THESIS

"FRIENDS DON'T LET FRIENDS FAT TALK": MEMORABLE MESSAGES AND THE IMPACT OF A NARRATIVE SHARING AND DISSONANCE-BASED INTERVENTION ON SORORITY AFFILIATED PEER HEALTH EDUCATORS

Submitted by

Shana Makos

Department of Communication Studies

In partial fulfillment of the requirements

For the Degree of Master of Arts

Colorado State University

Fort Collins, Colorado

Spring 2015

Master's Committee:

Advisor: Elizabeth A. Williams

John P. Crowley
Marilee Long

Copyright by Shana Makos 2015

All Rights Reserved

ABSTRACT

"FRIENDS DON'T LET FRIENDS FAT TALK": MEMORABLE MESSAGES AND THE IMPACT OF A NARRATIVE SHARING AND DISSONANCE-BASED INTERVENTION ON SORORITY AFFILIATED PEER HEALTH EDUCATORS

Previous peer health education research has demonstrated the benefits of peer health education to program participants and also to universities. However, the impact of peer health education on the peer health educators themselves has not been researched. Thus, the purpose of this study is to first examine the experience of peer health educators and determine how they benefit personally from a narrative sharing and dissonance-based facilitation training. Second, this study aims to identify which types of messages are most memorable to the peer health educators and ascertain the characteristics of those messages, such as their source, context, and content. A "memorable message" is a meaningful unit of communication that affects behavior and guides sense-making processes. To examine these purposes, the author surveyed, observed, and interviewed participants in Colorado State University's training, The Body Project—a dissonance-based body-acceptance program designed to help college-age women resist the pressure to conform to the cultural thin-ideal standard of female beauty. Findings suggest that participants showed increases in their ability to reject the thin ideal and had more positive perceptions of their weight. In addition, participants experienced decreases in self-esteem one month after The Body Project training. Additionally, several themes of memorable messages were found, including messages remembered due to activities and the opportunity for participants to co-create their own meanings and memorable messages as new ways of thinking.

These findings shed light on the complicated relationship of peer health education programs, health interventions, and memorable messages on peer health educators' self-esteem and self-efficacy.

ACKNOWLEDGEMENTS

I am forever indebted to the individuals who have supported me down this challenging, yet rewarding path.

First, thank you to the Office of Fraternity and Sorority Life at Colorado State University. In particular, I want to thank Lindsay Sell for allowing me the opportunity to observe The Body Project and gain access to interviewing the women who participated. In addition, thank you to the creators and facilitators of The Body Project. Specifically, Alan Duffy – thank you for so graciously allowing me to observe the workshop and contribute research that will hopefully continue to improve The Body Project's effectiveness to participants and peer health educators alike. The work you are doing is spectacular.

I want to thank the sorority women who dedicated their time as participants of this study. Always remember that sorority membership affords you many benefits and opportunities past your collegiate years. Please continue to stay involved and represent the Greek community well. Your strength and determination makes me proud (again and again) to be a Panhellenic woman.

To my family. Daddy, you are my world. When I was little, we'd lie in the back of your truck and you'd teach me about the moon and the stars and the planets and the universe. During those times, you taught me that "For small creatures such as we, the vastness is bearable only through love" (Carl Sagan). I love you. Thank you for your support, guidance, and endless patience. Gram & Pop, Auntie & Mikey, and Uncle Snob – I have learned so much from your strength, endurance, and willingness to persevere through challenging times. Thank you for not being upset when I would only return home for Christmas. Thank you for calling me and sending

me cards. Thank you for making me feel special and that I am worth something. I appreciate and love you with my entire being.

To my beep-boop, Jena Schwake. You are the only person who will fully understand the last two years of my life. Thank you for teaching me that rhetoric is more than just "making stuff up" and for reminding me that I am good enough. Thank you for your laughter, for your friendship, your understanding. I love you.

Joe, thank you for making me fear SPSS (less) and for your constant support, encouragement, and deep talks when I really needed it. Thank you for always reminding me to "transfer the samples" ☺. You will do great things and I am proud of you.

Dr. Long, thank you for time you have taken to help a lone student from outside of your department succeed on her thesis. I appreciate what you have done, not to mention while you're on sabbatical, and how you have so patiently provided me with constructive feedback to improve. I am indebted to your insight.

Dr. Crowley, whom I have never mustered up the courage to call John, thank you for taking a chance on an eager student in your interpersonal communication class. Thank you for teaching me that the truth is always more interesting. Thank you for allowing me to be your lead researcher, your recitation TA, and, hopefully now, your friend. The guidance you've provided on my thesis—and my life—is something I will never forget. Namaste.

Finally, Elizabeth – I have learned many things from you, one of which being that when one is grateful, fear disappears and abundance appears. You have always taught me to take deep breaths, realize that I can do it, and step back and be grateful for what I have. I intentionally came to Colorado State University to study with you, and I am so proud to say that I have done so. Thank you for reading my drafts late at night, for teaching me how to be a better writer, and

for providing me with more and more opportunities to learn and succeed. Being your co-author and research assistant were two of the most rewarding things I was able to do here. Thank you for being my shining light down this sometimes treacherous path. Thank you for your grace, your patience, your kindness, and your willingness to coach me every step of the way. I aspire to be like you and one day change someone's life like you have mine. I am so grateful for you.

Silent gratitude isn't much to anyone. So, thank you.

TABLE OF CONTENTS

LIST OF TABLES

Introduction and Rationale

The higher education experience is often a life changing one for students. Exposure to new ways of thinking, unexpected academic trials, and the pressure to make new friends while adjusting to a new space can be both challenging and rewarding. Some students thrive in this environment, with 56 percent across the country graduating within six years to pursue professional careers or graduate school (Shapiro, Dundar, Ziskin, Yuan, & Harrell, 2013). This statistic, however, indicates that a substantial amount of students do not complete their education. This may be related to a number of factors including stress, alcohol abuse, or low self-esteem.

One challenge that is relevant to collegiate women in particular is body dissatisfaction. In a recent survey of American college women, 20% of respondents said they had suffered from an eating disorder at some point in their lives (National Eating Disorders Association, 2006). Body dissatisfaction, or the "negative subjective evaluation of one's physical body," is a high-risk factor that contributes to outcomes such as eating disorders, depression, and low self-esteem (Stice & Shaw, 2002, p. 985). Negative self-talk[1] and the internalization of the thin ideal[2] are a common practice amongst an estimated 70% of adolescent girls (Levine & Smolak, 2004).

To combat issues like this and others involving overall mental wellness, some colleges and universities have turned to peer health education, or the sharing of health information by peers similar in age or experience (White, 1994). Peer health educators promote campus-based preventative programming that addresses the sometimes taboo campus topics of body image, eating disorders, stress management, or healthy relationships (White et al., 2009). The majority

[1] Self-talk refers to "what people say to themselves either out loud or as a small voice inside their head" (Theodorakis, Weinberg, Natsis, Douma, & Kazakas, 2000, p. 254).
[2] The thin ideal refers to the concept of a highly-desired tall, toned, busty female body (Stice et al., n.d.).

of research on peer health education focuses on how peer health education programs benefit universities and program participants, not the peer health educators themselves. Thus, the current study seeks to expand upon research on peer education by exploring the benefits for the peer health educators.

Colorado State University's Office of Fraternity and Sorority Life recently decided to train peer health educators when they announced their partnership with The Body Project, a narrative sharing and dissonance-based body-acceptance program designed to help college-age women resist the pressure to conform to the cultural thin-ideal standard of female beauty. The Body Project trains students to become peer health educators so they may facilitate the body-acceptance program to different groups—such as sorority chapters—at a later date.

Because of their use in The Body Project's curriculum, narrative sharing and dissonance-based interventions are central to this study. Narratives, or stories, are how humans establish identity, solicit social support, and communicate thoughts and feelings (Green, 2006). Narratives have been found to increase identification and feelings of empathy (Green, 2006), and The Body Project encourages participants to share their own stories about struggling with self-confidence, body image, or eating disorders. Additionally, dissonance-based body acceptance programs are commonly used health interventions that seek to encourage healthy behaviors by exposing participants to information that is inconsistent with their existing beliefs (i.e., exposing a woman with an eating disorder to information suggesting that being thin is not the desired beauty standard). It is the psychological discomfort brought forth by being exposed to these attitudes that often causes individuals to change their beliefs and behaviors. Both of these approaches are crucial components of The Body Project's curriculum.

No matter what approach an intervention takes to encourage healthier behavior, it is crucial that the information provided is relatable and memorable. According to Knapp, Stohl and Reardon, (1981) a "memorable message" is a meaningful unit of communication that affects behavior and guides sense-making processes. Memorable messages are an important facet of communication to research because they have been linked to increased socialization (Stohl, 1986), higher indicators of college student success (Kranstuber, Carr, & Hosek, 2012), and directly influence sorority members' body images (Reno & McNamee, 2014).

Thus, building on research on peer health education, narrative sharing, dissonance-based interventions, and memorable messages, I present the two goals for this study. First, this study seeks to examine the experience of peer health educators (i.e., the students learning how to facilitate the program) and determine how they benefit personally from a narrative sharing and dissonance-based facilitation training. Second, this study aims to identify which types of messages are most memorable to the peer health educators and ascertain the characteristics of those messages, such as their source, context, and content. This study may lead to more effective curriculum design, thus encouraging behavior change among participants in health programs administered by university and inter/national sorority organizations. Before providing an overview of peer health education, health interventions, and memorable messages, it is necessary to provide more context as to why it is important to study women who are members of the sorority community.

The sorority population is a significant subgroup of today's college women who may be affected by body dissatisfaction. There are 325,772 undergraduate sorority members in 3,127 chapters on more than 666 campuses throughout the United States and Canada (National Panhellenic Conference, 2014). Though sorority members are not the only students on college

campuses who struggle with body image or self-confidence, sororities are often pinpointed by the media (Eating Disorders Review, 2010; Goldman, 2010; Williams, 2006) as being most susceptible to these pitfalls. For example, a news article from *The New York Times* portrayed sorority women as participants in the "Olympics of extreme weight loss" in an effort to lose weight before exposing their bodies in bikinis during spring break (Williams, 2006, p. 6). Yet, the majority of research conducted in sorority communities to date is concerned with the effects of alcohol (Capone, Wood, Borsari, & Laird, 2007; Larimer, Turner, Mallett, & Geisner, 2004). Additional research is needed to investigate the mental health issues sorority members attempt to manage that may actually be a catalyst for alcohol abuse, such as low self-image or low self-confidence.

Research has found that sorority membership can be linked to diminished health and well-being, including an increased rate of eating disorders (Schulken, Pinciaro, Sawyer, Jensen, & Hoban, 1997). Additionally, Rolnik, Engeln-Maddox, and Miller (2010) investigated the impact of sorority membership recruitment on self-objectification and body image disturbance and found that women who participated experienced higher levels of self-objectification. In fact, a woman's body mass index (BMI) predicted whether she continued to participate in recruitment until the end, with higher BMIs dropping out of the process earlier (Rolnik et al., 2010). Rolnik and colleagues (2010) acknowledge the success of dissonance-based intervention techniques and suggest that these types of interventions can be used to "move away from a focus on appearance and toward a set of norms that encourages healthy eating habits and more positive approaches to body image" (p. 15).

The Body Project is one such narrative sharing and dissonance-based intervention that attempts to encourage healthy behaviors. Additionally, The National Panhellenic Conference

(NPC)—a governing body for the 26 affiliated sororities across the United States and Canada—has ensured that each of its affiliates have implemented some kind of educational initiatives to address mental health and wellness. For example, Delta Delta Delta Fraternity developed Fat Talk Free Week, a social marketing campaign released in 2008 that was designed to increase awareness about the harmful effects of fat talk[3] (Garnett et al., 2014). Universities regularly engage in prevention strategies targeted at these groups, including counseling services, required health education and awareness speakers, and social norms marketing campaigns (Wechsler et al., 2003).

Despite these initiatives and efforts to improve the community, the rate at which sorority members experience mental health disorders is increasing (Hunt & Eisenberg, 2010). More research is necessary to determine the best way to connect with sorority women and encourage healthier behaviors. Previous research has demonstrated that individuals who are taught specific material knowing they will later have to teach it to someone else (e.g., a peer health educator) retain information at a higher rate than those who are taught the material without intention of teaching it later (e.g., participants in peer health education programs) (Annis, 1983; Gregory, Walker, Mclaughlin, & Peets, 2011). This research has focused more on information retention than impact of the information on the facilitator. Thus, research is necessary to determine how peer health educators affiliated with sororities might benefit personally from learning how to facilitate these programs. Knowing this information may help decrease this sorority population's rate of eating disorders and body dissatisfaction and increase their self-confidence and ability to provide support to one another. This study was designed with these goals in mind.

[3] Fat talk is a construct that "describes gendered body talk whereby typically women and girls engage in self-disparaging conversations about their bodies, weight, and eating-related behaviors" (Garnett et al., 2014). The term was coined by Nichter and Vuckovic (1994).

