to review, with clients, times when they were able to follow their own values and opinions instead of succumbing to external viewpoints. Following the mores of narrative therapy (White & Epston, 1990), coaches can work with clients to re-author a life story wherein their own views and opinions are important, influential, and trusted in the face of a multitude of external demands. A coach could ask questions that tap into the narrative therapy concept of unique outcomes (White & Epston, 1990) such as: "tell me about a time when you felt pressured to do something, but decided to follow your own perspective and made a decision that felt right to you," or "tell me about a time you faced a lot of stress about something, but were able to manage that stress and did not let it define you." Coaches can then shift their conversation into how clients deal with pressures for thinness and appearance in various media outlets, including social media—and how their personal views and values can protect them from ascribing to these societal values and pressures.

Coach educators can also integrate such information into various coaching classes. For example, classes on theories can provide practical applications for how to use various theoretical approaches with clients. A case study could be presented to students that involves a body-dissatisfied client at risk for developing eating disorder symptoms. Students could be informed that variables like self-esteem, self-determination, "I" position, and self-compassion may protect individuals from engaging in disordered eating—and a shared theme among these factors is a self that is trusted and important. Students could be asked to use narrative therapy to help this client develop and enhance a sense of trust in their own views, values, and opinions.

Focus on Client View of the Body

Another key finding from the literature on body dissatisfaction and eating disorder symptoms involves how individuals view their physical body. Individuals who experience body dissatisfaction but do not engage in eating disorder symptoms appear to place a lower value on physical appearance (Showers & Larson, 1999). More specifically, these individuals may value being healthy instead of looking a certain way (Buser et al., 2016; Buser & McLaughlin, 2019).

If certain life values are protective, coaches could have clients reflect on their values and/or complete values assessments to identify their current values. Concepts and exercises from Acceptance and Commitment Therapy (ACT) may be helpful, in terms of ways to identify and discuss client values (Hayes et al., 2012). For example, Hayes et al. (2012) presented an intervention termed: "*What Do You Want Your Life to Stand For?*" (p. 304). In this exercise, a client is guided through an imaginary scenario (e.g., one's own funeral, one's retirement from work). In this imagined situation, the client is asked to reflect on what they

want to be remembered for and then, to think about how their current life is aligning with those identified values. Motivational interviewing (Miller & Rollnick, 2013) also highlights client values as a key area for clinical intervention; these authors suggest assessing for values by asking open questions, such as inquiring about what a client deems valuable/important in their life, how they came to ascribe to this value, and how their lives reflect this value.

Ultimately, coaches can help clients identify what they value in life and potentially, how their present way of living coincides with or contradicts these values (Hayes, et al., 2012; Miller & Rollnick, 2013). Kater (2010) summarized a key principle of ACT for client care—to help clients "connect with what is of greatest importance to them and what they want their life to stand for" (p. 176). It is possible that a client will see that, while they value being a support and role model for their younger siblings, eating disorder symptoms would detract from that core life value (Kater, 2010). A client may then be more motivated to avoid engaging in such behaviors, because they can see how they would conflict with their life values (Kater, 2010).

As related to the personal value of health, clients may also identify taking care of themselves as being a value they hold; coaches can then use psychoeducation to inform clients about the ways in which eating disorder symptoms are contradictory to health (Buser et al., 2016). A review of the multiple points of damage that eating disorder symptoms can inflict may be beneficial—for example, noting that many physical and mental adverse outcomes are associated with symptoms such as extreme dieting, purging, over-exercising, and binge eating. Coaches can provide information on the comprehensive damage associated with eating disorder symptoms, such as heart issues, bone damage, and multiple other adverse physical and mental health impacts discussed in the literature (Klump et al. 2009; Giel et al., 2022). Discussion of the damage of eating disorder symptoms may alert clients and participants to the ways in which such symptoms are completely counter to values of health. This issue of valuing health may also intersect with the previous variable of a trusted and important self, in that an individual is adhering to their own value system of health versus following social pressures to be thin (Buser & Gibson, 2018; Brannan & Petrie, 2011).

Coach educators could address this theme of the body as more than physical appearance in various classes, such as a coaching skills-based course that reviews the use of psychoeducation in client care. Students can be trained in addressing, with clients, the detrimental impact of certain mental health problems. Students could be asked to complete a role play wherein they practice sharing the adverse impact of eating disorder symptoms with a mock client to highlight the unhealthy and physically and emotionally damaging nature of these behaviors. This can be a way to help students understand how important it is to approach such client psychoeducation in a way that is empathic and patient—not lecturing the client about the adverse effects in order to scare them into change but, as theories such as motivational interviewing recommend (Miller & Rollnick, 2013), asking the client for permission to discuss the negative impact, gathering the client's input and insight on this issue, and using empathic reflections throughout the process.

