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# Shame And Negative Body Image In Adolescent Females

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Shame And Negative Body Image In Adolescent Females

by

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Presented to the Faculty of the  
Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

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Newberg, Oregon

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Shame and Negative Body Image in Adolescent Females

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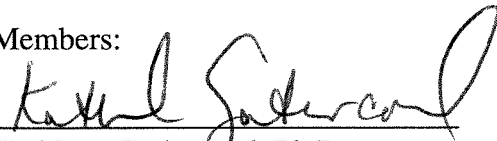
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## Shame and Negative Body Image in Adolescent Females

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### Abstract

Current research in the fields of shame, body image, and adolescent female weight has had little convergence until recently. Biological changes that occur during adolescence, particularly weight gain for females, may result in feelings of shame. Shame is an involuntary reaction to the belief that the self is inherently flawed. Body image begins to form in early childhood, and “is a multidimensional construct that refers to subjective perceptual and altitudinal experiences about one’s body, particularly one’s physical appearance” (Cash, Melnyk, & Hrabosky, 2004, p.305). Body image may be negatively impacted when the adolescent female’s belief that her actual body is at odds with her internalized body ideal.

This study examined body image and shame of average weight and obese adolescent females. Eighty females from northwest high schools and church youth groups were administered The Body Esteem Scale for Adolescents and Adults (Mendelson, White, & Mendelson, 1997), the Thurston Cradock Test of Shame (TCT) (Thurston & Cradock, 1998), and were assessed for weight according to the Body Mass Index (Wilson and Jeffrey’s study as cited in Hersen & Bellack, 1988). Participants also filled out a demographic questionnaire.

Participants were randomly assigned to one of two TCT presentation conditions. Half of the participants were given the revised card six (an obese child being punished) and the other half were given the original card six (a non-obese child being punished).

Shame, as measured by the TCT, did not have a significant relationship with the participants' BMI or the participants' Body Esteem Scale (BES)-appearance (subscale) rating, neither did the resolution scores of the TCT cards. The only significant differences were revealed between testing locations (private high schools, public high schools, or church youth group).

Future research may benefit from revising this study. Location differences indicate focus on matching the selection sample by either testing at all public high schools, all private high schools, or all youth groups may limit sample variance. A clinical interview that includes history of environmental influences (home, school, peers, media, etc.) which have contributed to how the individual's body image developed is also worth considering for future research.

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## Chapter 1

### Introduction

Shame is powerful. Shame, once internalized, wreaks psychological havoc on an individual. Negative body image may be one of the results of an individual internalizing body shame. There can be a rejection of the body for the obese individual. According to Thone,

Since I have become heavier, I get to learn what large women have always known, that people have no compunctions against talking negatively about large people, especially women, even in front of them. Somehow they think they have an inalienable right to judge and comment on fat people, especially women (Thone, 1997, p.7-9).

Shame stems from a variety of antecedents and is a profound affective state. Shame is an involuntary reaction to the belief that the self is inherently flawed and objectionable. According to Bartky (1988) internalization of the cultural ideals of body standards may be the impetus behind intense body shame. The affective state of shame has only been of interest in the clinical community for the past few decades. McFarland and Baker-Baumann (1990) discuss how when an individual experiences shame related to the body the affective state experienced is unlike that associated with other shame experiences in that one cannot escape from their body. The individual cannot separate from the body in order to avoid the affective experience of shame.

#### *Shame Defined*

Shame has been defined by many different authors, researchers, and theorists and is not

easily distilled into one concise definition. Kaufman (1996) indicated that, “To live with shame is to feel alienated and defeated, never quite good enough to belong. And secretly the self feels to blame; the deficiency lies within...The source of low self-esteem, poor self-concept, or diminished self-image is shame” (Kaufman, 1996, p. 24).

Shame can occur in the presence or absence of others. Katz (1997) indicated that shame is “a fearful and chaotic sense of an irresistible and eerie revelation to self, of a vulnerability in one’s nature” (Katz, 1997, p.232). Interpersonal interaction is not necessary for shame to occur (Kaufman, 1996). According to Kaufman (1996), “no other affect is more deeply disturbing [than shame]. Like a wound made from the inside by an unseen hand, shame disrupts the natural functioning of the self,” (Kaufman, 1996, p.5) and continued, “Shame is a loss of face. Shame is hanging the head. Shame is dishonor, fallen pride, a broken spirit” (Kaufman, 1996, p.24).

Morrison (1998) defines shame as:

fundamentally a feeling of loathing against ourselves, a hateful vision of ourselves through our own eyes-although this vision may be determined by how we expect or believe other people are experiencing us. This self vision is accompanied by self-consciousness, and by a conviction of important failure that often generates a wish to hide or conceal (Morrison, 1998, p.14-15).

Shame occurs when an individual believes that he or she is the mistake, blunder, or failure (Noll & Fredrickson, 1998).

Morrison (1994), in the language of Self Psychology, defined shame as the experience that occurs when an individual’s expectation or hope to receive “affirmation and mirroring [as well as] participation with the idealized self-object” (Morrison, 1994, p.24), is disappointed.

Tomkins (1963) illustrated interpersonal shame by stating,

If I wish to look at you but you do not wish me to, I may feel ashamed. If I wish you to look at me but you do not, I may feel ashamed. If I wish to look at you and at the same time wish that you look at me, I can be ashamed. If I wish to be close to you but you move away, I am ashamed (Tomkins, 1963, p.192).

Shame has been conceptualized as the moment a secret experience is exposed (McFarland & Baker-Baumann, 1990). Shame is an internalization of a comment, a behavior, or an idea, taken to the extreme, and owned by the individual as part of the individual's core negative identity.

Regardless of the cause of shame, the phenomenological reaction to shame seems fairly universal. According to Lewis (1995), shame causes the individual to "desire to hide or disappear" (p.34). Anastasopoulos (1997) reported that the experience of shame may be related to a desire to escape the situation.

#### *Overview of Shame Research*

Most of the research appears to be in agreement that shame must be distinguished from the notion of guilt. Guilt is the belief that one made a mistake, while shame takes that notion one step further and believes that the self is a mistake. Shame is often accompanied by a physical manifestation, a loss of the sense of identity, loss of ability to control, a sense of failure, weakness, or deficiency, and the frequent feeling of being dirty or disgusting. Shame is often seen as a conflict between the real image of the self and the ideal image of the self (Anastasopoulos, 1997).

The role of shame can take either a positive or negative affective state. In his book *Healing the Shame that Binds You*, Bradshaw defines that there are two types of shame: "nourishing shame and toxic/life-destroying shame" (Bradshaw, 1988, p.3). Nourishing shame

or healthy shame is thought to be a fleeting experience. Regarding healthy shame, Bradshaw (1988) states, it...

is part of every human's personal power. It allows us to know our limits, and thus to use our energy more effectively. We have better direction when we know our limits. We do not waste ourselves on goals we cannot reach or on things we cannot change (Bradshaw, 1988, p. 4).

Furthermore, nourishing shame may promote healthy growth. Healthy shame plays a positive role by regulating behavior. Toxic shame is an internalized reaction related to feeling exposed. An example of this is given by Byrd-Bredbenner and Grasso as cited in Frances Berg's book:

*Underage & Overweight: America's childhood obesity crisis-what every family needs to know* (2004):

For me, living is literally hell, says Jonelle, a teenager. The insults I must endure, the pity, the loneliness, the self-hatred and the loathing are all punishments I would not wish on anybody. I didn't do anything wrong. I am fat...My life is a Catch-22. I'm lonely and don't have friends because I'm fat, and I eat because I'm lonely. Nobody wants to be seen with me including some of my family...There is nothing I would not give to be thin (Berg, 2004, p.195).

Toxic shame causes the self to retreat from others and chastize oneself (Bradshaw, 1988). Toxic shame will be the focus of this paper and will be referred to as shame. Toxic shame is incendiary and has the tendency to be long-lasting and far-reaching in its capacity for psychological upheaval. An individual who has experienced toxic shame may show signs of feeling hopeless or worthless.

*Shame in Adolescence*

Shame may be incorporated into an individual's existence sometime during puberty. As the adolescent moves into puberty, biological changes are rapidly taking place. The biological changes occur at different rates for males and females and at varied rates among individuals (Anastasopoulos, 1997). Biological changes may contribute to an increased opportunity to experience shame. The adolescent often begins to feel out of control due to the changes that are taking place and often times this encourages the development of shame (Kaufman, 1989).

The developmental changes of puberty may create in the adolescent a sense of heightened visibility, or a sense that they are scrutinized more closely by others. The adolescent sense of being on stage in front of an audience is "a consequence of shame affect" (Kaufman, 1996, p.42). An adolescent may "feel exposed, seen, scrutinized; they feel open to view. Adolescents feel as if others can see inside of them, see their faults or defects, maybe even read their thoughts. This is how shame feels on the inside" (Kaufman, 1996, p.42).

An individual's significant relationships commonly foster or perpetuate the shame experience. In order for shame to take place, the individual must first value the person doing the shaming in order for the shame to be internalized (Bradshaw, 1988). Studies suggest that females who report a history of being teased as children and adolescents are more likely as adults to report appearance dissatisfaction (Grilo, Wilfley, Brownell, & Rodin, 1994, p.444; Cash, Winstead, & Janda, 1986). While shame can be multi-generational, passed on from one generation to the next (Bradshaw, 1988), shame is also developed as the adolescent struggles with individuation from the parent(s), and attempts to find autonomy separate from that of their parent(s) (Miller, 1985).

*Body Image Defined*

There has been a great deal of empirical research on body image in recent years.

According to Cash et al. (2004), “Body image is a multidimensional construct that refers to subjective perceptual and attitudinal experiences about one’s body, particularly one’s physical appearance” (Cash et al., 2004, p.305). Others (Cash & Pruzinsky, 1990, 2002; Thompson, Altrabe, Johnson, & Stormer, 1994; Tiggemann, Gardiner, & Slater, 2000) have agreed.

Body image “forms gradually, beginning in childhood” (Cash, 1997, p.43). According to the Renfrew Center Foundation,

[body image] is influenced by our parents, caregivers, peers, and life experiences. The development of good self-esteem, a strong identity, the capacity for pleasure, and the ability to connect emotionally to one’s self and to others are all linked to a positive body-image (The Renfrew Center Foundation, p.2).