Literature Review

The intention of this thesis is to first explore which messages delivered during a health intervention training are most memorable and then determine how these messages might affect the body image and self-confidence of the peer health educators. As Rolnik and colleagues (2010) suggested, more positive approaches to discussing body image and educational initiatives that encourage healthy eating habits may be a useful approach for the sorority community. The programming approach taken by Colorado State University's Office of Fraternity and Sorority Life is one instance that does so. Exploring the implementation of this program and the experience of the selected peer educators holds both theoretical and practical importance as it contributes to existing literature addressing how narrative sharing and dissonance-based interventions may impact audiences. Additionally, it may lead to information about what makes messages most memorable and can inform facilitators what types of messages are most beneficial to deliver during a workshop. In turn, this may help guide program design for similar narrative-focused and dissonance-based health interventions.

The goal of a health intervention is to change a particular unhealthy behavior. To do so, programs need to change participants' attitudes and beliefs. Approaches to this can include the utilization of peer health educators and their ability to communicate relevant, relatable messages. Therefore, the sections that follow will review peer health education, health interventions, and memorable messages. Peer health education refers to the transferring of health information through counseling, workshops, or one-on-one conversations between members who may be of similar age, experience, sexuality, or social class. Health interventions refer broadly to approaches to health behavior change. Memorable messages refer to the memorable components

of communication that can influence the sense-making process. The study's research questions are also posed.

Peer Health Education

Mental health services are underutilized on college campuses, with a reported 10 percent of students receiving services across the country (American College Health Association, 2011). When professional counseling services are utilized, however, they are often expensive for the university and include high wait times for the students. As an alternative, some universities have turned to the support of peer facilitators and peer health education (White et al., 2009). A majority of the research conducted to explore the benefits of peer health education addresses the benefits to the university and program *participants*, not the peer health *educators* themselves. A goal of the current study is to identify benefits to the peer health educators. Therefore, the sections that follow first discuss the functions of peer health education, then how universities and student participants benefit from peer health education, and finally the little that is known about how peer health education programs benefit the facilitators themselves.

Functions of peer health education. Peer health education is defined as "the teaching or sharing of health information, attitudes, values, and behaviors by members of groups who are similar in age or experiences" (White, 1994, p. 24). Peer education initiatives have taken place throughout history, with the earliest examples being traced back as far as Aristotle (Wagner, 1982) and the first reported workshop taking place on college campuses in 1957 (Helm, Knipmeyer, & Martin, 1972). Peer health educators are most often unpaid college/university student volunteers (Klein & Sondag, 1994) and a wide variety of demographic groups participate in these programs, including high school students (Boud, Cohen, & Sampson, 2014; Jennings, Howard, & Perotte, 2014), the elderly (Wilson & Pratt, 1987), and refugees (Drummond, Mizan,

Brocx, & Wright, 2011). For purposes of this study, I am examining the benefits of peer health education programs on the peer health educators themselves.

Though the above definition includes groups who are "similar in age or experiences," the literature defining "peer" is somewhat inconclusive. Scholars question whether the term "peer" refers to close friends, acquaintances, leaders on campus, or relative strangers (Shiner, 1999). As Shiner (1999) notes, though potentially important, it cannot be assumed that age as a "master status overrides all other possible sources of identity" (p. 558). Instead, ethnicity, sexuality, social class, and sex all contribute to constructing a "peer group." For example, a program intended to prevent prostitution may include peer educators who were previously prostitutes, while a program intended to encourage regular breast examinations may include peer educators who are breast cancer survivors. Regardless, it is important to note that age alone does not necessarily dictate "peer" for peer health education.

Social cognitive theory, also known as social learning theory, offers one explanation as to why peer health education has been widely used throughout American colleges and universities. Social cognitive theory examines psychosocial influences on behavior and posits that modeling (i.e., observing other people's behavior in an effort to understand how to behave) is a crucial component to the learning process (Bandura, 1972). Bandura (1977) states that "Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them of what to do" (p. 12). According to social cognitive theory, credibility, role modeling, empowerment, and reinforcement play a role in allowing people to model or imitate behavior. How frequently someone might perform these learned behaviors is dependent upon several factors, including reinforcement and identification. According to Fox and Bailenson (2009), vicarious reinforcement suggests that "individuals need not experience

rewards or punishments themselves in order to learn behaviors" (p. 3). Instead, they can simply observe the consequences when they view that behavior as exhibited by a model. Identification refers to the extent to which an individual feels similar, or relates to, the observed model (Fox & Bailenson, 2009, p. 3). Thus, individuals are more likely to learn and observe models that are the same gender, race, or skill level to themselves.

Research suggests that peer health education is most often used for two reasons: (a) because sensitive information is often more easily shared between people of a similar age and (b) peer influence is more persuasive than teacher, or "expert" testimony (Mellanby, Rees, & Tripp, 2000). Scholars suggest that material may be more easily understood when delivered by a peer as opposed to an expert, such as a teacher or more seasoned health professional (Damon, 1984). According to Sloane and Zimmer (1993), young adults are be more likely to listen to a peer educator because he or she faces similar concerns and pressure when it comes to social pressures or frustrations (Sloane & Zimmer, 1993). Students may feel more comfortable relating to and receiving information from a peer, thus making participants more responsive and increasing the likelihood for behavior change (Klein & Sondag, 1994).

In addition to facilitating health workshops, peer health educators provide counseling, offer general health advice, and lead discussion groups (Klein & Sondag, 1994). Topics covered by peer health educators are broad and include sexual health (Jennings et al., 2014), managing diabetes and glucose levels (Philis-Tsimikas et al., 2004; Wilson & Pratt 1987), preventing youth violence (Wiist, Jackson, & Jackson, 1995), and smoking cessation (Wiist & Snider, 1991). These programs take place in a number of settings, ranging from schools, community organizations, within informal networks, or at youth centers (Turner & Shepherd, 1999).

Methods often include structured group trainings, one-on-one discussions, or informal discussions (Turner & Shepherd, 1999).

Benefits to student participants and universities. Peer health education has a large effect on students during their undergraduate careers (Jennings et al., 2014; White, 1994). One benefit of peer health education is that it can create a more comfortable and relatable environment for the participants because the workshops are often lead by those who have encountered similar life experiences (Mead & MacNeil, 2006). This can generate more feelings of empathy and validation by workshop participants, the creation of more ideas, and a more receptive attitude toward receiving advice. Additionally, this may lead to an environment that is more supportive of open discussion at changing behavior (Solomon, 2004). Studies show that peer facilitated workshops are most successful when diverse perspectives are present, including races, genders, and ages (Solomon, 2004). These workshops often provide the opportunity for participants to engage each other in group discussion, allowing for more intimate conversations and increased understanding of specific health topics.

Peer health education can be a cost effective aid in reducing anxiety associated with numerous issues including eating disorders, low self-confidence, or being diagnosed with clinical depression (Mackenzie et al., 2011). Because of their basic knowledge and training, peer health educators can relieve professional university staff from added responsibilities. This not only saves university health programs money, but also frees professionals for situations that require deeper expertise (Klein & Sondag, 1994). To illustrate the effectiveness of peer health education, Stice, Rohde, Durant, Shaw, and Wade (2013) compared the effects of peer versus clinician-led eating disorder prevention programs. They evaluated the effectiveness of both the peer-led and clinician-led dissonance-based programs and found that the prevention groups led

by peer facilitators "produced greater reductions in eating disorder risk factors" (p. 197) when compared with the control group. The effects of the peer-led groups were still smaller when compared with the clinician-led groups, but the authors suggest that peer educators may be a more cost effective way to gain somewhat similar results. Peer health education programs, through their function of providing information and potential role models in the peer health educators, aid in providing cost-effective services that educate students about how to cope with everyday stressors.

Benefits to peer health educators. The majority of research on peer health education focuses on how peer health education programs benefit universities and program participants, not the peer health educators. This study expands upon research directed at determining benefits that may exist for the facilitator. Peer health educators are often viewed as more credible than their peers, are exposed to professional development opportunities, and have the opportunity to make a positive impact in their community (Jennings et al., 2014). Thus, the section that follows will provide an overview of relevant research that details how peer health education programs may affect the peer health educators.

Peer health educators (i.e., the student facilitators) receive additional training on subjects they host workshops about and are more accessible than an expert might be, thus increasing their credibility. Though not deeply trained in any particular field, peer health educators can be called upon to provide health information at a basic level that is likely higher than the average, untrained student. Jennings and colleagues (2014) examined the impact of a peer-led sexuality education program designed to prevent sexually transmitted diseases and pregnancy. The researchers found that the teens trained as peer health educators for this workshop were able to more successfully talk to their friends, parents, and sexual partners about birth control methods

than their peers who were not trained as peer health educators and were perceived as "more credible" (p. 319). The amount of time young people spend socializing with their own age group contributes to the influence they are naturally able to provide (Turner & Shepherd, 1999). Thus, peers can more easily reinforce socially learned and acceptable behavior. To do so, however, peer educators must have ongoing contact with the target population, with contact lasting more than one brief workshop (Turner & Shepherd, 1999). This repeated contact can lead to peer health educators serving as role models, sustaining a certain level of credibility that allows students to observe their (the peers') health decisions and engage in these behaviors on their own.

Peer health education programs allow student facilitators to be exposed to professional development opportunities, such as facilitating workshops in large groups or networking with professionals who share their interests. Peer health educators have reported gaining more confidence in public speaking environments, becoming more comfortable talking to strangers with similar interests, and gaining a deeper understanding of potential job prospects (Klein & Sondag, 1994, p. 4). Additionally, previous research suggests that individuals who are taught specific material knowing they will later have to teach it to someone else retain information at a higher rate than those who are taught the material without intention of teaching it later (Annis, 1983; Gregory et al., 2011).

To determine what might motivate someone to serve as a peer health educator, Klein and Sondag (1994) conducted focus groups with students serving as peer health educators at their universities. Social cognitive theory was used as a framework, with the researchers examining the environment, expectations, reinforcement, and self-efficacy experienced by the participants. Many students disclosed that previous experiences with family members or friends had

motivated them to serve as a resource to others. According to Klein and Sondag (1994), the students' motivations were "altruistic, such as wanting to help others; egoistic, such as wanting job training; or related to self-efficacy beliefs, such as satisfying a personal need for health education" (p. 1). Family experiences, interactions with friends, and personal experiences were clearly defined motivators for peer health educators to participate. Some students chose to participate because they were positively impacted by previous presentations they had attended that were facilitated by other peer health educators. Overall, it was observed that life experiences, the genuine belief that they are making a difference, and the positive reinforcement received from others are the major factors considered by students who decide to be trained as peer health educators.

Peer health education is perceived as a positive, cost-effective addition on college campuses, and research has begun to explore how peer health educators themselves benefit from serving in this capacity. This study is designed to extend the literature on this topic by gathering detailed accounts of peer health educators' experiences. To do so, it is necessary to understand the type of health interventions that peer health educators in this study used. Therefore, the section that follows will detail health interventions, including the role of self-efficacy, narrative theory, and dissonance-based interventions.

Health Interventions

A health intervention is "an effort to persuade a defined public to engage in behaviors that will improve health or refrain from behaviors that are unhealthy" (Springston, 2005, p. 670). The sections that follow will first discuss health interventions and their relationship to participants' self-efficacy. Then, two approaches to health interventions will be discussed: narrative sharing and dissonance-based interventions. These particular interventions are

included because they are the two used in The Body Project training. During their training, peer health educators were first encouraged to share their own experience in relation to body image and self-esteem and then were instructed to critique the thin-ideal. Additionally, narrative sharing and dissonance-based interventions illustrate some of the most common health intervention practices over the past decade.

Health interventions and self-efficacy. Health intervention literature suggests that successful behavior change takes place when programs are combined to include educational components, such as behavior change steps and processes, social support, cognitive restructuring, and self-reflection. Self-efficacy, or the perceived ability to successfully change a behavior and reach one's goals, is needed to impact overall behavior change (Bandura, 1977). An individual's confidence and belief that he or she can achieve his or her desired outcomes is a cumulative result of many factors, including physical self-presentation and the perception of physical ability (Lockwood & Wohl, 2012). Self-esteem, while related to self-efficacy, is a different concept. Self-esteem is an individual's evaluation of his or her self-worth as an individual (i.e., I am a good, valuable person) (Neff, 2011). Thus, while self-efficacy would measure how confident one feels in being able to reach his or her goals, self-esteem would measure how that individual feels about him or herself.

According to Bandura (1977), when choices are made that lead to positive consequences, self-efficacy and confidence improve and strengthen the adherence to the prescribed behavior. For example, intentional wellness courses that focus on changing behaviors in the areas of physical activity and nutrition have been found to positively influence behaviors and improve confidence. Lockwood and Wohl (2012) found that a 15-week "lifetime wellness" course (one that focused on students' wellness behaviors and tracked progress) positively impacted self-

efficacy and prompted students to change physical activity and nutrition behaviors. The students had a higher sense of self-efficacy because they felt they had the tools necessary (e.g., the exercises to do and the healthy foods to eat) to make a positive change. This research indicates that confidence, high self-efficacy, and adequate information are needed collectively to successfully influence behavior change.