Focus on Client Coping

Finally, the third category of protective variables involves client coping mechanisms—namely forms of coping that do not concentrate on emotion-management and the presence of a body-positive support system (Buser et al., 2016; Showers & Larson, 1999). Coaches may thus want to explore clients' common ways of coping—clients who tend to use emotion-focused forms of coping may benefit from clinical interventions that teach alternate coping

styles, such as active, problem-focused (Folkman & Lazarus, 1980) styles of coping. Engaging in advocacy efforts related to body image issues could be one alternate active coping method. Thompson and Heinberg (1999) summarized the value of "teaching skills for media advocacy" (p. 347) in efforts to combat the damaging messages about thinness in appearance. These authors noted that some prevention programs engage participants in advocating against harmful media messages about the body, such as writing letters to certain outlets.

Moreover, clients can engage in active strategies to reduce their body dissatisfaction. The Body Project curriculum, which is an empirically supported prevention program to reduce body dissatisfaction and eating disorder symptoms (Stice, Becker, et al., 2013; Stice et al., 2008), includes behavioral challenges (Stice, Rhode, et al., 2013). In these exercises, participants commit to engaging in previously identified behaviors (e.g., wearing clothing that they may want to avoid due to body image concerns) that can help them lessen body displeasure; Stice, Rhode, et al. (2013) shared language from the session protocol wherein the facilitator comments that "Doing this should disprove your body image fears and increase your confidence" (p. 106).

Another important part of coping involves support systems—specifically ones that promote body-positive messages. Coaches can help clients take stock of their support systems—in terms of who/what gives them positive body messages and who/what gives them harmful messages. The idea of certain social media sites promoting negative social messages may be helpful, as coaches can then work with clients to replace negative messages with helpful ones—perhaps via switching to media sites that promote healthy messages. The National Eating Disorder Association (NEDA) has a tip sheet on the *Media and Eating Disorders* and suggests that reducing time spend on social networking and intentionally choosing value-consistent media to view is vital for self-care in this area (NEDA, 2024). Others have also asserted the import of "[cleaning] up your social media feeds" in an effort to promote healthier body attitudes (Poirier, 2021, 5 steps section). The NEDA tip sheet also discussed becoming a critical consumer of media messages, such as noting the artificial nature of many media images and the purchase-driven goals of advertising (NEDA, 2024).

Clients can also identify people in their lives who are helpful versus detrimental and nurturing relationships with those who give positive appearance feedback. Moreover, coaches may want to hold educational sessions for parents/guardians and others close to those facing body dissatisfaction to highlight how hearing positive messages about body acceptance can protect individuals from engaging in disordered eating. It may be that parents/guardians or other significant others are afraid to comment on someone's appearance for fear of communicating that they value appearance. While it can be a fine line, and parents/guardians and those in other significant relationships would not want to communicate valuing a certain kind of appearance (e.g., thinness) or placing value on appearance over other aspects of an individual, communicating positive messages about appearance and body size and shape may be important preventive tactic to help individuals avoid eating disorder symptoms.

Coaches can share with program participants that it is appropriate—and even warranted—to comment specifically on appearance, especially when asked and in the context of an individual's negative commentary about their body. Parents/guardians and others close to those who struggle with body image concerns want to counteract this damaging way of talking about one's body. Authors have documented the adverse impacts of negative body

talk (Hooper et al., 2023; Katrevich et al., 2014). For example, a psychoeducation program for parents/guardians could present this hypothetical scenario:

> A young adult (she/her) comes home from the summer for college and is out with her mom trying on clothes for the summer. She comes out of the dressing room and asks her mom if she gained weight in her first year at college; she worries that her friends from high school will be thinner and complains about how her stomach looks in a shirt.

The coach leading the session could ask participants for their thoughts on what could be said in response—facilitating a discussion around appropriate and less appropriate responses. The coach could also share information on Health at Every Size®, which is a movement to define health in a holistic manner versus just focusing on body size (Association for Size Diversity, 2013). NEDA (2024) discusses ways to personally apply this HAES® framework, such as self-reflecting on one's own views about weight and health and modeling attitudes about eating that are counter to pressures around eating. After this background, the coach could share that a parent/guardian could respond to this comment in a helpful manner by saying something like:

> You look great in that shirt! I know you see media images or friends that look different. But everyone looks different. Health is more than appearance or weight. You have a healthy diet and are active—you play college intramural sports and take walks at home.

There may be opportunities for integration of these concepts in coach training coursework. For example, students may design workshops for different populations in certain classes. One group of students could design a psychoeducation workshop for parents/guardians of those struggling with body image that addresses how to assist parents/guardians in learning to be helpful support systems for their children. Students can also be trained in certain courses on how to incorporate active coping strategies into coaching approaches for various client concerns—including those around body dissatisfaction.

Conclusion

Body dissatisfaction is a common mental health struggle; in fact, authors have termed it to be "normative" for certain groups (Striegel-Moore et al., 1986, p. 246). Body dissatisfaction is also an enduring struggle for many individuals (Wang et al., 2019) and is associated with multiple adverse outcomes, such as eating disorder symptoms (Foster et al., 2024; Stice, 2002). Given the common, persistent, and deleterious nature of body dissatisfaction, coaches should be equipped to address this issue with clients. Specifically, coaches should be prepared to intervene with variables that may protect individuals facing body dissatisfaction from engaging in eating disorder symptoms. Addressing variables such as a client's sense of self, a client's value system related to the body, and the coping methods and supports available to a client may help prevent eating disorder symptoms for those who struggle with body dissatisfaction.

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