Zerbe (1993) posited, “We are constantly comparing our mental image of what we believe our body is or should be with an ideal human body or figure” (p.153). Cash (1997) identified two basic categories influential on the development and maintenance of body image: historical and current influences. The historical influences “are the forces from your past that shaped how you came to view your appearance” (Cash, 1997, p.43). The current influences “are the experiences of everyday life that determine how you think, feel, and react to your looks” (Cash, 1997, p.43).

According to the Eating Disorder Awareness and Prevention Program (EDAP, 2000), body image is:

How you see yourself when you look in the mirror or when you picture yourself in your mind, what you believe about your own appearance (including your memories, assumptions, and generalizations), how you feel about your body, including your height,

shape, and weight, [and] how you sense and control your body as you move. How you feel in your body, not just about your body (EDAP, 2000, p.1).

A concept that continues to surface in body image research is the relationship between self-esteem and body image. According to McFarland and Baker-Baumann (1990), the degree of an individual's body satisfaction is related to the individual's self-concept. Furthermore, there is a significant relationship between "body image, body satisfaction and self-image" (McFarland & Baker-Baumann, 1990, p.80). Finally, an individual's perception of his or her body strongly effects how that individual perceives himself or herself (McFarland & Baker-Baumann, 1990).

An individual with a healthy body image is not often concerned with changing or altering his or her body (McFarland and Baker-Baumann 1990).

#### *Negative Body Image for Obese Adolescents*

According to Striegel-Moore and Cachelin (1999), as the adolescent female's body changes during puberty her appearance begins to look different than the cultural ideal of feminine beauty. In particular, when the adolescent female begins to confront pubescent weight gain her developmental stress is compounded as she is also confronted with heightened gender role expectations. As a natural reaction to the developmental stresses, body image dissatisfaction may emerge (Striegel-More & Cachelin, 1999). According to Friedman (2000),

Girls get the short end of the stick. Along with their newly developed bodies comes the pressure to look good and to fit into a narrowly defined ideal of female beauty. They begin to feel as if their bodies are out of control as they gain weight. They deal with their discomfort by feeling fat (Friedman, 2000, p.134).

Negative body image or body image disturbance is activated when an individual has thoughts, feelings, and perceptions of his or her body that are at odds with the individual's ideal



body image (McFarland & Baker-Baumann, 1990). McFarland and Baker-Baumann (1990) also report that negative body image may be related to a distorted body size, and dissatisfaction with body size. Brumburg (1997) indicated “by age thirteen, 53 percent of American girls are unhappy with their bodies; by age seventeen, 78 percent are dissatisfied” (p.xxiv). “Even among girls who never develop full-blown eating disorders, the body is so central to definitions of the self that psychologists sometimes use numerical scores of body esteem or body dissatisfaction to evaluate a girl’s mental health” (pp.xxiv-xxv).

According to Pesa, Syre, and Jones (2000), males and females may first experience the negative results of body image as a reaction to the developmental changes of adolescence. Furthermore, as the adolescent female experiences an increase in body weight her well-being may be negatively impacted (Pesa et al., 2000).

Does the failure to achieve the ideal body that often leads to negative body image in turn lead to shame? Berg (2000) reported that shame is:

Often felt as the result of humiliation and failure to measure up to high standards of appearance. Shame is the response to being violated, harassed and stigmatized, the overwhelming sense of being inadequate and wrong. Shame as a result of harassment and oppression can make women want to disappear, become invisible, disconnect from their bodies (Berg, 2000, p.45).

Currently in American culture there is a thin ideal that is nearly impossible for most adolescent females to attain. According to Berg (2000),

Women today are afraid to gain weight. From girlhood to adulthood, they’re afraid to gain weight and terrified of failing to lose it. They’re afraid their bodies will be

unacceptable in a society obsessed by thinness. It's a fear that consumes, shatters lives, even kills (Berg, 2000, p.15).

The adolescent's drive for thinness is a cause for concern in western societies (Sands, 2000). "Health professionals, psychologists, educators, and sport administrators" (Sands, 2000, p.399) have noticed and are concerned about adolescent females' discontent with body image. Behaviors that may stem from distorted body image include exercising excessively (Overdorf & Gill, 1994), depression (Sands, 2000), decreased self-esteem (Fox, 1990), and disordered eating (Sands, 2000).

Littleton and Ollendick (2003) indicated that the primary influences on body image include media, peers, and family. Littleton and Ollendick (2003) reported media as a factor which "has been repeatedly mentioned as playing a key role in the development of disordered eating and body image dissatisfaction," and continued by reporting that the most harmful effects on body image include "exposure to the thin media messages, particularly among adolescent girls" (Littleton & Ollendick, 2003, p.55). Children and adolescents with preexisting eating disorders and negative body images may look to the media for "information about how to improve their appearance" (Littleton & Ollendick, 2003, p.55).

The influence of a peer group also plays a role in influencing body image. According to Littleton and Ollendick (2003), Lieberman, Gauvin, Bukowski, and White (2001) conducted a study of peer factors associated with body image dissatisfaction. They found that "being pressured or teased by peers regarding body weight, and modeling of body concerns and disordered eating behavior by peers all play an important role in the development and maintenance of negative body image and disordered eating" (p.56).

Finally, family attitudes can play a key role in the development and maintenance of negative body image. Littleton and Ollendick (2003), indicated “parents and siblings can pressure young women to lose weight and lead girls to view their body weight negatively,” (p.56). Keel, Heatherton, Harnden, and Hornig (1997) as cited by Littleton and Ollendick, found that comments made by parents regarding their daughter’s body weight was related to body image dissatisfaction and dieting and “paternal weight dissatisfaction was associated with weight dissatisfaction in their daughters” (Littleton & Ollendick, 2003, p. 56).

Stunkard and Mendelson (1967) were the first researchers to report body image disturbances present in some obese individuals. They asserted that not all obese individuals have body image disturbances but disturbances are likely to be present in individuals with a history of pre-adolescent onset obesity, who were negatively evaluated by significant others, and who had a disturbing emotional experience (Stunkard & Mendelson, 1967). Mertens and Vandereycken (1998) followed a group of 257 girls through high school and found that adolescents who have negative body image may have been overweight children.

Cash, Counts, and Huffine (1990), found that women who had been overweight and lost weight, still perceived themselves as being too fat. In fact, formerly overweight women were almost as dissatisfied about their appearance and weight as overweight women. They also found that formerly overweight women were more dissatisfied about their appearance than women who were never overweight.

Weight loss and food habits affect body image. According to Noll and Fredrickson (1998), negative body image or body shame can increase for individuals who have failed attempts to lose weight as well as those who have lost weight but have failed to maintain the weight loss. Furthermore, as an individual’s weight loss and weight gain becomes a pattern, the

amount of shame can compound and become entrenched. Sanftner and Crowther (1998) conducted a study that examined self-esteem, moods, shame, and guilt in women who binge. They found that there are significantly greater self-esteem, negative affect, shame, and guilt fluctuations in women who binge compared to women who do not binge.

Factors that prevent against a negative body image include positive family relationships, positive social and peer relationships, participation in organized sports, and belonging to an accepting body-inclusive cultural group (Littleton & Ollendick, 2003).

### *Obesity Defined*

According to Ronch, Van Ornum, and Stilwell (1994), obesity is defined as body weight that is greater than twenty percent fatty tissue according to the Body Mass Index (BMI) (Ronch et al., 1994). In most studies, a BMI greater than thirty is considered obese. The BMI (Wilson and Jeffrey's study as cited in Herson & Bellack, 1988) is a tool used to index an individual according to height and weight ( $BMI = \text{Weight [in pounds]} \div \text{Height [in inches]} \times 703$ ). Obesity often has physical consequences that include hypertension, adult-onset diabetes, high cholesterol, dermatological problems, and back problems (Ronch et al., 1994).

### *Contributing Factors of Adolescent Obesity*

Berg (2004) sites six developmental periods across the female's lifespan when she is particularly vulnerable to the development of obesity. Prenatal influences, adiposity rebound in early pre-school years, adolescence with increased fat deposition, early adulthood with the reduction of physical activity, pregnancy, and menopause are all periods of vulnerability to weight gain. Adolescent obesity may be linked to "the rise in consumption of highly processed foods and the growing popularity of fast-food restaurants" (Rimm, 2004, p.24). Rimm (2004) further indicated that:

when you take increased television watching, decreased physical activity, greater consumption of over-processed foods and foods from fast-food restaurants, and lower consumption of fruits and vegetables among our children, the combined effect is a perfect storm of circumstances that are driving the childhood obesity epidemic (Rimm, 2004, p.25).

### *Results of Adolescent Obesity*

Adolescent obesity is associated with a variety of negative health effects. The NIH Strategy Development Workshop for Public Education on Weight and Obesity (1992) lists hypertension, increased total cholesterol, and hyperinsulinemia as health risk factors associated with adolescent obesity. Berg (2004) also indicated that obstructive sleep apnea, early puberty, polycystic ovary syndrome are associated with adolescent obesity.

### *Obesity Trends*

According to the Center for Disease Control & Prevention (CDC), obesity rates in the United States have been steadily climbing. The CDC has been conducting a Behavioral Risk Factor Surveillance System (BRFSS) since 1985. One of the focal points of the survey is obesity (obesity is defined as a BMI  $\geq$  30). Initially, only a few states participated. In 1991 all states participated in the survey, four of which reported obesity prevalence rates of 15-19%, no states reported rates above 19%. In 2003, all states continued to participate and fifteen had prevalence rates from 15-19%, 31 had rates from 20-24%, and four had rates greater than 25%. According to Berg (2004), 15% of individuals age six to nineteen are overweight.

### *Obesity Discrimination and Prejudice*

Current American culture contributes to low body image of overweight persons by emphasizing that being thin is the ideal, while demonstrating that discriminating against

overweight individuals is acceptable (Ronch et al., 1994). Zerbe (1993) asserts, “The societal contempt often directed at people who are obese causes them great emotional pain and can lead to interpersonal rejection” (p.301). Discrimination against the obese seems to be based on the Western cultural belief that obesity is considered unattractive and associated with a lack of willpower (Sobal, 1991).

Discrimination against obese individuals permeates many spheres of society, in educational, occupational, as well as medical settings (Allon, 1982). Berg (2000) quoted Camryn Manheim, a plus sized actress who eloquently stated the social stigma of being fat:

Our culture really hates fat people...There are billion-dollar industries invested in me hating my body: the fashion industry, the diet industry, the nutrition industry, and the cosmetic surgery industry are all invested in my hating my body. If women of my size were to actually enjoy being their size, those industries would collapse...I think it's a miracle that I laugh every day and walk through my life with pride, because our culture is unrelenting when it comes to large people. I don't understand. We hurt nobody. We're just fat people (Berg, 2000, p.114).