Research has also examined what makes health interventions not as effective. Conley, Travers, and Bryant (2013) suggest that interventions with a homework-focus, or extrinsic motivation are not as successful as ones that include a practice-focus, or intrinsic motivation. This suggests that knowledge alone does not necessarily produce desirable behavior outcomes. Behavior change research indicates that strategies and skills must be included in interventions in order to encourage improved behaviors (Lockwood & Wohl, 2012). This suggests that changing behavior is a complex process that requires significant self-reflection, goal-setting, and time.

Eating disorder interventions historically use a more homework-focused, information gathering model. The majority of women with eating disorders never seek treatment, and this may explain why most attention has been devoted to developing prevention programs (Welch & Fairburn, 1994). Interventions intended to prevent eating disorder behaviors typically provide only psychoeducational information about the behavior, including weight control techniques and consequences for behaviors such as anorexia and bulimia. They often do not include an intervention that allows for the women to solicit peer support or actually apply the information they learn (Stice, Chase, Stomer, & Appel, 2001). Universities often employ intervention methods that do not provide an opportunity for women to gather social support, and Stice and colleagues (2001) argue that this is why university health education programs have seen somewhat limited success.

Psychoeducational information alone is not enough to change behavior. Thus, health interventions are most beneficial when they include components that will build a higher sense of self-efficacy in order to initiate and sustain a change in beliefs, attitudes, and behaviors. These interventions often incorporate personal narratives, and cognitive restructuring in the form of dissonance-based interventions.

Narrative theory. Testimonials and narratives are a popular tool for interventions and the promotion of positive health behaviors (Green, 2006; Kim, Bigman, Leader, Lerman, & Capella, 2012). I first define narrative theory, then discuss how it serves as a foundation for health promotion, and finally describe some related theories that further the assertions of narrative theory.

Narrative theory suggests that meaningful communication comes from storytelling and that our past experiences influence our future communication and behaviors (Fisher, 1984). The theory is founded upon cultural knowledge and practices and suggests that "cultural narratives intrinsically shape behavior, including health behavior" (Larkey & Hecht, 2010, p. 118). The majority of our social interactions are framed by narratives, and narratives are how humans establish identity, including communicating thoughts and feelings, telling stories, and soliciting responses. Our narratives often shape our attitudes and beliefs, including how we feel about particular health behaviors. Ultimately, narratives help us make sense of the world around us and share our perceptions with others. This is particularly relevant to interventions that incorporate the use of narrative as an educational tool to elicit behavior change.

Narratives are how humans navigate thinking about, knowing, or understanding a particular topic. Larkey and Hecht (2010) argue that health related narratives "reflect the underlying values and norms of the culture as well as [provide] message forms that are consistent

with cultural practices" (p. 119). This creates a more grounded and often more believable message. Humans form cultural norms and beliefs through storytelling, a process that is often shaped by the fabric of interwoven anecdotes and experiences. For example, a woman might be more likely to perform regular self-breast examinations if she learns from other friends or family members that their breast cancer was detected and treated quickly because of self-examinations. That is, the stories told by her friends and family members encouraged her to engage in healthier behaviors. Narratives can provide role models for behavior change, highlight stages people experience while attempting to change behaviors, and help shape the attitudes of those who hear the narrative based on both cognition and emotion (Green, 2006).

Kim and colleagues (2012) suggest that narrative's positive influence is due to the process of narrative engagement through transportation theory, or the "transportation into the narrative, perceived similarity to story characters, and empathetic feeling toward the characters" (p. 474). That is, we become engaged and emotionally moved by a story when it is told by those we identify with. According to Green, Brock, and Kaufman (2004), transportation is "a pleasurable state that contributes to media enjoyment" thereby transporting participants directly into written, spoken, or visual narratives (p. 311). This generates perceived similarity and empathy with the story's character which further creates the notion of identification.

There are four characteristics of transportation theory that speak to why individuals may identify more deeply with narratives, including increased identification, modeling, communication norms, and emotional responses (Green, 2006). First, transportation theory posits that participants can relate and care more deeply about the characters in the narrative when the stories shared are personal and not generic. This can increase identification and feelings of empathy with XXXX. According to Green (2006), this finding is consistent with additional

research suggesting that tailoring health messages to specific groups might be an effective strategy (Rimer & Kreuter, 2006). Second, the individuals delivering the stories firsthand come to serve as role models. Participants in the intervention may be more likely to follow the same behavior of someone in the story they identify with, while avoiding the problems of the characters in the story they did not like (Green, 2006). Third, an individual's previously held or normative beliefs speak to stereotypes of those who may or may not engage in healthy behavior; for example, that all smokers have bad teeth or that runners tend to have fit bodies. Finally, transportation theory posits that emotional responses can be created in an effort to more deeply connect with characters in the narratives. For example, listening to someone else who has already experienced negative consequences related to poor health behavior may evoke feelings of fear, uncertainty, or anger that may provide a push toward behavior change.

To examine how transportation theory works, Kim and colleagues (2012) used the theory to assess the task of influencing participants to quit smoking. Participants (n = 1,219) who identified as regular smokers were randomly exposed to one of two written narratives, including (a) a personal exemplar that detailed the health struggles of "Joanne," a life-long smoker who had been diagnosed with lung cancer; and (b) an exemplar about "people" or "residents" who had been diagnosed with lung cancer. Results revealed that participants who read a story with the personal exemplar about "Joanne" were more likely to identify with the story and its characters, thereby elevating participants' intention to quit smoking. This study illustrates the potential of personal narratives as they may be more influential than generic narratives when incorporated into a health intervention. It is this increased sense of identification and realism, in addition to modeling, perceived norms, and emotional response that may contribute to why using narratives has been a useful tool for implementing health interventions (Green, 2006).

Increased realism, according to Green (2006), can be a powerful effect that may lead to behavior change. In relation to changing cancer beliefs and behaviors, Green (2006) notes that "Providing a list of the benefits of cancer screening may not capture recipients' attention or inspire action in the same way that hearing a woman talk about how getting a mammogram allowed her to catch her cancer in time to save her life" (p. 169). In other words, an intervention that allows participants to hear a personal narrative from a real person with whom they can engage and ask questions may be more effective than those participants only reading the same information in a pamphlet or online. Additionally, the more realistic a narrative is, the more likely it is that someone will be influenced by it (Green, 2006, p. 169).

Research also suggests that a narrative may be more realistic to an individual if it aligns with his or her cultural practices and values. Health messages are often best when they are created with specific audiences in mind and grounded in specific cultural practices. For example, Larkey and Hecht (2010) examined the effects of narratives on the "keepin' it REAL" campaign, a culture-centric health promotion and substance abuse prevention program created at Arizona State University for Latino middle school students in areas of Arizona and Mexico. For these purposes, the authors defined culture as "code, conversation, and community" (p. 115) with code denoting systems of rules and meanings, and conversation denoting how and what members of a specific culture say and do when they interact with the same or different cultures. Mexican American middle school students attended workshops facilitated by Mexican American high school students who talked about ways to say no to alcohol, cigarettes, and marijuana that were be aligned with Mexican American cultural practices. The high school students were viewed by the middle school students as credible role models who discussed real-life scenarios. The middle school students in this program were 72 percent more likely to discontinue their use of alcohol

than students who did not participate in the program over a two-year period (Arizona State University, 2014).

These types of culture-centric interventions are often grounded in providing a narrative that is aligned with what is typically shared in that culture. Larkey and Hecht (2010) suggest that narratives are the best way to effectively reach a target population because they are culturally representative, specific, and meaningful (p. 115). The authors note that the narratives are most effective when the message starts within the culture as opposed to creating an entirely new message and adding it to the culture's already existing messages (for example, a Caucasian American high school student delivering the material to a Mexican American middle school student).

All things considered, this practice of incorporating culture into health interventions can be very difficult. Identity complexities account for a myriad of ways someone may or may not identify with a cultural story, or even the storyteller. It is necessary for the participant to view the storyteller as a "like self" character, enabling the participant to place him or herself into the narrative and increase identification. Personal factors, such as an individual's personality or social role, have demonstrated that a cultural intervention approach is not something that is one size fits all (Larkey & Hecht, 2010). For example, Brown and Basil (1995) used Magic Johnson, a famous basketball player who had recently been diagnosed with HIV/AIDS, as an example to investigate the impact media celebrities could have on public health. The researchers found that those who had greater identification with Johnson (those who were invested in his basketball career or cared about his well-being) were more likely to share personal concerns about HIV/AIDS and reduce their risky behaviors. Conversely, those who did not identify with Johnson (only knew of him by seeing him occasionally play basketball) were less likely to share

personal concerns about HIV/AIDS or reduce their risky behavior. This research suggests, once more, the importance of interventions including a storyteller with whom participants highly identify.

Close cultural identification, believable personal testimony, a highly realistic story, and "like self" storyteller identification all contribute to how narratives can positively impact health interventions and behavior change. In addition to the use of narratives, one promising approach to increasing mental well-being on college campuses is the use of dissonance-based interventions; specifically, the use of these interventions to reduce the thin-ideal in high risk females (Becker, Smith, & Ciao, 2005; Stice, Mazotti, Weibel, & Agras, 2000). The Body Project curriculum first encourages peer health educators to share their own stories in relation to how they feel about their own body image and self-esteem (i.e., share their narratives). Then, peer health educators are instructed to begin the dissonance-based portion of the intervention by critiquing the thin-ideal. The section that follows will provide more insight into dissonance-based interventions and their use in promoting positive health behaviors.

Dissonance-based interventions. Dissonance-based interventions are a common, often successful tool to encourage healthy behaviors (Stice, Trost, & Chase, 2003). Dissonance theory states that "the possession of inconsistent cognitions creates psychological discomfort, which motivates people to alter their cognitions to restore consistency" (Stice et al., 2001, p. 249). In this method of intervention, participants are provided information that is inconsistent with their existing beliefs. It is the psychological discomfort brought forth by being exposed to these attitudes that often causes individuals to change their beliefs and behaviors. However, if individuals do not assume the counter-attitudinal stance, no behavior change will take place (Freijy & Kothe, 2013). For example, The Body Project's dissonance-based intervention

encourages participants to critique the thin-ideal, or the concept of a highly-desired tall, toned, busty female body. The selected passage is a sample from a script used by The Body Project to illustrate this point:

> **Facilitator (F):** "How do thin-ideal messages from the media or other people in your life affect how you feel about your body?"
> **Anticipated participant response (AP):** "Feeling inadequate because they do not look like a model, dislike of their own bodies, negative mood."
> **F:** "What does the media suggest will happen if we look like the thin-ideal?
> **AP:** "We will be accepted, loved, happy, successful, wealth [*sic*]."
> **F:** "Do you really think these good things happen if you get thinner?"
> **AP:** "No, they will likely have little impact." (Stice, Shaw, & Rohde, n. d.)

This example illustrates the facilitator's attempt at questioning the thin-ideal status quo, ultimately making the participants question what benefits they would truly gain from adhering to the American standard of "beauty."

Dissonance-based interventions started to become a popular approach to treating eating disorders after research noted that the previously mentioned psychoeducational approach to education was ineffective (Stice, Shaw, Becker, & Rhode, 2008). These prevention programs have been found to decrease factors that contribute to eating disorders, including thin-ideal internalization, body dissatisfaction, and eating disorder symptoms (Stice, Presnell, Gau, & Shaw, 2007). While comparing the effectiveness of two different eating disorder programs, Stice and colleagues (2007) found that dissonance intervention programs produced more positive outcomes in relation to body dissatisfaction and eating disorder symptoms than a healthy weight management program. A similar study by Stice and colleagues (2000) compared a dissonance-based intervention with a prevention program promoting healthy weight management and another utilizing expressive writing. The dissonance program resulted in greater reductions of thin-ideal internalization, body dissatisfaction, and bulimic symptoms than the program promoting healthy weight management. These reductions may be because the psychological

discomfort associated with critiquing the thin ideal encourages participants to lessen the extent to which they internalize negative self-talk.

It is clear that narrative sharing and dissonance-based interventions are an often productive way to encourage healthy habits and counter the traditional psychoeducational approach to health interventions. How participants benefit from these interventions has also clearly been demonstrated (Stice et al., 2000; Stice et al., 2007). What still needs to be investigated, however, is how messages delivered during a peer health educator facilitation training (i.e., when a peer health educator learns how to facilitate the program) might impact *the peer health educators personally*. For example, the woman learning how to facilitate a program about positive body image may not struggle with body image herself, but might she still benefit from receiving the training and see an increase in self-confidence? Because this study seeks to investigate the experience of the peer health educator, I present the following research question:

RQ1: What impact does a narrative sharing and dissonance-based training have on individuals trained as peer health educators?

Two goals of The Body Project are to increase self-esteem and positive body image. This result has been demonstrated when The Body Project has been facilitated with other student populations. For example, previous research evaluating the impact of The Body Project's narrative sharing and dissonance-based interventions on participants has shown decreased rates of body dissatisfaction (Stice et al., 2006) and decreased eating disorder symptoms (Stice et al., 2013). Therefore, I present the following hypotheses:

H1a: Peer health educators will be less likely to identify with the thin ideal over the one month time period.

H1b: Peer health educators will have more positive perceptions of their bodies over the one month time period.

H1c: Peer health educators will be more comfortable with their weight over the one month time period.

H1d: Peer health educators will show positive increases in their self-esteem over the one month time period.

To further the discussion, the section that follows will detail the most recent literature on memorable messages and describe how it relates to peer health education and health interventions.

Memorable Messages

Memorable messages have been investigated in a variety of contexts, including organizational communication: how organizational members are socialized into their work environments (Stohl, 1986) and how volunteers identify with their organizations (Steimel, 2013); interpersonal communication: listening (Bodie, 2011); and in health communication: breast cancer awareness messages (Smith et al., 2009), messages about aging (Holladay, 2002), and body satisfaction (Anderson, Bresnahan, & DeAngelis, 2014). The purpose of this study is to investigate what makes messages memorable in a narrative sharing and dissonance-based health intervention for peer health educators. To do so, it is necessary to consider what memorable messages are and what characteristics, including their source, context, and content, contribute to their memorability.

Humans receive thousands of messages each day, most of which are processed and released from short-term memory. Some, however, are perceived as important units of communication, and their persuasive effects can impact behavior change and sense-making

processes (Holladay, 2002). According to Knapp and colleagues (1981), a "memorable message" is a meaningful unit of communication that affects behavior and guides sense-making processes. Memorable messages have the potential to influence behavior, even after they are recalled long after the initial exposure. A message must be recalled to influence one's behavior after initial exposure to the message (Rimer & Glassman, 1984).

Message topic and source both play a role in determining how easily a message can be recalled and whether or not that message impacts behavior (Smith et al., 2009). Additionally, the longer someone is exposed to a message can dictate the degree to which a person may perform according to behavior recommendations. For example, several studies demonstrate that repeated exposure to breast cancer awareness messages can influence how often a woman may engage in breast cancer prevention behaviors (Earp et al., 2002; Smith et al., 2009). There are several characteristics associated with memorable messages, including:

> 1) the structure and form of the message, 2) the circumstances surrounding the enactment and reception of the message, 3) the nature of the content of the message and 4) the nature of the relationship between the recipient and source of the message. (Stohl, 1986, p. 27; see also: Knapp et al., 1981)

According to Knapp and colleagues (1981), the most memorable messages have a short, simple structure because more complex verbal utterances are more difficult to replicate. Knapp and colleagues (1981) also note that the words "must," "should," and "should not" are commonly used and the desired outcomes of the message are often included. The circumstances surrounding the enactment and reception of the message refers to the situation in which the message is received. It is noted that a message is most memorable when received in a private as opposed to a public setting because of its directness and intentionality. Additionally, messages are often more memorable when received personally by the sources as opposed in mass communication situations. In general, communication that holds personal significance to

someone is more likely to be remembered than communication that is less personal (Keenan, MacWhinney, & Mayhew, 1977). This reflects the previously mentioned research on successful health interventions and the necessity for a believable personal testimony, a highly realistic story, and "like self" storyteller identification.

Messages are most memorable when received early in the circumstance—for example, early in someone's career or early in a workshop—because that is when people are most interested in obtaining information that may help them succeed in the given situation. If the message contains specific role-related content, or content that "perscribes specific behaviors that can be applied to a variety of situations," it is considered by most as more memorable (Stohl, 1986, p. 237). Additionally, the role the receiver plays within the organization is linked to how memorable a message is. For example, a new employee may be eager to gain experience, so he or she may recall more messages than an employee who is close to retirement (Stohl, 1986).

The final memorable message characteristic, according to Knapp (1981), is the nature of the relationship between the receipient and the source. Message sender characteristics have been found to make a profound difference on how memorable a message is. For example, Holladay and Coombs (1991) suggest that memorable message senders tend to have a higher status than the receivers, and are often regarded as "older and wiser" than the receivers. Research also indicates that the gender of the senders and receivers can influence the memorability of a message. For example, Knapp (1981) found that roughly one third of the male participants reported receiving a memorable message from a female, whereas one half of females reported that the memorable message was delivered by a male.

Research has specifically investigated the relationship between body image health and memorable messages. Anderson and colleagues (2014) investigated the impact of personal

metaphors and memorable interpersonal communication exchanges on body satisfaction. Using a mixed methods approach the study asked participants to answer open- and closed-ended questions about the most memorable messages they received interpersonally that related to body image. Body image was defined as "a person's perceptions, thoughts, and feelings about his or her body" (p. 727). The results showed that the most memorable messages came from a doctor and that the most common situation in which women received a memorable message was at a social occasion or a party. Approximately one third of the participants reported that a third party was present when the unfavorable comment was received, noting that the added presence increased their embarassment. The researchers found that "there was a pattern of associations between memorable messages, body metaphors, feelings of body dissatisfaction, and comparisions with the ideal body" and body dissatisfaction increased as memorable messages increased in negativity (p. 374).

Little research has been done to examine the influence of the source, context, and content of a message delivered during a training in which a peer health educator learns how to be a facilitator. The messages peer health educators find memorable are important because it is those messages that will be delivered to participants in the subsequent workshops they will facilitate. Thus, this study seeks to address the following research question in relation to The Body Project facilitatior training:

RQ2: What messages are memorable to the peer health educators and what are the characteristics of those messages (source, context, content)?

The chapter that follows will detail the methods I utilized to answer the research questions.

Methods

This study seeks to investigate what makes messages memorable in a narrative sharing and dissonance-based health intervention for peer health educators. A mixed methodological approach was used to examine the benefits of a peer health education program on the peer health educators themselves. In the sections that follow, I provide information about The Body Project training, the participants in this study, the modes of data collection, and the procedures utilized in the project.

About The Body Project Training

As noted above, The Body Project is a dissonance-based body-acceptance program designed to help college-age women resist the pressure to conform to the cultural thin-ideal standard of female beauty. The program was formed by Eric Stice and Carolyn Becker and has been facilitated to more than 200,000 women since 2012 (The Body Project Collaborative, 2014). Through written, verbal, and behavioral exercises, participants critique the thin ideal with the intention of reducing the pursuit of unhealthy thinness and their obligation to subscribe to it. To establish an environment that allows the participants to experience true dissonance, it is important to note the participants, not the group facilitator, critiques the thin ideal. Throughout the workshop, participants discuss the thin ideal and its origin, the costs of pursuing that ideal, how to resist pressures to be thin, how to talk more positively about their bodies, and how to respond to future pressures to be thin (Stice et al., n.d , p. 10).

Participants in this study were individuals who were trained to be peer health educators. In order to become peer health educators, they engaged in a two-day workshop that taught them the content of the program so they could facilitate it to their peers at a later date. The Body Project representative encouraged the peer health educators to engage in self-disclosure about

their own experiences in order to most effectively prepare them for their own facilitation of the program. Additionally, six professional facilitators—higher education professionals with experience in program development and facilitation—provided feedback about their performance.

At Colorado State, the peer health educator training took place over two days (October 4 and 5, 2014). As the researcher, I took a participant observer role during the training. Participant observation allows the researcher to view the situation "from the perspective of people who are insiders or members of particular situations and settings" (Jorgensen, 1989, p. 13). The Office of Fraternity and Sorority Life at Colorado State gave me permission to conduct research using the group participating in The Body Project peer health education training. Proof of permission is included in Appendix A.

Several studies have investigated the impact of The Body Project on its participants. Stice, Shaw, Burton, and Wade (2006) explored The Body Project's dissonance-based intervention in comparison to expressive writing and assessment-only interventions aimed at preventing eating disorders. They found that the dissonance-based participants showed greater reductions in eating disorder symptoms than the other two groups. Additionally, in a study that investigated the long-term effects of The Body Project's dissonance-based intervention, Stice, Rohde, Shaw, and Gau (2011) found that there were significant reductions in eating disorder symptoms in female high school participants up to three years after the program was facilitated compared to XXXXX.

The Body Project was chosen because of its nature as a body acceptance program and because it was a planned program with Colorado State University's Panhellenic community. I am a member of a National Panhellenic Conference sorority and the knowledge I have from

extensive involvement with the sorority community has given me insight into the behaviors sorority women often engage in on college campuses. I have limited contact with CSU's sorority community, and I had no personal relationships with any of The Body Project peer health educator participants. However, self-identifying as a sorority member helped me build rapport with participants and aided in recruitment efforts.

This study complements the research previously conducted on The Body Project in several ways. First, instead of focusing on the participant outcomes (i.e., how this program performs as an intervention), this study investigates the impact of the training on the student peer health educators, which the program relies upon, as they learn how to facilitate the program. I chose not to focus on how the training performs as an intervention because other studies (Stice et al., 2000; Stice et al., 2007, Stice et al., 2013) have already tested its performance. Previous peer health education research (Mead & MacNeil, 2006; Solomon, 2004) focuses on the impact of peer health education programming on other students, not the peer health educators themselves. Thus, this study extends peer health education research by examining the experience of the peer health educators.

Second, this study identifies which of the messages delivered during the peer health educator facilitation training are most memorable. This can ultimately lead to determining the best source, context, and message content The Body Project facilitators should deliver during the program in an effort to make the program relatable and memorable. Lastly, this study explores how this particular type of narrative sharing and dissonance-based intervention may impact those trained to be peer health educators, who are also sorority women, a demographic found to have more body weight and negative self-talk issues than other unaffiliated females on college campuses (Rolnik et al., 2010).

Participants

Through an application process, participants (n = 12) were selected by the Office of Fraternity and Sorority Life at Colorado State University's sorority community. One participant did not attend both days of the workshop, and was thus removed from participation in this study, resulting in a sample size of 11 participants. Participants were all females between the ages of 18 and 21. Ten participants identified as white (non-Hispanic) and one participant chose not to disclose the race with which she identified. Four identified as college freshmen, one identified as a college sophomore, three identified as college juniors, and three identified as college seniors. Four reported living in on-campus (non-sorority) housing, four reported living in sorority housing, and three reported living off-campus. Four indicated that they served as chapter officers while seven said they did not. The participants had a variety of academic majors. Participants are referred to by pseudonyms throughout this thesis.

Procedure

A mixed methodological approach was used to determine the benefits of peer health education programs on the peer health educators themselves. This mixed method approach—one that analyzes both qualitative and quantitative data in a single study—was chosen because collecting diverse types of data can provide a deeper understanding of a research question (Creswell, 2003). Additionally, mixed methodology allows for triangulation of data. That is, comparing two or more forms of data increases the validity of the claims made (Lindlof & Taylor, 2002).

A mixed method approach was necessary for answering the research questions presented here for several reasons. Recall, the research questions were as follows:

> RQ1: What impact does narrative sharing and dissonance-based training have on individuals trained as peer health educators?

RQ2: What messages are memorable to the peer health educators and what are the characteristics of those messages (source, context, content)?

First, qualitative data is necessary for adequately answering each of the RQs because there are multiple meanings to the individual narratives shared by the peer health educators. Second, RQ1, in particular, requires quantitative data to measure any changes in ideal body stereotypes (Stice, Fisher, & Martinez, 2004) and self-esteem (Rosenberg, 1965).

Data collection. The study consisted of three data collection methods: surveys, observation, and interviews. A pre-test survey was administered at the start of The Body Project peer health educator training on October 4, 2014, and a post-test survey was given approximately one month after the training. The post-test survey was sent with the email reminder indicating when the peer health educator's follow-up interview was. Observation took place during The Body Project's peer health education training at CSU. Additionally, interviews with the participants were conducted approximately one month after completion of the training. More detail about each of these processes is included below.

Pre- and post-test surveys. The first data collection method was surveys. The codebook I utilized during data analysis is included in Appendix B. To address RQ1 and H1 (peer health educators will show positive increases in their body image and self-esteem over the one month time period due to the narrative sharing and dissonance-based intervention facilitation training provided by The Body Project), a pre- and post-test survey was distributed to all peer health educator participants. While this study's sample is too small and specific to make any generalizations, the quantitative information gathered at the start and one month after the training was critical because it helped contextualize the individual changes for participants after the training. This also captured changes the participants were not aware of, or were not able to verbalize, during their interviews. For example, changes in self-esteem may not have been

noticed by the participants; they may not have wanted to express changes in self-esteem during interviews for fear of judgment or the desire to respond in the "correct way."

The surveys collected demographic data and measured ideal body stereotypes and self-esteem at two points in time: (a) immediately before the start of The Body Project training (see Appendix C for pre-test survey) and (b) approximately one month after the training was complete (see Appendix D for post-test survey). While previous studies examining memorable messages (Keeley, 2004; Steimel, 2013) have waited three months after the event in question, this study administered the second survey and interviews one month after the training. This time frame was chosen for several reasons. First, the population size was small (N = 11) and a shorter time frame between the training and interviews aided in retaining participants. Second, because a timely return of results was desired, one month was the preferred time frame by the Office of Fraternity and Sorority Life at Colorado State—the organization that granted access for this research. Finally, previous research on The Body Project follows up with participants in varying time periods ranging from six months to 2-3 years (Stice et al., 2007; Stice et al., 2011). Surveying the participants within a shorter time-frame examines the short-term effects of The Body Project on peer health educators.