Discrimination against obese individuals is reinforced by educators. Berg (2000) indicated discrimination has been found, “in the way teachers evaluate and interact with larger students. Acceptance into prestigious colleges is lower for large women even when they do not differ in academic qualifications” (Berg, 2000, p.124). Discrimination of the obese individuals also takes place in the workplace. According to Berg (2000), “In their work and careers, large women frequently meet size prejudice in hiring, in advancement, in salary. Sometimes they are first to be fired” (Berg, 2000, p.114). Prejudice against obese individuals is also prevalent in the health care industry. “Fat patients often receive no intelligible diagnosis—the diagnosis is that the patient is

fat. Naming Obesity as a cause without offering a successful, affordable cure puts the blame squarely on the victim ” (Berg, 2000, p.116).

Obese individuals in general experience discrimination, while social attitudes and reactions are different for men and women (Wardle, 1995). Women, even those within healthy weight ranges, are more likely to participate in weight control treatments whereas men, even in the heaviest of weight groups, do not (Wardle, 1995).

An issue that obese individuals struggle with is that they continue to be a socially accepted target of prejudice. Berg (2004) states, “Obesity is the last socially acceptable form of prejudice” (p.196). The stigma of obesity goes as far back as childhood. Berg (2004) discussed a 1961 study that has been replicated with evidence of increased prejudice,

children as young as six described silhouettes of an overweight child as lazy, dirty, stupid, ugly, cheats and lies. When shown drawings of a normal weight child, an overweight child, and children with various handicaps, including missing hands and facial disfigurement, children rated the overweight child as the least likable (Berg, 2004, p.196).

Who can be more cruel to each other than teens? The overweight teen is an easy target. Does this create shame in the overweight teen? Negative body image often develops by experiencing prejudice against body size from peers. Zerbe (1993) asserted, “adolescent girls who are obese are particularly vulnerable to narcissistic wounds caused by the teasing of their peers” (p.302). In a study conducted by Crandall (1994) prejudice against obese people was examined. Crandall proposed an analogy between racial attitudes and anti-fat attitudes, and found parallels on the dimensions of “the association between values, beliefs, and the rejection of a stigmatized

group, the old-fashioned antipathy toward deviance of many sorts, [and] the lack of self-interest in out-group antipathy” (Crandall, 1994, p.882).

While Anorexia Nervosa and Bulimia Nervosa are considered psychiatric disorders, obesity is considered a medical disorder as exhibited by its ICD-9 coding and lack of a specific DSM-IV coding. The etiology and effects of obesity are not yet professionally recognized.

#### *Family Reaction to Obesity*

The family is a microcosm of the world, and the first exposure a child has to a number of factors including how others will accept or reject body based on a number of factors including size. Zimetkin, Zoon, Klein, and Munson (2004) indicated, “For 5-year-old obese girls, the mothers’ restriction of food and the father’s opinion of the child’s obesity were significantly associated with the child’s negative self-perception” (p.137). Trombini, Baldaro, Bertaccini, Mattei, Montebanocci, and Rossi (2003) examined attachment styles in mothers of obese and mothers of non-obese children. They found that the attachment style for mothers of obese children was significantly more insecure when compared to the mother-child relationship of non-obese children. They also found that mothers of obese children tended to “make the family their exclusive centre of interest” (Trombini et al., 2003, p.613). Stradmeijer, Bosch, Koops, and Scidell (2000) found parental concern to be more significantly correlated with self-esteem problems than was BMI for 10- to 16-year-olds.

#### *Theories of Obesity*

There are several causes for obesity. There is currently no definitive answer for the exact nature or cause of an individual’s obesity. Some causes of obesity include genetics, fat cell theory, set point theory, calorie intake and expenditure, metabolism, cultural factors, stress and yo-yo dieting or weight cycling.



*Genetics Theory of Obesity.* The genetics theory is backed up by studies conducted on twins. According to Ronch et al. (1994), twin studies revealed that twins who are reared together have adult weights that are more likely to correlate positively with their biological rather than adoptive parent's weight. An individual with non-obese biological parents has only an 8% chance of becoming obese, while an individual with one biological parent who is obese has a 40% chance of being obese. An individual with two obese biological parents has an 80% chance of becoming overweight (Ronch et al., 1994).

*Fat Cell Theory of Obesity.* The Fat Cell Theory is based on the notion that an individual's fat cell count is determined early on in life, and is maintained across a lifetime. According to Ronch et al. (1994), an individual's fat cells will expand as fat is metabolized until they can hold no more at which time they will divide. The growth of new fat cells in children can lead to hyperplastic obesity. Adults do not gain new fat cells, according to this theory, but instead just expand the existing fat cells which can lead to hypertrophic obesity. The fat cell division continues across the individual's life-span (1994). The basic belief in this theory is that once fat is gained, it is challenging to lose weight.

*Set Point Theory of Obesity.* The set point theory is based on the belief that an individual's body is biologically and genetically determined to weigh within a certain weight range (Berg, 2004).

Berg (2004) stated:

Our setpoint or settling point is not fated at birth, but is the result of both genetic and environmental factors up to this time in life. It's the weight our bodies want to weigh now. Environment makes a difference, so does lifestyle later in life. It appears that setpoint can be gradually lowered somewhat, through increasing activity, and perhaps

changed eating patterns and other changes. Setpoint creep is gradual weight gain that often happens through the years... The body has some kind of weight-thermostat that regulates this. After weight has been threatened with a severe diet, the body may become more efficient next time. It appears that we cannot easily change this weight, whether we want to or not (p.187-188).

*Calorie Intake and Expenditure Theory of Obesity.* The calorie intake and expenditure theory according to Ronch et al. (1994) states, “When calorie intake exceeds the calories burned through physical activity (exercise), digestion (dietary thermogenesis), and other bodily functions (such as respiration, excretion, etc), people gain weight” (p.409).

*Metabolism Theory of Obesity.* Metabolism is affected by calorie intake. When the body is restricted of calories, it becomes more efficient burning calories and essentially slows down. Once the metabolism is slowed down by caloric restriction, reintroducing calories can cause weight gain. Repeated dieting can further slow down one’s metabolism (Berg, 2004). The metabolism theory suggests that weight may be affected for some people due to thyroid irregularities (Ronch et al., 1994).

*Cultural Factors Theory of Obesity.* The Cultural Factors theory is based on the notion that fat and obesity is perpetuated by the high-fat food that is easily attained in American culture. Ronch et al. (1994) assert that when individuals from countries who have had healthier diets lower in fat intake come to the United States and adopt the food habits of Americans, they are at risk of developing obesity.

*Stress Theory of Obesity.* The stress theory is based on the notion that opiates (natural chemicals) are released in the brain when carbohydrates are consumed. Opiates tend to reduce

anxiety, stress, and pain. Therefore, people who experience stress may eat foods rich in carbohydrates to reduce stress (Ronch et al., 1994).

*Yo-Yo Dieting Theory of Obesity.* Yo-yo dieting or weight cycling is the repeated cycle of losing and gaining weight. Berg (2004) stated, “When weight continuously fluctuates and leads to weight cycling, the person may be worse off than before [the weight was lost]” (p.28) and “The chronic dieter experiences...yo-yoing...But instead of regaining up to the initial level, her weight often ratchets up higher and higher each time” (p.49).

Regardless of the cause of obesity, the effect of obesity may have a profound effect on body image. Miller and Downey (1999) found in their meta-analysis of weight and self-esteem that high weight is associated with lower self-esteem. Mendelson, Mendelson, and Andrews (2000) found in their study that adolescents who believed that their weight was an important factor tended to rate their appearance and weight satisfaction low. Weight and body image seem to have a relationship that is worth examining further.

#### *Purpose of Study*

The purpose of the proposed study is to investigate the different body images and different levels of shame between a sample of obese adolescent females and a sample of average weight adolescent females. Body image will be investigated using Mendelson et al.'s (1997) Body Esteem Scale for Adolescents and Adults. Shame will be evaluated using cards 1, 6 (original or revised version), and 8 of the Thurston-Cradock Test of Shame (TCT) (1998). Obesity and average weight will be separated using the Body Mass Index (BMI) (Wilson and Jeffrey's study as cited in Herson & Bellack, 1988). Obesity will be determined as  $BMI \geq 30$ , and average weight will be  $BMI \leq 29.9$ .

The present study will investigate the following hypotheses:

1. Obese participants who report low body esteem will project more shame onto revised card six of the Thurston Cradock Test of Shame (TCT) (1998) than onto the original card six of the TCT.
2. Shame scores will be lower on TCT card 8 (baseball scene) than TCT card 1 (girl looking at herself in mirror) shame scores.
3. Obese participants who report high body esteem will have shame scores on TCT card 6/6R (average weight/ and high weight child being punished) which will be greater than shame scores on TCT card 1, which will be greater than shame scores on TCT card 8 (shame scores: TCT card 6/6R > card 1 > card 8).
4. Obese participants who report low body esteem will have less adaptive story resolutions to card six revised of the TCT than obese adolescents who report high body esteem.
5. Obese participants who report high BES appearance will have adaptive resolutions to card six revised, card six original, card one, and card eight of the TCT.

## Chapter 2

### Method

#### *Participants*

Participants were selected from high schools and church youth groups in the Pacific Northwest. Three hundred and twenty informed consent forms were given out, and 80 were returned (25% return rate). Of the 80 returned informed consent forms, 79 agreed to participate. See Table 1 for number of informed consent forms handed out and returned at each testing location.

The target participant group included 80 female adolescents between the ages of 13 to 18 (Mean age = 16.4 years, *SD* 1.28) who volunteered to participate. The mean Body Mass Index of the group was 25.29 (*SD* 6.57). Sixty-six females were considered normal weight (Body Mass Index  $\leq 29.9$ ), while 13 were considered high weight or obese (Body Mass Index  $\geq 30$ ). This matches the national prevalence of adolescent obesity. Table 2 provides demographic information for the high weight group (BMI  $\geq 30$ ) and the average weight group (BMI  $\leq 29.9$ ).

Participants were recruited, compensated for their participation, and treated in accordance with the “Ethical Principles of Psychologists and Code of Conduct” (American Psychological Association, 1992). Participants were informed that the purpose of the study was to expand previous knowledge in the area of adolescent concerns and that responses would be kept confidential. Of the 80 participants, one declined to participate after she read the informed

consent. She, like the other participants, was compensated for her time with a \$5.00 Hollywood video gift card.