To measure ideal body stereotypes, I used three scales within the Ideal Body Stereotype Scale-Revised created by Stice and colleagues (2004). First, in the pre-test, individuals were asked to rate on a scale of 1-5 (with 1 being strongly disagree, and 5 being strongly agree) the extent to which they agreed about perceptions of the thin ideal *today* (that is, the day they took the survey). Sample items included "Slender women are more attractive" or "Tall women are more attractive." On the post-test, individuals were asked to rate the extent to which they agreed with the statement *within the previous month*. This measure, which included six items, is

identified as “Pre-perception other ideal” and “Post-perception other ideal” in tables and descriptions moving forward. The pre-test measure was reliable with a Cronbach’s alpha of .79. The post-test measure was also reliable with a Cronbach’s alpha of .90.

Second, participants were asked to rate on a scale of 1-5 (with 1 being “strongly disagree” and 5 being “strongly agree”) the extent to which they were satisfied with certain aspects of their bodies *today* (e.g., weight, thighs, hips). Due to the longitudinal nature of the study, participants were asked in the post-test survey to reflect on their satisfaction with their bodies over the course of the previous month. Given that initial reliability scores were low in the pre-test (pre-test Cronbach’s alpha score of .57), two measures were removed from the original scale (“How satisfied are you with your legs?” and “How satisfied are you with your hips?”). These two items were removed from both the pre- and post-test for purposes of consistency in comparing the two scores at T_1 and T_2. This measure, which included seven items after the items were removed, is identified as “Pre-perception self” and “Post-perception self” in tables and descriptions moving forward. The pre-test measure Cronbach’s alpha reliability was .63. The post-test measure had a Cronbach’s alpha of .88. The Cronbach’s alpha score of .63 is marginal; future research should test this study with larger sample sizes to obtain a more accurate assessment of the scale’s reliability.

Third, participants were asked to rate on a scale of 0-6 (with 0 being “extremely” and 6 being “not at all”) the extent to which each statement applied to them *today*, such as “Have you felt fat?” or “Has your weight influenced how you think about (judge) yourself as a person?” On the post-test, individuals were asked to rate the extent to which they agreed with the statement *within the previous month*. Given that the original reliability scores were low in the pre-test (pre-test Cronbach’s alpha of .59), one measure was removed from the original scale (“Have you had

a definite fear that you might gain weight or become fat?"). The same item was removed from both the pre- and post-test for purposes of consistency and needing to compare the same scales in a paired sample t-test. This three-item measure (after the items were removed) is identified as "Pre-perception weight" and "Post-perception weight" in tables and descriptions moving forward. The pre-test measure had a Cronbach's alpha of .64. The post-test measure was reliable with a Cronbach's alpha of .71.

Finally, to measure self-esteem, the Rosenberg Self-Esteem Scale (1965) was used. Recall that self-esteem is an individual's evaluation of his or her self-worth as an individual (i.e., I am a good, valuable person) whereas self-efficacy measures how confident one feels in his or her ability to reach set goals. Previous research conducted on The Body Project measures participants' self-esteem (Stice et al., 2000; Stice et al., 2013), and the goal of this study was to move beyond looking at participants in the program to determine the role of self-esteem in the experience of a peer health educator. The goal of the study was to not necessarily determine one's perceived ability to facilitate the program. Thus, participants were asked to rate on a scale of 1-4 (1 being "strongly disagree" and 4 being "strongly agree") the extent to which statements such as "On the whole, I am satisfied with myself" and "I wish I could have more respect for myself" applied to them *today*. On the post-test, individuals were asked to rate how the extent to which they agreed with the statement *within the previous month*. This ten-item measure is identified as "Pre-Rosenberg Self-Esteem" and "Post-Rosenberg Self-Esteem" in charts and descriptions moving forward. The pre-test measure was reliable with a Cronbach's alpha of .84. The post-test measure was reliable with a Cronbach's alpha of .82.

In addition, demographic data was also collected during the survey. Participants were asked to indicate their year in school, housing (sorority housing or not), sorority initiation date, and whether or not she served as a chapter officer.

The pre-test survey was provided to the peer health educators at the start of the training in a pencil and paper format. The post-test survey was distributed via email along with the interview reminder. The post-test survey was created in Qualtrics, an online survey provider. To maintain participant anonymity, I matched the pre- and post-test surveys to each other by assigning each of the peer health educators an identification number that was a combination of the last four digits of their telephone number and their month of birth (i.e., 7058-06).

In order to determine how The Body Project training impacted participants' ideal body stereotypes and self-esteem, I conducted a paired sample t-test for each of the measures. Modeled after Williams and Connaughton (2012), paired sample t-tests allowed me to examine the differences between T_1 and T_2.

Observation and the role of the researcher. The second data collection method was observation. Specifically, I observed the peer health educator training. During this observation, I compiled notes about the interactions that took place between the participants, including interaction between the facilitator and the peer health educators and among the peer health educators. This contributed to the overall research process because it aided in helping identify what messages were originally presented and which ones eventually emerged as being most memorable. Additionally, I was able to include notes about what the facilitator said originally and explore how the messages may have shifted or been translated by the peer health educators one month after the training took place. Participant observation resulted in 44 pages of typed, double-spaced observation notes.

In order to "cultivate rapport, not friendship; compassion, not sympathy; respect, not belief; understanding, not identification; [and] admiration, not love," (Tedlock, 2003, p. 168) I acted as a participant observer. I remained removed from the conversation except during my initial introduction, the distribution of the pre-test survey, the post-test survey, and the participant interviews that took place approximately one month after the training. The recruitment script I used when introducing the study to the peer health educators is included in Appendix E and a handout I provided them with study information is included in Appendix F. Additionally, the follow-up email I sent to each peer health educator—including a link to the post-test survey and reminder of their interview time—is included in Appendix G.

Interviews. The final data collection method was participant interviews. After gaining participant permission, the interviews were recorded. I asked the participants to provide the same identification code I assigned at the start of the study (last four digits of their phone number and their day of birth). I used that code to match pre- and post-test surveys and the interview transcription in order to triangulate the data collected among the multiple modes of data collection. Participant interviews resulted in a total of 6 hours and 30 minutes of recorded interviews and 93 typed pages of transcription, with each interview averaging 35 minutes in length. I transcribed the recorded interviews and saved the transcripts in a locked file on my computer. Once the interviews were transcribed, I deleted the audio files, in accordance with Institutional Review Board guidelines.

Interviews included both open- and closed-ended questions aimed at determining how participants made sense of the training and how they translated or incorporated the information into their daily lives. Interviews were one-on-one and were held in a private room on Colorado State University's campus (i.e., a study room in the Behavioral Sciences Building and a

conference room in the Department of Communication Studies). The location was mutually agreed upon with the participant. Interviews were conducted between the hours of 9 a.m. and 8 p.m., Monday through Friday between Monday, November 3 and Friday, November 14, 2014. This fixed time frame was important as extending data collection might have influenced how individuals remembered facets of the training. Participants signed up for an in-person interview on the first day of The Body Project training. An email reminder with their appointment information was sent individually to each participant approximately one week prior to their interview. Another reminder was sent the day before. Interviews were conducted between one and three days after participants completed the post-test survey.

The interview was comprised of three subsets of questions addressing peer health education, memorable messages, and the personal impact of the overall health intervention. To contribute to literature addressing why students decide to become peer health educators (Klein & Sondag, 1994) and contextualize the rest of the interview, I first asked about their motivations to participate in The Body Project training.

I then modeled my study after Steimel's (2013) research addressing the characteristics (source, context, and content) in memorable messages. To determine the characteristics that make a message memorable, participants described, in detail, the most memorable message they took away from the two days of The Body Project training. A memorable message was defined as "a piece of advice" or "some words of wisdom" (Stohl, 1986). Specifically, questions focused on when they received the message and who they received the message from, including (a) The Body Project facilitator, (b) another participant, (c) another participant with whom she had a substantial previous relationship—substantial defined as having more than one conversation and would greet when seen outside of class—or (d) another individual. Participants

were also asked to describe what made those messages memorable (i.e., perhaps because it came from a peer, was similar to her own experience, or was shocking in some way). After recalling the most memorable message, participants were asked to recall any additional memorable messages they received from The Body Project training that had an impact on their life in some way after their participation, including who they received the message from. Participants were encouraged to recall and share as many memorable messages as they could from the training.

To determine what made messages memorable in relation to body-image and negative self-talk, I mirrored the method used by Anderson and colleagues (2014). Though slightly modified to fit this specific study, two additional questions were intended to address RQ2 and addressed message source, context, and content: (a) "What important information have you learned from the other participants in the workshop about your body?" and (b) "Is there one instance or experience that stands out to you during the last month related to how you feel or what you think about your body?" I had originally intended to investigate how the memorable messages received in the training were utilized when the peer educator implemented the program to an outside group, but none of the participants facilitated the program during the one month period. The interview questions are included in Appendix H.

Analysis. A grounded theory approach was used to analyze participant observation notes and interview transcripts. According to Strauss and Corbin (1998), "Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action" (p. 12). Grounded theory allows the researcher to be open to multiple possibilities and harness the variability of human behavior. I used the process of open, axial, and selective coding (Strauss & Corbin, 1998) while reviewing the participant observation notes and the transcripts. Open coding is the process in which "concepts are identified and their

properties and dimensions are discovered in data" (Strauss & Corbin, 1998, p. 101). I developed axial codes by putting these concepts into subcategories. This process allowed me to identify overall themes that more precisely explained the observed situations. Lastly, I used selective coding to refine my subcategories, thereby reducing the amount of individual categories and creating broader categories that were used to create explanatory statements.

As I read through the transcripts, I used the constant comparative approach to generate and "plausibly suggest" the general phenomenon observed in the data (Glaser, 1965, p. 438). To observe how messages may have shifted during the one month time period between the training and interviews, I compared the transcript notes with the notes gathered during the observation. I did not use preestablished codes but instead used codes that emerged naturally from the data.

In addition, triangulation was used to compare multiple forms of evidence in order to answer the two research questions. According to Lindlof and Taylor (2002), triangulation allows for the biases of individual methods to "cancel out," enhancing validation of the claim. I approached triangulation in several ways. First, multiple reports were gathered from mutlitple sources. Eleven participants were interviewed about the same training workshop that they each participated in. The observation notes I took as a result of acting as a participant observer during the training were also considered during the analysis. Next, multiple methods were used in this study. The use of observation notes, participant survey responses, and participant interview responses provided multiple perspectives on a common area of research. While qualitative interviews served as the primary dataset, observation notes and quantitative survey results complement and support the results presented here.

Finally, modeled after Sonenshein, DeCelles, and Dutton's study (2014), multiple researchers were used in order to overcome the biases of shortcomings of myself as the only

reseacher (Douglas, 1976; Lindlof & Taylor, 2002). My faculty advisor and director of this thesis, Dr. Elizabeth Williams, and I engaged in discussion about the themes that emerged from my observations and interviews. After I identified open, axial, and selective codes, we discussed their relationships and made revisions to the categories, leading to the data structure presented in Table 1.

In the chapters that follows, I address the resuts of this study, including an overview of the training weekend, the pre- and post-test survey results, memorable messages, and the overall impact of the training on the peer health educators.

Table 1: Data Structure

First-Order Categories (open)	Second-Order Themes (axial)	Theoretical Dimensions (selective)
What a participant expected before participating	Participation challenges	Workshop impact, importance of proper recruitment and follow up
Feeling too busy to participate		
Why a participant decided to participate		
Opportunity to share or not share with someone else	Impact on self-efficacy and self-esteem	
Feeling comfortable facilitating the workshop	Gauge of workshop value	
Frustrations experienced throughout the workshop		
When a participant felt comfortable during the workshop	Participation comfort	Importance of co-creating the message
When a participant felt validated during the workshop		
Memorable messages from the workshop	Memorable messages	
Remembering messages from professional facilitators		
When a participant felt confidence because of the workshop	Activities, or learning through doing	New knowledge leads to personal transformation
Participants noticing others or self-engaging in fat talk		
The direct mention of impact of the workshop	Workshop impact	
Mentions of feminism or feminist ideals		

Results

The data collected through observational analysis, participant surveys, and participant interviews resulted in a rich, complex data set that allowed the investigation of memorable messages in the body-positivity workshop, The Body Project. The intention of this study was to examine the experience of peer health educators during facilitation training. Additionally, the goal was to determine types of messages most memorable to peer health educators and ascertain the characteristics of those messages, such as their source, context, and content.

The following chapter provides an overview of the research results. First, I will provide an overview of the training, including addressing my participant observer notes in order to provide context for what took place during the two day workshop. I will then address what participants considered to be the most memorable messages of The Body Project facilitator training and present themes observed in these messages. Finally, I provide insight into the overall impact of The Body Project on the peer health educators.