Table 1

## Informed Consent Forms

Location	Informed Consent Forms		Return Rate
	Handed Out	Returned	
Fir Ridge High School	80	23	28.75%
C.S. Lewis High School	20	7	35.00%
Westside Christian High School	140	2	1.43%
Lake Ridge High School	20	20	100.00%
Newberg High School	40	10	25.00%
Yakima Youth Group	20	18	90.00%
Total	320	80	25.00%

Exclusionary criteria included the presence of mentally retardation, learning disabilities, and physical handicaps. These criteria were used because individuals with these conditions are more likely to have experienced shame not exclusively due to their weight.

Table 2

## Demographic Data

Variable	Normal Weight*	High Weight**
Age (years)	( <i>n</i> = 66)	( <i>n</i> = 13)
13	2	2
14	3	0
15	7	0
16	17	1
17	28	4
18	9	6
Ethnicity		
White	57	12
Hispanic/Latina	6	1
Black/African American	2	0
American Indian/Alaskan Native	1	0

\*Normal Weight = BMI  $\leq$  29.9.

\*\*High Weight = BMI  $\geq$  30.

*Materials*

*Demographic questionnaire.* Participants responded to a demographic questionnaire (see Appendix A) that asked about subjects' age, race/ethnicity, grade, weight, and height.



*Thurston Cradock Test (TCT)*. Three cards from the Thurston Cradock Test (TCT) were shown individually to each participant. The standardized form of the TCT consists of 10 stimulus cards with an additional revised optional card that depicts every day situations. In this study, three of the ten cards were presented; card one, card six (either the original card or the revised card), and card eight. Card one is an image of a girl with acne (one form was shown to all participants). Card six had two versions. The original version depicts a non-obese child who is being punished; the revised version holds every aspect of the picture constant except for the additional presence of food wrappers and the child is obese. Half of the participants, chosen at random, saw the card with an obese child (revised form of card six) and half saw a non-obese child (original form of card six). The third card each participant saw was card eight, which is a picture of a baseball scene. The participants were asked to tell a story based on each of these cards, with a beginning, middle, and an end. They were also asked to include any thoughts or feelings of the individuals in the pictures. The responses were scored based on affect of the participant, resolution to stories, type of shame material elicited, and response style to testing experience.

The scoring for the TCT has already been standardized for each card. An individual researcher, blind to the purposes of this study, examined each story for content. A second researcher, also blind to the purposes of this study, scored 10% of the responses ( $n=8$ ) for the purpose of establishing inter-rater reliability. Inter-rater reliability for scoring the TCT cards was 0.86. Cradock (1997) conducted a pilot study using the TCT to measure shame and found inter-rater reliability on items ranging from .83 to .95. Studies examining shame using the TCT conducted by Cradock (1999) and Rote (2002) found sturdy construct validity of the TCT. Testing with only three TCT cards gives the opportunity to test construct validity further.



The two variables of the TCT that were examined included affect elicited (whether or not shame was indicated in the story) and story resolution. Affect elicited was scored either 1 (shame was present in the story) or 0 (no shame was present in the story). Story resolution was scored from one to five (1=highly adaptive resolution, 2=adaptive resolution, 3=unresolved resolution, 4=maladaptive resolution, or 5=severely maladaptive resolution).

*Body Esteem Scale (BES).* The Body Esteem scale (see Appendix B) asks participants to “report their degree of agreement with various statements about their bodies” (Gardner, 2001, p. 200). The 23-item Body-Esteem Scale consists of three aspects of body esteem: general feelings about appearance (BES Appearance subscale), weight satisfaction (BES Weight subscale), and the individual’s perception of how others’ evaluate her body and appearance (BES Attribution subscale). Responses to items on the BES range from 0 (never) to 4 (always). “The higher the score for a particular subscale, the more positive is the respondent’s body esteem on that dimension” (Mendelson et al., 1997, p.4). The BES Appearance subscale consists of ten items (six of which are scored in reverse) that are added then divided by ten to get the overall subscale score. The BES Weight subscale consists of eight items (three of which are scored in reverse) that are added then divided by eight to get the overall subscale score. The BES Attribution subscale consists of five items that are added then divided by five to get the overall subscale score. The Body Esteem scale has internal consistency (split half reliability) of 0.85. The internal consistency (alpha) for the current sample is 0.92 and (split half reliability) of 0.93. Measures of self worth (The Rosenberg Self-Esteem Scale and the Global Self-Worth subscale of the Self-Perception Profile for College Students) were administered with the BES during its norming and partial convergent validity was found (BES-Appearance only).

*Procedure*

Subjects were recruited through a letter sent from the school to the parent or guardian of the potential participant. Parents were informed of the study, and asked to give consent for their adolescent daughter's participation. Potential participants were then informed of the study and asked to give their assent. (See Appendices C, D, and E for the letters.)

Each participant was seen individually during school hours or at another agreed upon time. Participants were first asked to fill out the demographic questionnaire. Each participant then responded to the three TCT cards (cards 1, 6, and 8). Participants were randomly assigned to one of two TCT presentation conditions. Half of the participants were given the revised card six (an obese child being punished) of the TCT, and the other half were given the original card six (a non-obese child being punished). The TCT was followed by the body esteem scale, and finally each participant was weighed, and her height was measured (see Appendix F for measurement form). This testing session required from 15 to 30 minutes. When the data collection was completed, participants were compensated with a \$5.00 Hollywood Video gift card, and informed that they could request the results of the study.

## Chapter 3

## Results

*Demographics*

Table 3 provides information about the participant's self-reported weight, self-reported height, body mass index based on self-reported weight and height, actual weight (weighed by researcher during study), actual height (measured by researcher during study), and actual body

Table 3

Participants' Self Reported and Actual Weight and Height.

Variable	Mean	SD	Range
<b>Participants' Self Reported</b>			
Weight (pounds)	137.49	25.36	95-210
Height (inches)	64.23	2.69	56-70
BMI	24.91	5.93	17-43.71
<b>Participants' Actual</b>			
Weight (pounds)	145.63	32.93	96-252
Height (inches)	63.84	2.98	54-70
BMI	25.29	6.57	17.28-54.44

Note. Body Mass Index (BMI) = Weight/Height<sup>2</sup> x 703



mass index based on actual weight and height. See Table 4 for the Means and Standard deviations of the TCT card one, six, and eight responses for affect elicited and story resolution.

Table 4

Means and Standard Deviations for TCT cards 1, 6, 6R, and 8

Variable	Mean	SD
Card 1		
Shame Present	0.19	0.39
Resolution to Story	1.55	0.65
Card 6		
Shame Present	0.50	0.51
Resolution to Story	1.92	0.86
Card 6R		
Shame Present	0.61	0.49
Resolution to Story	2.36	0.81
Card 8		
Shame Present	0.15	0.36
Resolution to Story	1.60	0.61

*Note.* Shame Present (0=no, 1=yes); Resolution to Story (1=adaptive, 2=unresolved, 3=maladaptive).

Of the 79 females who participated in the study, 13 (16.5%) were considered obese as determined by a score of  $BMI \geq 30$ , and 66 (83%) were considered to be average weight as determined by a score of  $BMI \leq 29.9$ . The Center for Disease Control & Prevention (CDC) reported that in 2002 the prevalence of obesity ( $BMI \geq 30$ ) for Washington and Oregon ranged from 15-24% of the population.

The participants' reported and actual weight were significantly correlated,  $r = +.92$ ,  $p < .01$ .

The participants in the study had slightly higher BES subscale scores (they rated the scales more positively for appearance, weight, and attribution) than were expected. See Table 5 for the actual and expected means and standard deviations of the Body Esteem Scale subscales of appearance, weight, and attribution.

Table 5

Actual and Expected Means and Standard Deviations for the Body Esteem Subscales

Subscale	Mean	<i>SD</i>	Mean	<i>SD</i>
	Actual	Actual	Expected	Expected
BES Appearance	2.34	0.66	2.11	0.88
BES Weight	2.32	0.98	2.01	1.11
BES Attribution	2.14	0.68	2.03	0.78

### *Hypothesis One*

Obese participants who report low body esteem will project more shame onto revised card six of the Thurston Cradock Test of Shame (TCT) (1998) than onto the original card 6 of the TCT.

A 2 (average BMI and High BMI) x 2 (low BES appearance and high BES appearance) ANOVA was conducted for shame scores on TCT cards 6 (average weight child being punished) and 6R (obese child being punished) to examine whether obese adolescent females who report low BES appearance scores would have more shame responses on TCT card 6R than TCT card 6. The ANOVA revealed no significant main effects,  $F(1, 71) = .93, p = .34$ . The ANOVA revealed no significant interactions according to Cohen (2003), ( $\eta^2 = .01$ ). Hypothesis one rejected.

### *Hypothesis Two*

Shame scores will be lower on TCT card 8 (baseball scene) than TCT card 1 (girl looking at herself in mirror) shame scores. A 2 (average BMI and high BMI) x 2 (low BES appearance and high BES appearance) ANOVA was conducted for shame on TCT cards 1 (girl looking at herself in the mirror) and 8 (baseball scene) to see whether less shame would be projected onto card 8 than onto card 1 of the TCT. The ANOVA using shame scores on TCT card 1 and card 8 revealed no significant main effects,  $F(1, 76) = .70, p = .50$ . The main effect size was insignificant, according to Cohen (2003), ( $\eta^2 = .02$ ), and no interactions among the variables. Hypothesis 2 rejected.

### *Hypothesis Three*

Obese participants who report high body esteem will have shame scores on TCT card 6/6R (average weight/ and high weight child being punished) which will be greater than shame scores on TCT card 1, which will be greater than shame scores on TCT card 8 (shame scores: TCT card

6/6R > card 1 > card 8). A 2 (average BMI and high BMI) x 2 (low BES appearance and high BES appearance) was conducted for shame scores on each of the three cards of the TCT to see whether shame scores for TCT card 6/6R would be greater than shame scores on TCT card 1 which would be greater than shame scores on TCT card 8 (Shame on Card 6/6R > Shame on Card 1 > Shame on Card 8).

The ANOVA using shame scores on TCT Card 6/6R, Card 1, and Card 8 revealed no significant main effects and no interactions among the variables.