The Body Project Training Weekend: Observations

In order to provide full context for the training that took place, it is helpful to tell the story of what took place during the two day Body Project workshop. Here, I include information about the configuration of the training rooms, what participants discussed, and those things that struck me as I was a participant observer.

The training took place on Colorado State University's campus in two different rooms. The first day of training took place in a classroom. The Body Project organizer configured the room so the peer health educator participants were seated in chairs in a circle toward the center of the room, a structure that was conducive to generating conversation. Meanwhile, a long, rectangular table and chairs were set up to outside of the circle for the professional facilitators.

The professional facilitators were a group of six higher education professionals selected by The Body Project organizers to attend the workshop in order to provide facilitation feedback to the peer health educator participants. The professional facilitator group consisted of a wide variety of representatives, including four females (one representative from the office of Fraternity and Sorority Life at Colorado State, one psychologist from Colorado State, one representative from the CSU Health Network, one high school teacher from the local area) and two males (one graduate student, and the representative from The Body Project's main office).

When not being delivered as a "train the trainer" presentation, The Body Project is intended to take place in two sessions over the duration of two days with each session being two hours. The first session of the program is dedicated to defining the thin ideal and addressing its costs, verbally challenging fat talk, and preparing the group for the mirror exercise and the letter to a younger girl (homework activities). The second session covers homework debriefing from the first session, role playing, brainstorming body activism, and developing quick comebacks for fat talk. Thus, in order to train the peer health educator participants to feel comfortable facilitating the program to an outside group, more time was used than would have been required in the usual two session training. Day one of the weekend workshop was dedicated to session one while day two was dedicated to session two. Descriptions of each of the activities are presented in Table 2. Participants met for eight hours each day.

Table 2: Activity Content

Activity Name	Activity Content
Body activism	A facilitated exercise in which participants are asked to create a list of at least 10 things girls/women could do to critique and resist the thin ideal and fight social pressures. For example, confronting a friend who engages in fat talk.
Costs of the thin ideal and critiquing the thin ideal	A facilitated exercise in which participants are asked to define the thin ideal by verbalizing its characteristics, such as "blonde," "flat stomach," "tall," "white," and "skinny." Participants also identified future pressures to be thin.
Letter to a younger girl	A homework activity that asks participants to write letters to a younger girl telling her of how to avoid developing body image concerns as she gets older.
Mirror exercise	A homework exercise in which participants were asked to stand in front of a mirror with as little clothing as possible and write down 10 positive qualities about themselves, including physical, emotional, intellectual, and social qualities.
Role play/Scenarios	A small-group exercise in which acting facilitators take on the role of someone intensely pursuing the thin ideal and then participants actively try to dissuade that person from pursuing the thin ideal. This is different from the "verbally challenging fat talk" exercise because it takes place in small groups and facilitators are asked to act in a pre-determined persona.
Verbally challenging fat talk	A facilitated exercise in which participants are read statements of fat talk and then asked to challenge them using the information they learned from The Body Project curriculum. This activity also prompts participants to reject negative self-talk.
Self-affirmation	A facilitated activity in which participants were prompted to express aloud positive attributes of their personal character and/or body. For example, “I am an honest person,” or “I like my legs.”

To simulate what it might be like to truly facilitate the workshop to an outside group, the peer health educators were split into four groups of three and instructed that they needed to facilitate the workshop as a team. This required that the peer health educator participants act as actual participants in the training while the selected group of three assumes the facilitator role. In order to ensure that each group facilitated the material at least once, the workshop was repeated four times. However, not every part of the workshop was repeated each time. Instead, the peer health educators were asked only to repeat what The Body Project representative deemed more technical and worthy of repeated facilitation. This included defining and critiquing the thin ideal, the verbal challenge, the role play, body activism, and the self-affirmation exercise.

Session one. As the participants entered the room on the first day, each of them seemed to do so with caution. Chairs lined the room and participants sat down next to each other as they entered. One by one, they began to engage in small talk and it quickly became apparent that some women knew each other prior to the workshop whereas others did not. The Body Project representative asked the participants to sit in the circle of chairs and began introductions including name, sorority chapter affiliation, year in school, and major. Following introductions, The Body Project representative passed out the facilitation manuals, provided an introduction of the programming, and explained that the group was there to learn how to be peer health educators. The Body Project representative then split the participants into their groups and explained that the training would include repetition of the content by each of the groups. According to my observation notes, the participants seemed confused during this time; eyes darted to each other in an effort to find common understanding and they shifted in their seats,

nonverbally indicating their nervousness. The Body Project representative acknowledged their nerves, stating "You will be pros by tomorrow" to reassure the group.

The participants continued with the workshop material and began the discussion of defining and critiquing the thin ideal. The facilitation script prompts facilitators to ask the group about what was bothersome to them from how women were portrayed in the media. Participants shared what irritated them about women in the media (e.g., alcohol ads, the use of PhotoShop in magazines, never seeing a woman on television without makeup on). This topic prompted a passionate discussion during which it became clear that the group started to feel comfortable with one another. According to my observation notes, this first conversation prompted genuine responses and the participants appeared excited about their participation in the training. During this time, individual moments of self-disclosure began.

Roughly two hours into the training, one woman disclosed she had been raped and addressed the response she received after telling someone what had happened, saying she was blamed for being raped and "slut-shamed" for what she was wearing when it happened. This participant's self-disclosure shifted the conversation to not only include critiques of the thin ideal, but also discussions in which multiple women shared their experiences of street harassment and feeling uncomfortable because of comments made by men. The group continued to follow the facilitation script—which largely addressed the thin ideal—but periodically shifted into conversations about sexual assault, equal pay for equal work, and heteronormativity associated with fraternity and sorority membership. At the end of the first group's facilitation turn, The Body Project representative commented that it was some of the most positive discussion he had ever witnessed, but that their time management had suffered. It was in this

moment that the participants were simultaneously praised and instructed to facilitate more effectively.

The remainder of the day followed a similar structure with each group facilitating the material one time. Different moments of self-disclosure took place each time, with some women, for example, revealing their physical insecurities and others sharing their battles with anorexia. As the day progressed and the same material was discussed up to four times, participants began shifting in their seats and vocally expressing their annoyance with the repetition (e.g., "We have to do that *again*?") and often struggled to include new information when responding to the acting facilitator prompts.

At the end of each group's facilitation, the professional facilitators would provide feedback about their performance. Feedback generally included remarks such as being more mindful of time management, allowing silence when nobody answers a question, and intentionally using open-ended questions. On several occasions, professional facilitators also included feedback about language use (e.g., referring to each other as "women" and not "girls" or saying "you all" instead of "you guys" to promote gender inclusivity) and being aware of multiple identities someone might have and not speaking for those identities (e.g., do not make assumptions of what other people's experiences are). The first day was concluded with professional facilitator feedback and by assigning the group "homework" activities, including the mirror exercise and the letter to a younger girl.

Session two. Scheduling conflicts on the second day of training required the training be moved to a smaller office-type room in a different building on campus. This room was more intimate, with chairs closer together and the professional facilitators sitting around the circle as opposed to at one single table. The mood was more relaxed on the second day and participants

sat down next to each other in the circle as soon as they walked in. Again, they engaged in small talk, discussing what they did the night before, asking questions to clarify information they learned about each other the day before, and joking about not getting enough sleep. The mood was collegial and it seemed as if they were starting to become friends.

The second day began by addressing the previous day's "homework." Participants were each prompted to read the letter they had written the night before and also discuss how they felt about participating in the mirror exercise. There were mixed reviews by the participants during this time, and it was clear that each of these activities were either very difficult or enlightening for the participants in some way. My observation notes indicated that comments were made suggesting that the homework was "challenging, but a good challenge."

As session two progressed, the group engaged in brainstorming body activism and committed to complete two instances of body activism over the next two weeks. Additionally, participants were separated into groups to engage in the role play, an activity they performed four times in total. Steady eye contact and erect posture were nonverbal indicators that led me to believe that the participants took this exercise seriously, often providing insightful comments in an effort to dissuade their conversational partner from adhering to the thin ideal. The workshop closed with each participant sharing something positive she liked about herself, an activity that was, according to The Body Project representative, strategically placed at the end in order to end the workshop positively. Finally, according to my observation notes, The Body Project facilitator asked the participants how the workshop had impacted them over the last two days, and responses included:

> "The role playing stood out and it was helpful." (Amber)
> "When we created our ideal woman, it was interesting to see that we all had the same kind of woman in mind." (Sofia)

"It has changed how I think about my own body and makes me re-think how I think of myself." (Jean)
"I feel really empowered by this group." (Celia)
"The space was welcoming and safe." (Kathy)
"I've made great friends here." (Leah)
"I am a lot happier right now." (Maegan)
"I have more ways to combat fat talk." (Chandra)

The comments participants made indicated what they felt they had learned during the experience, how it made them feel more empowered, re-defined how they thought of themselves, and exposed them to more women in the sorority community.

The observation notes presented here are intended to provide context to what took place during The Body Project training in an effort to provide insight into what was and was not remembered by the participants. The sections that follow present pre- and post-test survey results, the most memorable messages from The Body Project and also address the impact of the workshop on participant self-esteem.

Pre- and Post-Test Survey Results

The hypotheses in this study predicted that peer health educators will show positive increases in their body image and self-esteem over the one month time period due to the narrative sharing and dissonance-based intervention facilitation training provided by The Body Project. The results of paried sample t-tests partially support this prediction.

Hypothesis 1a predicted that peer health educators would be less likely to identify with the thin ideal after the one month time period. The perception other ideal scale indicated that scores were lower at T_2 ($M = 2.64$, $SD = .67$) than at T_1 ($M = 3.08$, $SD = .61$). A paired sample t-test was conducted and the results ($t(10) = 2.27$, $p < .05$) indicate that there was a statistically significant decrease after the training. This means individuals' perception of the ideal *increased.* Therefore, hypothesis 1a is therefore supported.

Hypothesis 1b predicted that peer health educators would have more positive perceptions of their bodies after the one month time period. The perception of self scale indicated that scores were higher at T_2 (M = 3.35, SD = .52) than at T_1 (M = 3.18, SD = .82). A paired sample t-test was conducted and the results ($t(10) = -.83$, $p > .05$) indicate that there was not a statistically significant increase after the training. Although the change in means suggests that participants were more likely to positively view different parts of their bodies, such as their weight, figure, or body build, the change was not significant. Thus, hypothesis 1b is not supported.

Hypothesis 1c predicted that peer health educators would be more comfortable with their weight after the one month time period following the training. The perceptions of weight scale scores were higher at T_2 (M = 5.27, SD = 1.32) than at T_1 (M = 3.36, SD = 1.43). A paired sample t-test was conducted and the results ($t(10) = -3.53$, $p < .05$) indicate that there was a statistically significant increase after the training. This means that individuals were more comfortable with their own weight and that it had less of an influence on their daily activities. Hypothesis 1c is therefore supported.

Finally, hypothesis 1d predicted that peer health educators would show positive increases in their self-esteem over the one month time period. The Rosenberg Self-Esteem scale scores were lower at T_2 (M = 1.69, SD = .40) than at T_1 (M = 3.38, SD = .42). A paired sample t-test was conducted and the results ($t(10) = 7.38$ $p < .05$) indicate that there was a statistically significant decrease after the training. This indicates that the participants' self-esteem *decreased* after the training. Therefore, hypothesis 1d is not supported.

According to these results, hypotheses 1a and 1c were supported whereas hypotheses 1b and 1d were not supported. Participants were less likely to identify with the thin ideal (H1a) and more likely to feel comfortable with their own body weight (H1c). Changes in participants

perception of self were not significant (H1b) and participants' self-esteem decreased (H1d). The pre- and post-test mean scores of each scale for each participant are indicated in Table 3. These pre- and post-test mean scores help contextualize the qualitative findings.

Table 3: Before and After Participant Survey Scores

Pre- and Post-Perception Other Ideal Scale

Participant Name	Pre-perception other ideal[4]	Post-perception other ideal	Net Change
Leah	3.5	3	-0.5
Sofia	3.5	3.5	0
Ria	2.83	2.5	-0.33
Jocelyn	3.17	2	-1.17
Celia	3.5	3.17	-0.33
Ella	3.83	2.17	-1.67
Amber	2.5	2.5	0
Kathy	2	1.5	-0.5
Maegan	3.83	3.17	-0.67
Chandra	2.5	2	-0.5
Jean	2.67	3.5	0.83

Pre- and Post-Perception Self Scale

Participant Name	Pre-perception self[5]	Post-perception self	Net Change
Leah	2.71	2.57	0.14
Sofia	2.29	2.29	0
Ria	2.14	3.43	-1.29
Jocelyn	3.57	3.29	0.29
Celia	3.43	3.14	0.29
Ella	5	3.43	1.57
Amber	3.57	3.29	0.29
Kathy	3.14	2.57	0.57
Maegan	4.29	4	0.29
Chandra	3.29	3.29	0
Jean	3.43	3.71	-0.29

[4] Low scores on the "pre- and post-perception other ideal" scale indicate that participants were less likely to identify with the thin ideal. For example, a score of one when responding to the item "slender women are more attractive" would indicate that participants highly disagree with the statement.