A 2 (shame present on TCT card 6/6R and shame not present on TCT card 6/6R) x 2 (shame present on TCT card 8 and shame not present on TCT card 8) ANOVA was conducted for shame present on TCT card 1. The ANOVA revealed a significant main effect for shame present on TCT card 8,  $F(1, 75) = 5.86, p < .05$ . The main effect size was small, according to Cohen (2003), ( $\eta^2 = .10$ ), and partially supports hypothesis 3. No significant interactions were found among the variables.

A 2 (shame present on TCT card 1 and no shame present on TCT card 1) x 2 (shame present on TCT card 8 and no shame present on TCT card 8) ANOVA was conducted for shame present on TCT cards 6/6R. The ANOVA revealed no significant main effects,  $F(1, 71) = 1.61, p = .21$ . No significant interactions were found among the variables according to Cohen (2003), ( $\eta^2 = .02$ ).

A 2 (shame present on TCT card 1 and no shame present on TCT card 1) x 2 (shame present on TCT cards 6/6R and no shame present on TCT cards 6/6R) ANOVA was conducted for shame present on TCT card 8. The ANOVA revealed a significant main effect for shame present on TCT card 1,  $F(1, 75) = 5.65, p < .05$ . The main effect was small in size, according to Cohen

(2003), ( $\eta^2 = .10$ ), which partially supports hypothesis 3. No significant interactions were found among the variables. Hypothesis 3 partially accepted.

#### *Hypothesis Four*

Obese participants who report low body esteem will have less adaptive story resolutions to card six revised of the TCT than obese adolescents who report high body esteem.

A 2 (low body esteem appearance or high body esteem appearance) x 2 (average BMI and high BMI) ANOVA was used for resolution scores on TCT card 1 and it revealed no significant main effects,  $F(1, 56) = .37, p = .55$ . No interactions were found among the variables according to Cohen (2003), ( $\eta^2 = .01$ ).

A 2 (low body esteem appearance or high body esteem appearance) x 2 (average BMI and high BMI) ANOVA was used for resolution scores on TCT card 6/6R and it revealed no differences between the original and revised version of card 6 in resolution scores,  $F(1, 5) = 1.94, p = .17$ . The main effect size was insignificant, according to Cohen (2003), ( $\eta^2 = .03$ ). The ANOVA using resolution scores on TCT cards 6/6R revealed no significant main effects,  $F(1, 56) = .31, p = .58$ . No interactions were found among the variables according to Cohen (2003), ( $\eta^2 = .006$ ).

A 2 (low body esteem appearance or high body esteem appearance) x 2 (average BMI and high BMI) ANOVA was used for resolution scores on TCT card 8 and it revealed no significant main effects,  $F(1, 56) = 3.50, p = .07$ . No interactions were found among the variables according to Cohen (2003), ( $\eta^2 = .06$ ).

Hypothesis 4 rejected.



*Hypothesis Five*

Obese participants who report high BES appearance will have adaptive resolutions to card six revised, card six original, card one, and card eight of the TCT. A 2 (average BMI and high BMI) x 2 (low BES appearance and high BES appearance) ANOVA was conducted for resolution scores on each of the three TCT cards to examine whether the obese participants' BES appearance scores would affect resolution scores on the three TCT cards.

See Table 6 for means and standard deviations for resolution scores for obese ( $BMI \geq 30$ ) participants with high BES appearance scores.

A 2 (average BMI and high BMI) x 2 (low BES appearance and high BES appearance) ANOVA was conducted for resolution scores on each of the three TCT cards to see whether story resolution would be more adaptive on TCT card 8 than TCT card 1, which would be more adaptive than the resolutions on TCT card 6, which would be more adaptive than the resolutions on TCT card 6R (Adaptive resolution: Card 8 > Card 1 > Card 6 > Card 6R) for obese ( $BMI \geq 30$ ) individuals with high BES appearance scores.

The ANOVA using resolution scores on TCT card 1 revealed a main effect for BES appearance,  $F(1, 71) = 4.19, p < .05$ . The main effect was small in size according to Cohen (2003), ( $\eta^2 = .10$ ). The ANOVA also revealed a significant interaction between BMI and BES appearance,  $F(1, 71) = 4.73, p < .05$ . This interaction was small in size, according to Cohen (2003), ( $\eta^2 = .10$ ).

The ANOVA using resolution scores on TCT cards 6/6R revealed no differences between the original and revised card in resolution scores,  $F(1, 71) = 2.62, p = .11$ . The ANOVA using resolution scores on TCT cards 6/6R revealed no significant main effects according to Cohen (2003), ( $\eta^2 = .04$ ) and no interactions among the variables.

The ANOVA using resolution scores on TCT card 8 revealed no significant main effects,  $F(1, 71) = 2.22, p = .14$ , and no interactions according to Cohen (2003), ( $\eta^2 = .03$ ) among the variables.

Hypothesis 5 rejected.

### *Presence of Shame*

Shame responses to cards 1, 6/6R, and 8 were analyzed using a Chi Squared test because the dependent variable was dichotomous. None of the shame responses differed significantly based on BMI, body esteem or whether participants were exposed to card 6 or 6R. Only the school the participants attended was related to shame responses on card 1 ( $X^2(5) = 17.16, p < .01$ ), card 6 ( $X^2(5) = 25.01, p < .01$ ), and card 8 ( $X^2(5) = 13.97, p < .02$ ). Specifically, Fir Ridge and Lake Ridge High Schools had more shame-based responses than would have been expected.

Table 6

Obese Participants with High BES Appearance

Card	<u>Resolution Scores</u>	
	Mean	SD
1	1.25	0.46
8	1.50	0.75
6	1.60	0.89
6R	2.0	1.0

*Note.* BES appearance = Body Esteem Scale, subscale appearance (1=low BES, 2=high BES).

*Resolution Data*

A 2 (card 6 and card 6R) x 6 (schools) x 2 (average and high BMI) x 2 (low and high BES appearance) ANOVA was conducted for the resolution scores on each of the three cards.

The ANOVA using resolution scores on card 1 (girl in the mirror) revealed a significant main effect for BES appearance,  $F(1, 49) = 7.00, p < .05$ . This main effect was small in size, according to Cohen (2003) ( $\eta^2 = .12$ ). No interactions among the variables was revealed.

The ANOVA using resolution scores on card 6/6R (average weight or obese child being punished) revealed no differences between the original and revised card in resolution scores. The ANOVA using resolution scores on card 6/6R revealed no significant and no interactions among the variables.

The ANOVA using resolution scores on card 8 (the baseball scene) revealed a significant main effect for school,  $F(5, 49) = 2.32, p < .05$ . This interaction was small in size, according to Cohen (2003) ( $\eta^2 = .19$ ). Post Hoc analysis, using a Sheffe test, revealed that the variances due to school were predominantly owing to differences between Yakima Youth group and West Side Christian High School. Specifically, the resolution scores of the Yakima participants were significantly lower (more adaptive) than the responses from all the other schools and the least adaptive responses came from participants at West Side Christian High School.

When school location is excluded from the variable list and the ANOVAs are re-run, no main effect or interactions are statistically significant for any of the resolution responses for any of the cards.

## Chapter 4

### Discussion

Factors affecting the accuracy of self-reported weight and height are important to consider. In this study, while there was a high correlation between reported and actual weight, the correlation for reported and actual height was not significant. Abraham, Luscombe, Boyd, and Olesen (2004), in Predictors of the Accuracy of Self-Reported Height and Weight in Adolescent Female School Students, found that, “younger, early pubertal and premenarcheal students were most likely to underestimate their height whereas older, post menarcheal students were most likely to overestimate their height” (p.76).

The lack of significance between BMI, BES appearance and shame scores on TCT cards 6 and 6R suggests that there may be more complexity to adolescent female obesity and her experience with shame and appearance.

This study attempted to find a relationship between obesity, body esteem, and shame. Sarwer and Thompson (2002) cited Foster, Wadden, and Vogt (1997) and Sarwer, Wadden, and Foster (1998) stating, “the degree of body image dissatisfaction appears to be unrelated to degree of obesity” (p.449). Wadden and Stunkard (2002) pointed out that in both studies, body mass index (BMI) had no correlation with body dissatisfaction.

For obese participants with high BES appearance, the most adaptive story resolutions were given to TCT card 6R, the next most adaptive story resolutions were given to TCT card 6,

followed by TCT card 8, with TCT card 1 having the least adaptive story resolutions. See Table 6. These findings run counter to what was expected. The reasons for this could be many. First of all, it is necessary to point out that the difference between TCT card 1 and TCT card 6R is only .75. Perhaps the best resolution score comes from TCT card 6R, from the obese participants with high BES appearance scores, because the obese participant may identify with the obese child in TCT card 6R.

An individual's body-esteem probably looks different from one individual to the next based on environmental influences (family of origin's beliefs about weight, cultural beliefs about weight, media influences, peer influences, and perceptions). An individual who grew up in a supportive environment where body esteem was fostered and encouraged regardless of weight and appearance will respond more positively to body esteem questionnaires than an individual who does not have the history in a supportive environment and may lack the resiliency to progress through life despite cultural shame targeted at the obese body. Perhaps history gathering by way of a structured interview focused on presence/absence of environmental or other shame-based materials would be necessary to investigate in future studies.

The lack of significant findings related to presence of shame is also worth considering. Only the school the participants attended were related to shame responses across the three TCT cards. Specifically, Fir Ridge and Lake Ridge high schools had more shame-based responses than would have been expected. Fir Ridge is an alternative high school, which may increase the internal shame experience and lead to more shame-based responses. Lake Ridge high school in contrast to Fir Ridge is located in a high socioeconomic or affluent portion of a suburb of a large northwest city. Females that attend such a school may be keenly aware of pressures and expectations put on them by parents and peers. The environment may encourage achievement-

oriented tasks while lacking in efforts to support non-shaming interpersonal and intrapersonal growth enhancing tasks. Participants from the Yakima youth group may have had less shame responses due to a number of factors. First, being a youth group, the participants may come from less shame-based environments. They may tend to self-select less shame-based peer groups. Being tested at a non-school environment may have reduced anxiety that may reduce shame-based responses.

Next, story resolution scores were examined. A small main effect was found for resolution scores on TCT card 1 and BES appearance. This small main effect may be related to the nature of the TCT card 1. Seeing a picture of a girl looking at herself in the mirror and creating a story about such a picture is likely to engage the viewer in thoughts related to appearance.

Story resolution scores on TCT card 8 revealed a small main effect for schools. Specifically, the resolution scores of the Yakima participants were significantly lower (more adaptive) than the responses from all the other schools. The least adaptive responses came from participants at West Side Christian high school. West Side Christian high school only included two participants and it is not worth discussing further the resolution scores for the two compared to eighteen participants.