[5] High scores on the "pre- and post-perception self" scale indicate that participants were more satisfied with parts of their body, such as their weight, figure, appearance of stomach, or body build. For example, a score of 2 when responding to the item "how satisfied are you with your weight?" would indicate that participants were somewhat dissatisfied with their weight.

Pre- and Post-Perception Weight Scale

Participant Name	Pre-perception weight[6]	Post-perception weight	Net Change
Leah	3	5.67	2.67
Sofia	3.33	5	1.67
Ria	2.33	4	1.67
Jocelyn	4	5	1
Celia	0.67	4	3.33
Ella	3.67	7	3.33
Amber	2	6.33	4.33
Kathy	4.33	3	-1.33
Maegan	6	6.33	0.33
Chandra	4.67	4.67	0
Jean	3.33	7	3.67

Pre- and Post-Rosenberg Self-Esteem Scale

Participant Name	Pre-Rosenberg Self-Esteem[7]	Post-Rosenberg Self-Esteem	Net Change
Leah	3.2	1.8	-1.4
Sofia	3.6	2.1	-1.5
Ria	2.9	2.1	-0.8
Jocelyn	3	2.2	-0.8
Celia	3.7	1.1	-2.6
Ella	3	1.5	-1.5
Amber	2.9	2.2	-0.7
Kathy	3.3	1.6	-1.7
Maegan	4	1.3	-2.7
Chandra	4	1.4	-2.6
Jean	3.6	1.3	-2.3

[6] High scores on the "pre- and post-perception weight" scale indicate that participants were less likely to allow factors such as feeling fat influence how they feel about themselves. For example, a score of 4 when responding to the item "Has your weight influenced how you think about (judge) yourself as a person?" would indicate that participants had slightly let weight influence how they felt about themselves.

[7] Low scores on the "pre- and post-Rosenberg Self Esteem" scale indicate that participants were less likely to have high self-esteem. For example, a scale of one when responding to the item "on the whole, I am satisfied with myself" would indicate that participants strongly disagree with the statement.

Memorable Messages

One of the primary aims of this research was to identify which types of messages are most memorable to the peer health educators and ascertain the characteristics of those messages, such as their source, context, and content. Participants were asked to identify messages they recalled from The Body Project training. The information presented in this chapter includes the quotes that most clearly map to of the concepts of source, content, and context (those factors that initially were supposed to guide analysis) within memorable messages. To recall, source refers to who the message came from. Content refers to what words were used in the message. Context refers to the situational circumstances in which the message took place. Two additional memorable message themes follow that came from a grounded theory analysis, including activities that allowed for co-construction of meaning and memorable messages as new ways of thinking. Finally, themes within messages presented by professional facilitators are addressed.

First, participants recalled personal stories from other women in the group, such as self-disclosure about being victims of sexual assault or the insecurities people disclosed about their bodies. Often, participants recalled remembering these stories because they either came from a woman they knew prior to the workshop, or were relatable, sad, or intense stories of self-disclosure. For example, Leah recalled a moment of self-disclosure in which another participant shared about a physical insecurity:

> I remember little things. Sofia (source) with the short blonde hair. She talked about how her mom was self-conscious of her arms, and because of that, Sofia was self-conscious of her arms (content). But then, she wore the tank top the next day (context). Little things like that that were kind of specific.

Additionally, Celia recalled a story from another women, Chandra, who shared she had formerly struggled with an eating disorder. Celia cited Chandra as being someone she respected as the reason she remembered her comment. Celia said:

> I remember Chandra (source) saying that she experienced an eating disorder when she was younger. I specifically remember that she didn't get emotional about it (context). She was really strong and just said, "Yeah, I've experienced it (content)." That was something that was very surprising to me.

Celia's comment illustrates the impact other participants' self-disclosure had on individuals in the group. Celia's ability to recall that Chandra was someone she admired demonstrates the importance of providing the opportunity for participants to get to know each other during the workshop.

It is important to note that I originally approached this research with the intention of identifying the source, context, and content of memorable messages. Previous memorable messaging research emphasizes, for example, that short, simple messages are most memorable, and that a private setting generates more memorable messages than a public one (Knapp et al., 1981). However, as demonstrated by the comments presented here, what emerged while sorting through the data is that messages were not recalled in the way I anticipated. That is, instead of remembering specifically how a message was worded, who it came from, or the context/situation in which it took place, participants remembered activities, which challenged their existing knowledge and led to behavioral and thought transformation. The details of these two themes are presented next.

Activities and co-construction of meaning. Memorable messages emerged as a result of participating in activities and having the opportunity to co-construct workshop messages. That is, meaning creation and value of information was tailored to each participant. The Body Project's curriculum is hands-on, interactive, and driven largely by participant interaction. In particular, participants remembered the activities in which they were prompted to critique the thin ideal, brainstorm body activism, and reject negative self-talk, examples of which are included here.

Many participants explained that critiquing the thin ideal and identifying costs of the thin ideal was the most memorable. For example, Chandra commented:

> I loved the part where we wrote on the board "the perfect woman" and we wrote all these things about her, that she's white and blonde and big boobs and all these things we described which is what the media wants us to believe and everything we've grown up with our whole lives. And then we crossed it out and wrote "the thin ideal." It was SUCH an eye opening thing. Wow, that's NOT the perfect woman! Anyone could be the "perfect woman" if they want to.

In this excerpt, we see that Chandra remembered the activity in which participants critiqued the thin ideal. The Body Project script prompted participants to write "the perfect woman" on the board and then each contribute to what they thought that was. Here, we see that Chandra was able to create her own definition of what the thin ideal is as opposed to being read a definition.

In addition, participants recalled an increased ability to be mindful of fat talk uttered by themselves or others. Specifically, participants cited an increased ability to identify fat talk and reported using this anti-fat-talk approach after the workshop. For example, Jean commented she did not know what fat talk was prior to the workshop and was not convinced that it had any actual impact on someone's well-being. After the workshop, however, she felt differently:

> I definitely shoot down fat talk RIGHT when I hear it. Like, I didn't think I'd be so passionate about it going through training but then after, when I'd hear people say it, I'd be like "stop." It was just weird. I didn't think it was such a big deal to me. But it turns out that it's a really big deal.

In this excerpt, Jean recalls a part of the same conversation Chandra mentioned in which the group took time to critique the thin ideal. The anti-fat-talk activity provided Jean with the opportunity to practice real-life tactics to rejecting fat talk, something she found highly valuable.

Similarly, several of the participants commented that the mirror exercise was the most memorable. The mirror exercise refers to a homework exercise in The Body Project training in which participants were asked to stand alone in front of a mirror with as little clothing as

possible and write down 10 positive qualities about themselves, including physical, emotional, intellectual, and social qualities. Ella reflected on what was most memorable to her about this exercise:

> It was the mirror exercise. It was empowering in a way and it just made me feel very comfortable in my own skin. It's not like I'm gonna walk around naked, but I feel better about myself. Not only for the physical aspects, but emotional as well. It was really eye opening. Physicality and attractiveness doesn't really matter. I have to think about personality traits and how powerful those are and why people like me.

The mirror based exercise and the messages remembered from it also represent the participants' desire to generate their own idea of what beautiful and body positive is. The homework activity initiated by The Body Project allowed her to construct an idea that was meaningful to her.

Another activity-related messages that was cited as most memorable, was brainstorming body activism. This activity refers to creating a list of at least 10 things girls/women could do to critique and resist the thin ideal and fight social pressures. For example, sharing an anti-thin-ideal movie with their sororities or confronting a friend who engages in fat talk. Ria commented:

> I think going through what we can do to promote body activism. I loved how we wrote it down. I'm a visual learner, too. When we wrote everything down of what we could be doing and brainstormed. That was important to me because I've always wanted to get the word out there and share with other people. So, I thought it was cool how we came up with ideas of how to do that.

Ria's comment highlights how she was able to make parts of The Body Project curriculum benefit her personal life outside of the training by sharing it with other people. This activity was memorable to her because it fit well with her personal life.

The activity in which participants practiced rejecting negative-self talk was identified as a significant memorable message and also a message that fit well in participants' personal lives. This activity referred to guided exercise in which participants were asked to generate anti-thin-ideal statements in response to a pro-thin-ideal statement, such as "My brother says I'm too fat,

what do you think?" or "I really wish I had the body of that runway model." In reference to this rejecting negative self-talk scenario, Celia explained:

> I think the scenarios where we did practicing fat talk and how to react when people did that was actually the most effective because that is something I have continued to see in my life. I didn't notice that before, but since the program, I have become very aware of when that happens. It's really difficult because in my head, the signals go off and I hear "Warning, warning! That's fat talk! You know how to deal with this!" But I find that I still struggle with how to call it out and deal with it.

As demonstrated in Celia's comment, she reported the activity to be something she experiences in everyday life. Her comment highlights that she had not noticed fat talk before, but has since become very aware of it, suggesting that the message was memorable because of it being highly relatable to life outside The Body Project.

Similarly, Chandra attributed her knowledge of fat talk to one of the activities that took place during the workshop. The role play scenarios, situations in which participants had to actively construct anti-fat-talk statements, allowed participants to practice these statements and also become more mindful of different ways fat talk may take shape in conversation. For example, Chandra commented:

> My usual approach [to rejecting fat talk] was to say, "Friends don't let friends fat talk!" But now, I've learned much better ways. Now, I'm like, "Don't say that EVER, not just right now." So, for example, someone was like, "My thighs were so gross today!" Instead I said, "Hey, remember when we went to the gym last week? Your thighs let you run for like, three miles. You should be proud for what you can do."

Chandra's comment demonstrates the value she places on the opportunity to reject negative self-talk when talking with her friends, including women who did not participate in The Body Project. In addition, this excerpt demonstrates how she identifies her skills as improving (i.e., emphasizing the importance of strength over weight).

The memorable messages above were the result of formally facilitated activities in The Body Project training. Activities allowed participants to become engaged in the material and

create their own ideas, personalizing the training and creating a unique space of their own. Instead of listening to a training in which facilitators lectured to them, active involvement kept them engaged and allowed them to apply the material to their lives in a way that was most relevant to them.

Memorable messages as new ways of thinking. Some of the memorable messages that emerged for participants were not prompted by any of The Body Project facilitated activities or co-construction of meaning. Instead, participants commented that they did not remember a specific activity or instance, but instead remarked that it was an overall "feeling" after the workshop. Specifically, participants mentioned feelings and observations from the workshop that were punctuated with new ways of thinking. These messages included increased media literacy and the comfort of understanding that nobody truly fits the thin ideal or is "perfect."

One of the changes that participants reported experiencing after the training was the ability to think critically about media by analyzing and evaluating its messages. For example, Amber commented:

> I don't know if it was a single thing we said. I think it was an overall feeling afterwards. I compared it a lot to my gender and the economy class. It seemed like a lot of the media stuff, for some reason, I think that stuck with me a lot more just because I already had knowledge of it before. How media affects body image. That one I think about A LOT. Probably almost every day.

In this quote, Amber refers to information learned in The Body Project that caused her to think critically about something she interacts with daily. She highlights that she had previous knowledge of how the media affects women before, suggesting that previous knowledge may influence what is most memorable. Here, Amber observed the reaction other participants had to women in the media and used it to build upon the knowledge she already had. In a similar

example, Jocelyn also recalled discussion about the computer photo editing system, Photoshop, because she uses the program often. She commented:

> I'm a journalism major, so I see the effects of Photoshop in a lot my classes. I've learned how to do a lot of the things the magazines can do with Photoshop. That doesn't mean I do it, but definitely when I'm learning about these ethics, it brings me back to the messages I've learned [from The Body Project].

Jocelyn recalled a specific example from the activity in which participants were asked to critique the thin ideal. Like Amber, the information related to knowledge Jocelyn already had regarding women in the media, and it is clear she continues to uses the information in her everyday life.

In addition, it was common for participants to recall an overall realization that not everyone is perfect or entirely fits the thin ideal. Several participants commented that this was a significant take away from the training. Maegan said:

> The most significant thing that I was surprised about was that every single person in the room had had body image issues or problems that they were either currently dealing with or had in the past. Initially, when I walked in, I was like, OH MY GOSH, all these people are so pretty and perfect. It was interesting to see that everyone has this problem. It was enlightening and reassuring.

In this excerpt, Maegan explains her initial reaction when walking into the training and that she expected other participants not to have body image concerns. By listening to other participants' narratives and watching the interactions that took place, she felt reassured in knowing that body image was a concern of each person in the group, not just herself.