The current research study may have been influenced by how the research was presented to the possible participants by the contact person (principal, teacher, counselor, youth group leader) at the schools/youth groups. Some schools/youth groups presented the research experience as that focusing on body image. The chief researcher asked that the potential participants receive general information about participating in a research study interested in the adolescent female's experience. The biggest obstacle in recruiting participants was in convincing principals, school

boards, counselors, teachers, and youth group leaders that the research was ethical, important, and non-threatening emotionally to the participant. When it was presented as a body image research project (by the contact person at Fir Ridge and West Side Christian high schools), fewer participants may have elected to participate and perhaps those with low body esteems self selected out of participating.

Future research may benefit from a few factors that were not present in this study. First, the sample was taken from a variety of different schools and youth groups in the Northwest. A more robust sample would focus on matching the selection sample, either testing at all public high schools, all private high schools, or all youth groups. A clinical interview that includes history of environmental influences (home, school, peers, media, etc.) which have contributed to how the individual's body image developed would be interesting to add to future research.

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Appendix A

Letter to Parent

Date\_\_\_\_\_

Dear Parent or Guardian:

Hello, my name is Erin. I am a graduate student in the clinical psychology program at George Fox University. I am currently conducting research with Dr. Nancy Thurston on the adolescent female's experience. This letter is being sent to ask for your assistance and permission with this study. During the month of \_\_\_ we will be at \_\_\_\_\_to collect data for this study.

This information will be used in a research study being conducted on adolescent development and behavior. Adolescence is a very important transition period during development and can be a time of increased psychological pain. It is our hope that this study will help us begin to better understand the everyday stresses for adolescents.

The information gathering process will require approximately 30 minutes of your child's time to complete. This time will be used to have your child complete portions of a standardized test, a survey, and a brief questionnaire. During this time, body measurements will also be taken (height, weight, heart rate). A unique number will identify your child instead of their name and no one except for the researchers will be able to see your child's score.

If you desire information about the final research, it can be obtained by contacting the researchers at the University. We will talk individually with each child after the testing is conducted to answer any questions that your child may have.

We hope that you will consent to your teen's participation in this important research. It is only through this type of research that we can understand and provide appropriate resources to the next generation. Please read the attached Consent Form and if you agree to have your daughter participate, return it to \_\_\_\_\_on Date.

If you have any questions or want additional information regarding this study, please contact one of the people listed below in the Department of Clinical Psychology at George Fox University. The telephone number is 503-554-2752. Thank you for your time and assistance.

Nancy S. Thurston, Psy.D.  
Erin K. Anderson-Fortier, M.A.





Appendix B

Parental Informed Consent Form

## Consent to Participate

The following test administration is part of a research project through the Department of Clinical Psychology at George Fox University. The primary researcher Erin K. Anderson-Fortier, M. A., currently has a Master's Degree and is entering the final portion of her formal schooling at George Fox University.

The testing is part of ongoing research at George Fox University run by Professor Nancy S. Thurston, Psy.D. of George Fox University (telephone 503-554-2752). The research goals of this project are to better understand the daily stresses of teenage life. We are trying to get information about how today's teens may differ from teens of ten or twenty years ago in their response to these questions.

There is a slight risk that while answering questions about the picture cards and answering questions from a survey they will be shown and given as part of the testing, that your daughter may experience an emotional response. Though unlikely, if this occurs, each researcher is fully trained to attend to those specific needs both at the time of the testing and after the testing is complete.

Your daughter will have an opportunity to ask questions about the research and its purpose after the testing is complete. We are simply asking to use the results for our research on teenagers. Your daughter's name will not be written on the test material at any time, only a code number, assuring that your child's identity will be confidential.

If you agree to allow your daughter to participate, please sign and return the portion below.

Respectfully,  
Nancy S. Thurston, Psy.D.  
Erin K. Anderson-Fortier, M.A., Principal Researcher

The nature of the testing has been explained to me, as well as the general purpose and potential benefits that may come from it. I understand that if my daughter participates in the testing she may stop at any point with no adverse consequences. I understand that if I have any questions I may contact Dr. Thurston or one of the researchers at 503-554-2752.

By signing below, I consent (agree) to have my daughter participate in the research described above.

Name of daughter \_\_\_\_\_

Signature of Parent/Legal guardian \_\_\_\_\_ Date \_\_\_\_\_



Appendix C

Informed Assent Form

### Assent to Participate

You are about to take part in a study which will include, a picture test, having some body measurements taken (height, weight, heart rate), and complete a brief questionnaire. You'll be telling a story about three different pictures while the examiner records your responses.

Your parent(s) have already given permission for this testing to be used as part of research being conducted by George Fox University, and we hope that you will also assent to it. The process will take a total of 30 minutes of your time and some report that it is an interesting and enjoyable experience. It might cause you to think about yourself and others a little bit. We would like you to complete the two parts seriously.

One or all of the researchers will talk with you individually after you have completed the four portions of this project. At that time, you can ask any questions about the process. We are asking to use the results of this research in our research projects. Your name will not be written on the test materials at any time, only a code number, assuring your identity will remain confidential.

Please sign below to indicate you assent to participate and thank you for supporting this important research.

Respectfully,

Nancy Thurston, Psy.D.

Erin K. Anderson-Fortier, M.A., Principal Researcher

The nature of the testing has been explained to me, as well as the general purpose, as well as the potential benefits to me that may come from it. I understand that I may stop at any point with no adverse consequences.

By signing below, I consent to participate in the research described above.

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Appendix D  
Demographics Form

BACKGROUND DATA SHEET

Research Code\_\_\_\_\_

Student Age\_\_\_\_\_

Grade in School\_\_\_\_\_

Family of Origin (circle)

White

Hispanic/Latino(a)

Asian/Pacific Islander

Black/African American

American Indian/Alaskan Native

Other \_\_\_\_\_

Weight\_\_\_\_\_lbs

Height\_\_\_\_\_'\_\_\_\_\_'

Appendix E

Body Esteem Scale-For Adolescents and Adults (BES)

BES

Participant # \_\_\_\_\_

Indicate how often you agree with the following statements ranging from 'never' (0) to 'always' (4). Circle the appropriate number beside each statement.

	Never	Seldom	Sometimes	Often	Always
1. I like what I look like in pictures	0	1	2	3	4
2. Other people consider me good looking	0	1	2	3	4
3. I'm proud of my body	0	1	2	3	4
4. I am preoccupied with trying to change my body weight	0	1	2	3	4
5. I think my appearance would help me get a job	0	1	2	3	4
6. I like what I see when I look in the mirror	0	1	2	3	4
7. There are lots of things I'd change about my looks if I could	0	1	2	3	4
8. I am satisfied with my weight	0	1	2	3	4
9. I wish I looked better	0	1	2	3	4
10. I really like what I weigh	0	1	2	3	4
11. I wish I looked like someone else	0	1	2	3	4
12. People my own age like my looks	0	1	2	3	4
13. My looks upset me	0	1	2	3	4
14. I'm as nice looking as most people	0	1	2	3	4
15. I'm pretty happy about the way I look	0	1	2	3	4
16. I feel I weigh the right amount for my height	0	1	2	3	4
17. I feel ashamed of how I look	0	1	2	3	4
18. Weighing myself depresses me	0	1	2	3	4
19. My weight makes me unhappy	0	1	2	3	4
20. My looks help me to get dates	0	1	2	3	4
21. I worry about the way I look	0	1	2	3	4
22. I think I have a good body	0	1	2	3	4
23. I'm looking as nice as I'd like to	0	1	2	3	4



Appendix F  
Measurements

Measurements

Participant #: \_\_\_\_\_

Weight: \_\_\_\_\_ Lbs (use scale and weigh them)

Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches (use tape measure)

Pulse: \_\_\_\_\_ Beats Per Minute (check using their wrist pulse)

Appendix G  
Curriculum Vita



Supervision: Two hours weekly

Supervisors:

Psychotherapy: Beth Ruiz, Ph.D.

Assessment: Darla Burnett, Ph.D.

Sept. 2002-  
Oct. 2003

Clinical Psychology Trainee

Yamhill County Family and Youth Programs, McMinnville, Oregon

Facility: Community Mental Health Agency

Population: Children, Adolescents, & Families

Clinical Duties:

- Provide individual, family, and group therapy to children, adolescents, and families.
- Generate treatment plans, annual assessment reports and other relevant documentation for clients.
- Participate in regular multidisciplinary family decision meetings.
- Complete intake interviews and reports.
- Refer clients within the agency and to other community resources.
- Co-lead sexual offender groups for adolescent boys aged 13-17.
- Co-lead social skills training group for children aged 5-9, and adolescents aged 10-14.
- Co-lead alcohol and drug rehabilitation group for adolescent females aged 14-17.
- Conduct assessments using cognitive-intellectual, behavioral, projective, and personality instruments and provide reports to referral sources and the families.
- Provide consultation with DHS, schools, and foster parents.
- Conduct a presentation for the Staff. Anderson-Fortier, E. (2003). The Treatment of Body Image Issues: Current Research and Techniques. Presentation at Yamhill Family and Youth Programs, McMinnville, Oregon, Staff Conference.

Supervision: Two hours individual supervision weekly

Supervisors: Dawn Hoffman-Gray, Ph.D.

Barb Smith, M.F.T

*Total Hours: 544*

Sept. 2002-  
May 2003

Clinical Psychology Pre-Intern

Oregon State Hospital, Salem, Oregon

Facility: State Mental Health Hospital

Population: Adolescent & Forensic Adult

Clinical Duties:

- Provide individual, milieu, and group therapy to adolescent population.
- Conduct comprehensive assessments using projective, cognitive/intellectual, neuropsychological, and personality instruments.
- Forensic evaluations (on forensic adult ward) of "aid and assist" patients with written comprehensive report.
- Generate written assessment reports.
- Consult in multiple weekly interdisciplinary team meetings with a

psychiatrist, a psychologist, social workers, nurses, mental health specialists, and clients.

- Complete intake evaluations.
- Co-lead psychotherapy group

Supervision: One-two hours weekly

Supervisors: Stephen Wilson, Ph.D. (Adolescent ward)  
Claudia Kritz, Ph.D. (Forensic adult ward)

*Total Hours: 435*

Sept. 2000-  
Dec. 2002

Clinical Psychology Trainee

Parent Care, Portland, Oregon

Facility: Parent Education Classes

Population: Parents of Toddlers, Children/pre-adolescents, & Teenagers

Clinical Duties:

- Co-facilitated first class, Lead-facilitated last 7 classes.
- Facilitate 8, 2 hour weekly parent education classes.
- Teach from a psycho-educational model, targeting teaching parents effective discipline strategies as well as assisting parents in building healthy relationships with their children enriched by communication and problem solving skills.

Supervision: One hour a week

Supervisor: Terri Bennink, Psy.D.

*Total Hours: 240*

May 2002-

Clinical Psychology Trainee

Multnomah County Corrections Health, Portland, Oregon

Facility: Juvenile Detentions

Population: Adolescents

Clinical Duties:

- Provide individual therapy.
- Conduct comprehensive assessments using projective, cognitive/intellectual, neuropsychological, and personality instruments.
- Generate written assessment reports.

Supervision: One hour a week

Supervisor: Stephen Huggins, Psy.D.

*Total Hours: 48*

May 2002-  
July 2002

Clinical Psychology Trainee

Multnomah County Corrections Health, Interchange, Portland, Oregon

Facility: Inpatient Drug and Alcohol Facility

Population: Adult Men

Clinical Duties:

- Conduct comprehensive assessments using projective, cognitive/intellectual, neuropsychological, and personality instruments.
- Generate written assessment reports.

Supervision: One hour of a week

Supervisor: Stephen Huggins, Psy.D.

*Total Hours: 98*

Jan. 2002-  
July 2002

Clinical Psychology Trainee  
Multnomah County Corrections Health, Inverness, Portland, Oregon  
Facility: County Jail, minimum security  
Population: Men & Women  
Clinical Duties:

- Provide individual therapy.
- Conduct comprehensive assessments using projective, cognitive/intellectual, neuropsychological, and personality instruments.
- Generate written assessment reports

Supervision: One hour a week  
Supervisor: Stephen Huggins, Psy.D.  
*Total Hours: 256*

Nov. 2001-  
Dec. 2001

Clinical Psychology Trainee  
Multnomah County Corrections Health, County Detentions Center, Portland, Oregon  
Facility: County Detentions, Maximum security  
Population: Men & Women  
Clinical Duties:

- Provide individual therapy.
- Conduct comprehensive assessments using projective, cognitive/intellectual, neuropsychological, and personality instruments.
- Generate written assessment reports.

Supervision: One hour a week  
Supervisor: Stephen Huggins, Psy.D.  
*Total Hours: 179*

Aug. 2000-  
May 2000

Clinical Psychology Trainee  
George Fox University Health and Counseling Center, Newberg, Oregon  
Facility: University Counseling Center  
Population: Adults  
Clinical Duties:

- Provide brief and long-term individual therapy utilizing various treatment modalities.
- Conduct intake and dictate assessment reports.
- Perform alcohol assessments for mandated clients.
- Create feedback letters based on results of alcohol assessments.
- Conduct personality assessment.
- Conduct cognitive/intellectual assessment.
- Teach Didactic session on Self Care techniques.
- Create and present psycho-educational materials on eating disorders for eating disorder awareness week, presented in classrooms, dorms, and at a community wide presentation.
- Create and present psycho-educational materials on substance abuse for undergraduate classes.
- Develop treatment plans and therapeutic goals.
- Write termination summaries.

Supervision: Weekly individual and group sessions.

Supervisor: Bill Buhrow, Psy.D.

*Total Hours: 553*

Jan 2000-  
May 2001

Student Counselor

George Fox University Health and Counseling Center, Newberg, Oregon

Facility: Outpatient, Department of Clinical Psychology

Population: Adults

Clinical Duties:

- Conduct intake and write assessment reports.
- Provide brief individual therapy utilizing interpersonal, cognitive-behavioral, and dynamic interventions.
- Conduct personality assessment (MMPI-II, MCMI, PAI, 16-PF).
- Consultation and case presentation with multidisciplinary mental health team.

Supervision: Individual and group, including weekly didactics.

Supervisors: Carol Dell'Oliver, Ph.D., and Brinelle Anderson, M.A.

*Total Hours: 124.5*

### Relevant Work Experience

Aug. 2003-  
May 2004

Graduate Teaching Assistant

George Fox University, Prepracticum Class, Newberg, Oregon

Duties:

- Assist in teaching Psy.D. Prepracticum class.
- Provide individual and group supervision to first year Psy.D. students.
- Review and provide feedback of video taped sessions.
- Prepare and deliver class lectures independently.

Supervisor: Clark Campbell, Ph.D., Director of Clinical Training.

Jan. 2002-  
June 2004

Graduate Assistant

George Fox University, Newberg, Oregon

Duties:

- Assist with administrative planning.
- Provide admissions committee (graduate school of clinical psychology) with secretarial assistance.
- Provide assistance to graduate applicants by providing follow up phone calls answering questions concerning the program.
- Assist with the graduate school of clinical psychology interview process.
- Format papers for publication.

Supervisor: Nancy Thurston, Psy.D.

Aug.2003-  
June 2004

Crisis Phone Counselor

ProtoCall, Portland, Oregon

Duties:

- Answer national Employee Assistance Plan (EAP), national private mental health provider, Community Mental health, and Managed care phone lines.



- Provide after hours support, intakes, and inpatient screenings.
- Utilize solution focused interventions.
- Assistance with emergency concerns.

Supervision: one hour each week

Supervisor: Nancy Nugit, LCSW

Hours: 26/week

May 2001-  
Aug. 2001

Crisis Phone Counselor

ProtoCall, Portland, Oregon

Duties:

- Answer national Employee Assistance Plan (EAP), national private mental health provider, Community Mental health, and Managed care phone lines.
- Provide after hours support, intakes, and inpatient screenings.
- Utilize solution focused interventions.
- Assistance with emergency concerns.

Supervisor: Jeff Chudner, M.A.

Hours: 40/week

Oct. 1999-  
June-2000

Youth Treatment Specialist

Chehalem Youth and Family Services, Newberg, Oregon

Facility: Residential Treatment

Population: Children and Adolescents

Clinical Duties:

- Provide Milieu, individual, and group therapy.
- Provide social and life skills training interventions to clients.
- Assist staff and clients in the planning and carrying out of recreational activities.

Supervisor: Steven Haney

Sept. 1998-  
June 1999

Resident Advisor

Western Washington University, Bellingham, Washington

Population: 52 Male & Female Freshman including 8 foreign exchange students.

Duties:

- Oversaw the community and residential needs of students.
- Integrated healthy living & academic wellness, as well as providing diversity education and awareness through active (educational groups & presentations) and passive (Bulletin Boards & Fliers) programs.
- Assisted with individual behavioral issues and provided appropriate referrals for issues such as drug & alcohol use, eating disorders, relationship issues, cross-cultural issues, depression, as well as college adjustment concerns.

Supervision: weekly two hour group & weekly one hour individual

Supervisor: Ronna Biggs, M.A.

## University Involvement

- Feb. 2001-  
Aug. 2003
- Peer Mentor Coordinator, Graduate School of Clinical Psychology  
George Fox University, Newberg, Oregon
- Duties:
- Pair incoming graduate students with 2<sup>nd</sup>, 3<sup>rd</sup>, & 4<sup>th</sup> year students.
  - Periodically check in with mentors and mentees regarding the mentoring relationship and support.
- May 2000-  
Present
- Peer Mentor  
George Fox University, Newberg, Oregon
- Duties:
- Mentor a new graduate student in professional development.
- Sept. 1999-  
May 2001
- Student Representative  
George Fox Graduate Student Council
- A peer elected position.
  - Attended monthly one hour meetings.
  - Discussed current issues relevant to Psy.D. students, managed emergency funds, sponsored monthly psych-sack lunches hosting a professional in the community to discuss their profession, as well as actively participated in committee work.
  - Committee membership:
    - Peer mentor committee chair-person.
    - Admissions committee student representative.
    - Spring Banquet committee chair-person.
- Jan. 2000
- Student Representative  
George Fox University, Graduate School of Clinical Psychology  
Admissions Committee
- Duties:
- Assisted in evaluating applications for admission to the Psy.D. program.
  - Assisted in the interview process.
- Oct. 1998-  
June 1999
- Diversity Committee  
Western Washington University, Resident Life
- Duties:
- Attend Monthly Meetings.
  - Plan and organize resident hall and campus wide diversity events.

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 Research Experience

- Sept. 2000-  
Present
- Dissertation: A look at shame and negative body image in adolescent females.

## Duties:

- Preliminary Oral Defense completed May 11, 2001.
- Data Collection completed July, 2004
- Final Defense December 6, 2004.

- This study compares the responses on a projective test of shame and a body image inventory between high weight and average weight adolescent females in the public high school population.

Dissertation Committee Chairperson: Nancy Thurston, Psy.D.

Aug. 1999-  
May 2004

Research Vertical Team

George Fox University Graduate School of Clinical Psychology

Duties:

- Meet Bi-weekly to discuss and evaluate progress, methodology, design, procedures, and various issues related to a wide range of research projects related to shame that are being conducted or proposed by students and faculty.

Supervisor: Nancy Thurston, Psy.D.

Dec. 2001-  
June 2002

Volunteer Research Assistant

Portland Veteran's Administration, Portland, Oregon

Title of Study: Neuropsychological Testing with Methamphetamine Users

Duties:

- Administered and scored a set of neuropsychological battery (Wisconsin Card Sort-Computer, RAVLT, Trails, Stroop, Grooved Pegboard, Shipley) for research study exploring the neuropsychiatric effects on chronic methamphetamine abusers.

Supervisor: Ray Templin, Ph.D.

*Total Hours: 50*

#### Additional Experience

Jan. 1999-  
June 1999

Street Outreach Volunteer

Whatcom County Health Department, Bellingham, Washington

Duties:

- Received extensive education and training regarding S.T.D.s and A.I.D.S., as well as other pertinent information about the sexually active street/homeless population.
- Handed out condoms, bleach kits, and information to the street/homeless population on the streets of Downtown Bellingham, Washington.
- Handed out referral cards to street/homeless population who desired to be tested and then treated for S.T.D.s and A.I.D.S.
- Provided support, condoms, and referrals at annual drag-queen coronation, proceeds went to the Western Washington University Lesbian Gay Bi-sexual Trans-gender association.

Supervisor: Rebecca Anderson

Nov. 1998  
June 1999

Hall Council Co-Advisor

Higginson Hall, Western Washington University, Bellingham, Washington

Duties:

- Oversaw hall counsel executive meetings.
- Oversaw hall counsel meetings and functions.
- Assisted in planning and directing special events.

Supervisor: Ronna Biggs, M.A.

Oct. 1998-  
June 1999      Psychology Club President  
                    Western Washington University, Bellingham, Washington

Duties:

- Initiated the club, which had been dormant for many years.
- Conducted bi-weekly meetings.
- Recruited new members.
- Held book sales to raise money for local charity organizations.
- Organized highway clean-up groups on the stretch of road the psychology club adopted.
- Facilitated campus clean-up day.

### Teaching Experience

Nov 2003      Guest Lecturer  
                    George Fox University  
                    First Year Psy.D. Student PrePracticum Class  
                    Topic: The Intake Interview Process: factors affecting the quality of  
                    Information received.  
                    Instructor, Clark Campbell, Ph.D., Director of Clinical Training

July 2002      Guest Lecturer  
                    Oregon Health Science University  
                    Senior Nursing Class  
                    Topic: Eating Disorders: Diagnosis and treatment Considerations  
                    Instructor, Meredith Moore, R.S.N.

Feb. 2002      Guest Lecturer  
                    George Fox University  
                    Personality Theory, Undergraduate Class  
                    Topic: Albert Ellis: Rational Emotive Behavioral Therapy  
                    Instructor, Sally Hopkins, Psy.D.

Feb. 2002      Guest Lecturer  
                    George Fox University  
                    Introduction to Psychology, Undergraduate Class  
                    Topic: Classic Conditioning  
                    Instructor, Sally Hopkins, Psy.D.

### Presentations

Anderson-Fortier, E. (2003). The Treatment of Body Image Issues: Current Research and Techniques. Presentation at Yamhill Family and Youth Programs, McMinnville, Oregon, Staff Conference.

Anderson-Fortier, E. & Van Wey, J. (2003). "Perfect" Bodies in the Media: How can we be satisfied with who we are? Presentation at Columbia River Eating Disorder Network for eating disorder awareness week, Portland, Oregon.

Anderson, E. & Lee, J. (2001). Fat: Weighing in on the Last Socially Acceptable Stigma. Presented at the Western Psychological Association, Maui, Hawaii.

Anderson, E. (2000). The Physiological Effects of Drugs and Alcohol. Presented at George Fox University during Drug and Alcohol Awareness Week.

Anderson, E., Martin, P., Gathercoal, K., Buckler, B. (2000). Childhood Sexual Abuse in Relation to Adult Promiscuity and or Prostitution. Presented at the Western Psychological Association in Portland, Oregon.

#### Additional Clinical Training

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|---|----------------------------------|
| <u>American Group Psychotherapy Association Annual Conference</u>   | March 2005<br>New York, NY       |
| <u>The A,B. Z's of DBT: Dialectical Behavior Therapy and Beyond</u><br>Speakers: Marsha M. Linehan, Ph.D., ABPP<br>Kathryn E. Korslund, Ph.D.   | November 2004<br>New Orleans, LA |
| <u>Dreams As a Guide On the Spiritual Path to Transformation</u><br>Speaker: David Schoen, MSW, LCSW  | November 2004<br>Baton Rouge, LA |
| <u>A Jungian Overview of Dreams</u><br>Speaker: David Schoen, MSW, LCSW   | October 2004<br>Baton Rouge, LA  |
| <u>HIPAA for Psychologists</u><br>Speaker: Rodger Bufford, Ph.D.  | April 2003<br>Newberg, OR        |
| <u>Profitable Behavior: Using Psychological Knowledge and Skills to Consult with Business</u><br>Speaker: Steven T. Hunt, Ph.D.   | March 2003<br>Tigard, OR         |
| <u>Counseling Issues of the Soul: Guilt, Shame, Loneliness, and Despair</u><br>Speaker: William C. Buhrow, Jr., Psy.D.  | January 2003<br>Newberg, OR      |
| <u>Explosive Noncompliant Children and Adolescents</u><br>Speaker: Stuart Albon, Ph.D.  | November 2002<br>Portland, OR    |
| <u>Integration of Religion and Psychotherapy: Explicit Implicit, or What? &amp; Interpreting Personality Dynamics with the Wechsler Scales</u><br>Speaker: Robert Lovinger, Ph.D., ABPP<br>Author & Mentor, Waldon University | October 2002<br>Newberg, OR      |
| <u>Assessment and Treatment of Traumatized Children &amp; Rorschach Interpretation</u><br>Speaker: Sophie Lovinger, Ph.D., ABPP<br>Author, Clinician, & Professor, Waldon University  | October 2002<br>Newberg, OR      |

- Treating Anxiety, Depression, and Anger Effectively:  
Therapeutic Methods That Work!  
Speaker: Albert Ellis, Ph.D. June 2002  
Portland, OR
- Attachment Disorder, Post-Traumatic Stress and Intergenerational  
Trauma: Etiological Implications for Brain Function in Tribal/  
Native Behavioral Health Treatment  
Speaker: Joseph B. Stone, Ph.D., CAC Level III, ICADC  
Confederated Tribes of Grand Ronde Behavioral Health Program April 2002  
Newberg, OR
- Prevalence Rates of Full and Partial PTSD and Lifetime Trauma  
in a Sample of Adult Members of an American Indian Tribe  
Speaker: Thomas J. Ball, Ph.D.  
Researcher & Professor, Oregon Social Learning Center April 2002  
Newberg, OR
- 7<sup>th</sup> Annual Columbia River Eating Disorder Network Conference for  
Professional Partners in Eating Disorders Research and Practice: A  
dedication to Lori Irving. March 2002  
Vancouver, WA
- Critical Incident Stress Management: Basic Course  
Membership #210716583397 July 2001  
Speaker: Lyle Labardee Portland, OR
- Assessment and Diagnosis of Tribal Behavioral health Issues  
Speaker: Joseph B. Stone, Ph.D., CAC Level III, ICADC  
Confederated Tribes of Grand Ronde Behavioral Health Program June 2001  
Newberg, OR
- Western Psychological Association  
Annual Convention April 2001  
Maui, Hawaii
- Play Therapy  
Speaker: Daniel Sweeney, Ph.D.  
George Fox University April 2001  
Newberg, OR
- Substance Abuse Disorders: Diagnosis & Treatment  
Speaker: Shane Hayden, Ph.D.  
Springbrook Treatment Center March 2001  
Newberg, OR
- Cross-Cultural Factors in Africa  
Speaker: Wanjau Murundi, M.A.  
George Fox University January 2001  
Newberg, OR
- Postmodernism  
Speaker: Hendrika Van de Kamp, Ph.D.,  
Fuller Theological Seminary October 2000  
Newberg, OR
- Western Psychological Association  
Annual Convention April 2000  
Portland, OR

Psychotherapy with African-American Clients

Speaker: Kumea Shorter-Gooden, Ph.D.  
Fuller Theological Seminary

January 2000  
Portland, OR

Training The Mind and the Self

Speaker; Jeffery McCall, M.A.  
George Fox University

November 1999  
Newberg, OR

Geropsychology

Speaker: Cliff Singer, M.D.

October, 1999  
Newberg, OR

## Psychometric Testing

Assessment Instrument# of Administration# of ReportsAdult Population:

## Personality Assessment

MCMII-III	5	4
MMPI-II	19	15
PAI	8	5
16PF	3	1
Beck Anxiety Inventory	4	2
Beck Depression Inventory	3	2

## Projective Assessment

Rotter Sentence Completion Test	6	5
Draw-a-Person Test	3	3
Kinetic Family Drawing Test)	1	1
Rorschach (scoring system: Exner)	9	7
Thematic Apperception Test	3	3

## Intellectual and Cognitive Assessment

WAIS-III	16	12
WMS-III	3	2
WRAT-III	14	10
WASI	2	2
WIAT	2	1
PPVT	3	2
WRIT	1	1

## Attention Deficit/Hyperactivity Assessment

d2 Test of Attention	1	1
Brown Adult Attention Deficit Disorder Scales	7	7
Conners Adult ADHD Rating Scale-Self Report: Long Version (CARRS-S:L)	1	1

<b>Neuropsychological Assessment</b>		
Aphasia Screening Exam	1	1
Booklet Category Test	2	1
Halstead-Reitan Full Battery	1	1
Rey Osterrieth Complex figure	14	3
Shipley-Institute of Living Scale	1	1
Bender Gestalt	2	2
Trail Making Test A & B	16	3
Wisconsin Card Sort Test	14	7
The Stroop Test	12	3
RBANS	2	2
Rey Auditory Verbal Learning Test	23	6
Boston Naming Test	2	1
Finger Tapping	2	2
Finger Tip Number Writing	2	2
Grip Strength	2	1

Child/Adolescent Population:

<b>Personality Assessment</b>		
MMPI-A	3	1
Connors Scales (ADD assessment)	2	2
Adolescent Psychopathology Scale	3	3
<b>Projective Assessment</b>		
Rorschach (scoring system: Exner)	5	3
Thematic Apperception Test	2	2
Rotter Incomplete sentence Test	2	2
<b>Intellectual and Cognitive Assessment</b>		
WISC-III	8	5
WRAT	1	1

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**Professional Affiliations and Memberships**

APA, American Psychological Association (Student Affiliate)

AGPA, American Group Psychotherapy Association (Student Affiliate)

Psi Chi Honor Society

ICISF, International Critical Incident Stress Foundation

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Relevant Course work:

## Theory and Practice:

Psychodynamic Psychotherapy  
 Object Relations Therapy  
 Theory of Personality and Psychotherapy  
 Psychopathology  
 Learning and Cognition  
 Family and Couples Therapy  
 Group Psychotherapy  
 Child Development  
 Adult Development  
 Psychometrics in Assessment  
 Statistical Methods  
 Research Design  
 Ethics for Psychologists  
 Cognitive-Behavioral Therapy  
 Social Psychology  
 Psychopharmacology  
 Biological Basis of Behavior  
 Behavioral Medicine  
 Psychoneurology  
 Geropsychology  
 An Academic Career in Psychology  
 Teaching Parenting  
 Professional Issues  
 Psychology of Shame

## Assessment:

Projective Assessment  
 Personality Assessment  
 Intellectual and Cognitive Assessment  
 Neuropsychological Assessment  
 Comprehensive Psychological Assessment  
 Clergy Assessment

## Diversity:

Cross-Cultural Psychotherapy  
 Therapy with Men  
 Human Sexuality/Sexual Dysfunction  
 Contemporary Religious World Views

GPA = 3.62