The message of increased confidence and empowerment, as demonstrated by Maegan's comment, emerged more than once and took several forms. Several participants claimed that the support they received and the insight they gained from other participants helped them be more comfortable with their own body, a message that they were consistently mindful of after the training. For example, Jocelyn commented she was relieved to know that she was not alone in having body image insecurities and felt comforted by the support she gained from other

participants: “It’s just nice to know that we’re all in this together, all in the same boat. We’re all trying to work towards supporting each other as well as supporting our own selves.” Ria recalled a similar message:

> It made me realize that I was more, I’m more comfortable with my own appearance and more reassured knowing that everyone else has these insecurities that they could talk about. It’s definitely helped me think more positively since then.

Ria’s comment demonstrates that The Body Project allowed her to observe interactions between different participants and herself that made her think more critically about her own appearance. The social support she received from others in the training provided the perspective she needed to understand how she can become more positive about her own body image.

Participants recalled that another memorable message from the workshop was the feeling of friendship they made and how comfortable they felt with the group. For example, Chandra reported that her participation in The Body Project and the support from the friends she made helped her feel more eager to get involved and more connected to the Panhellenic community:

> It made college really cool and made me being a Panhellenic woman really cool. It made me want to step up more, too. I’ve run into everyone at some point. You see them on campus and it’s another friendly face you see. I like their pictures on Facebook just for that extra support.

Whether participants remember the friendships they made because they have seen those women outside of the workshop and more recently within the month of lapsed time is unknown. However, the message of friendship was clear.

The most memorable messages that emerged here all had themes of being highly relevant, useful to participants, and transformed both their thoughts and actions. In addition to remembering messages specific to other participants, activities initiated by the workshop, or their own observations, participants recalled information from the professional facilitators (i.e., the professional practitioners or faculty members) present at the workshop.

Messages delivered by professional facilitators. It is necessary to note that the messages identified as most memorable by each of the participants were delivered either from an activity through the facilitation itself or from the moments participants individually observed. Although this was indeed a workshop intended to train women on how to be peer health educators, none of the participants cited their most memorable message as being feedback from the professional facilitators themselves.

Participants seldom made comments about remembering messages from the professional facilitators. When participants did remember messages from the professional facilitators, messages were often related to facilitation timing or logistics, positive comments from the facilitators, or comments or behaviors that disrupted the participants' learning objectives. For example, Amber recalled comments from one of the professional facilitators regarding logistics, stating "I just remember hearing a lot about time, our timing running over." Additionally, Jocelyn recalled "You don't often hear about eating disorders with men, and he [the facilitator] definitely brought up some facts about that." Ria shared:

> Mainly, just the "you guys are going too fast" or "you guys are going too slow" but honestly I don't think I really remember their critique. Mainly, we were just, and we were talking about this too, after we got done. All of the facilitators were talking about this. We can't really control where we're going with the conversations. Like, we like the technical feedback but the stuff of what we SHOULD be talking about and stuff like that, it just like happens.

Ria's comment demonstrates that she remembered the practical professional facilitator feedback, but it is also clear that she did not necessarily value it. Rather, it seems as if she found the feedback annoying and released her frustration about it with other group participants.

It is evident that some participants recalled being frustrated by professional facilitator comments, stating that comments were unrelated to the subject matter and mentally distracting. For example, Celia commented:

> That was very frustrating. I see where they are coming from but I think, I would say the majority of us agreed, that that was a little over the top. We just didn't, we don't really take offense to when someone says you're a girl or you're a woman. We had a discussion about that. In between breaks, we decided to talk about it and crack up about it. We were not making fun, but ridiculing them a little bit, joking. I think part of it was that we were so exhausted and it actually was really exhausting to sit there and run through the same thing, even though you're not doing anything. We were feisty and tired.

Celia's quote demonstrates that the lengthy workshop paired with distracting comments may have contributed to participant fatigue. In addition, participants commented that they were sometimes distracted by the professional facilitators who were male. For example, Ella shared:

> I thought it was interesting that a male led the workshop. Just because he doesn't have any idea what we go through. I know there is male stuff like this, but it's WAY different. Sexual harassment on the street, that kind of stuff. I wonder if there was a woman in charge if how it would have played out differently.

Ella's quote demonstrates the vexation she felt while having to receive instruction and feedback from a male, someone she felt was not a credible source for information about women's body image issues.

Additionally, several of the participants reported feeling uncomfortable when they interacted with one of the facilitators outside of the training. Some reported feeling a loss of control over what took place during The Body Project training because they would see facilitators outside of the training and felt as if their privacy was breached. Chandra commented:

> I definitely wanted to bring up that I've run into everyone. Even the facilitators. I ran into [facilitator name]. I've run into him before and he was like "HEY, HOW ARE YOU?!" And he knew SO MUCH ABOUT ME! At first, I was like WHOA, you know A LOT about me that A LOT of my friends and family don't know! I was kind of like, uncomfortable, but kind of awkward about it, but he knew way more than I thought he knew.

In this comment, Chandra discloses feeling uncomfortable when she saw a facilitator outside of The Body Project training. Because she had disclosed personal information, Chandra felt as if

her privacy had been violated, a problematic situation for a workshop intending to create a safe space and make participants comfortable.

However, some participants did find professional facilitator feedback helpful. On several occasions, professional feedback was deemed encouraging Recalling a positive comments, Sofia shared:

> I would just say that the "best group" comment was a really big one from the whole weekend. It stood out because this is [the facilitator's] livelihood. It's what he does for a living. The fact that out of the many hears he's done this and the many groups he has seen that WE were the BEST. We weren't just a random group of girls.

In this comment, Sofia recalls an instance in which The Body Project representative—someone who coaches peer health educators regularly—complimented the group on the depth and diversity of their comments. His praise was validating to her

To summarize, memorable message source, content, and context was not recalled as I would have anticipated. Instead of primarily remembering by revisiting the source, content, and context of a message, participants recalled moments in which they were prompted to co-create message and be exposed to new ways of thinking, ultimately transforming thoughts and behavior. Participants seldom recalled messages from the professional facilitators. When they did, those messages were often logistical, served to reinforce positivity, or disruptive to the participants' learning objectives. The implications of which messages were remembered and how messages may contribute to the overall impact of The Body Project are discussed in the next section.

Impact of Narrative Sharing and Dissonance-Based Training on Participants

An additional aim of this study was to identify the ways in which those being trained to be peer health education for The Body Project would benefit personally from the training. Two themes emerged to identify how participants were impacted by the workshop. First, participants

reported an increased sense of confidence and empowerment. Second, participants reported greater awareness of feminism and feminist ideals. Each theme is explained here.

Confidence and empowerment. During interviews, it became clear that participants experienced increased confidence and empowerment in their personal lives after participating in the training. For example, Amber reported being more likely to stand up for herself and others, saying she is less likely to "shrug it off" when she hears others fat talk. Additionally, being validated by other participants and being exposed to other people's experiences helped her feel empowered. Amber commented:

> It was the realization that… not even the realization. I KNOW as a woman, we KNOW that we have worth and matter and should feel good about ourselves all the time and feel good about other girls—or women—but I think it was actually having several other people in a group talk about it and hear that they're insecure at times and that they're not 100 percent at times. It's an empowerment thing.

Learning that one is not alone and that truly nobody is perfect emerged as an impact of The Body Project training. Jocelyn reported other participants' honesty and vulnerability regarding their self-disclosure about body insecurities empowered her to have more self-confidence. The workshop caused her to be more mindful about her negative self-talk, explaining:

> There were a lot of things that I saw that, I don't want to say were WRONG with me but that I wasn't necessarily comfortable with going into [The Body Project] conversation. I came out of that thinking, okay; I need to really watch what I say about myself. It definitely brought about more confidence in myself and my own image. I can definitely see that in the other women in the group as well.

Other participants shared similar sentiments to Jocelyn and reported feeling validated by the messages other participants shared. For example, Leah shared, "A big message was, if you believe you're confident and that you're beautiful, then other people will think that too. It's about having that confidence and knowing yourself." This message of self-confidence and

empowerment led some participants to conduct additional research on information they learned in The Body Project, including feminism and feminist ideals.

Feminism and feminist ideals. The Body Project, initially intended to be a body-positivity workshop for college-age women, expanded the facilitation conversation beyond confidence and empowerment and served as a consciousness-raising space for the participants. In several instances, participants commented on an increased awareness of feminism and feminist ideals. That is, some were prompted to seek more information about feminism because of discussions about rape culture, equal pay for equal work, and how feminism relates to body positivity.

On two occasions, participants recalled instances in which The Body Project training caused them to react to a situation in which they would not have otherwise. For example, Leah recalled that she shared the information she learned in the workshop with a male friend, hoping it would empower him because he also experiences pressures to fit a specific ideal. Leah shared:

> After I shared it, he was like, "You're becoming such a FEMINIST now!" and I was like, that shouldn't be a bad thing! That should be a good thing! I feel like people get the wrong image about it. I know it didn't come up a lot in The Body Project, but part of body image is women empowerment, and that has to do with being a feminist. But when the word "feminist" comes up, a lot of people say," No! That's not me!" I don't think a lot of people understand what it truly means or what it should be, so people shy away from it, which is kind of sad.

Leah disclosed she knew what feminism was before The Body Project training, partly because of her mother's education. She stressed, however, that The Body Project caused her to be proud of identifying as a feminist, namely because another participant she respected was so passionate about it and made a point to educate the group. Leah said, "Chandra was a huge feminist and she made me realize what it meant also. I feel like I was a feminist before, I just didn't identify with it, so I needed to know more about it." To summarize, The Body Project allowed Leah to explore

her definition of feminism, a process that was ultimately deeply impacted by both the curriculum and the other participants she interacted with.

In another situation, Amber recalled a story about one of her sorority chapter meetings in which a fraternity visited the meeting and engaged in performing a serenade, or a song and dance in which fraternity men attempt to persuade sorority women to attend their events and spend time with that organization. She described a situation in which the men were standing in front of the group, divided into two rows with one in front of the other and "literally the front row got on their hands and knees and the guys in the back acted like they were riding the guys in the front while singing the song." She expressed being made uncomfortable and frustrated by the sexual nature of the act, explaining:

> I mean, what am I supposed to say? Stand up and say "you're disgusting?" I don't know any of those guys individually and a ton of their brothers were there watching and our sisters were there watching, and I was just like, do you really think this is okay? Would you do this in front of a different crowd? You think it's okay because we're a sorority and you're a fraternity? So it's assumed that we're gonna get together. It was HORRIBLE. It was the most PAINFUL experience. I think I think about things too much now. I'm just like, that's the ONLY thing that matters to you? Like, our names and if we're single? I feel like a crazy person now because I think so deep into things.

This moment caused a visceral reaction for Amber, prompting her to eventually share her disgust and frustration with her other women who were present in the meeting, ultimately learning that they, too, were upset by the situation. As Amber disclosed, it was her training in The Body Project that caused her to think more critically about the situation because she learned that "Women are not made to feel like an object. We are worth so much more than that." Amber shared, "I felt a lot more comfortable with the word 'feminism' and 'feminist.' I have been looking into it and I feel more comfortable about the word and being like yeah, I am. I absolutely am [a feminist]." Amber's sense of self-worth that was gained from critiquing the thin ideal led

to feeling empowered to investigate feminism on her own and continue to critique other situations in which women may be devalued or mistreated.

Amber's story is an example of when information from The Body Project left the circle of women who attended the training and was shared with outside parties. Each of the participants reported sharing information with others after the training was complete. The sharing patterns of each of the participants are detailed in the section below.

Choosing to Share or Not Share Information with Outside Parties

On some occasions, impact of The Body Project on the participants extended to discussions with people who did and did not participate in the training. Participants reported discussing The Body Project's curriculum at greater depth after the training with women from their same organizations who also took the training (10 of the 11 participants had multiple representatives from their chapters). Additionally, participants also reported sharing information with their mothers, sisters, managers, and both male and female friends. Jocelyn, for example, shared information with a woman she knew struggled with an eating disorder. Jocelyn commented that she tried to help a friend learn not compare herself to other people or her previous body weight by sharing, "You just gotta learn how to be happy in your own skin rather than comparing yourself." Jocelyn's support sharing behavior with her friend was mirrored by other participants in the workshop. Jean, for example, became concerned about her mother during the training and shared anti-thin-ideal statements with her in an effort to reduce instances of body shaming. Jean commented:

> Recently, after going to The Body Project, I've realized how bad it is. I went home over the weekend and she said "I started using Jenny Craig." and I was like "WHY? Why are you on a diet?" I don't know. So instead, when I'm with her, that's when I hint about body positivity. I actually called my dad and told him all about fat talk, so when my mom does it, he stops it. It's really cool.

As seen by Jocelyn and Jean's comments, The Body Project training not only educated participants on how to critique the thin ideal but also to recognize its symptoms in others, extending The Body Project message and teachings to those who did not have the opportunity to participate.

While each participant shared information about The Body Project after the training, the extent to which participants shared the information varied. Some, for example, shared activities and general themes from the workshop whereas others spoke only of the fact that they participated and did not share specific details.

For example, Leah wanted to share what she learned at The Body Project in-depth with other women from her sorority, but her new membership in the organization made her apprehensive to do so, mentioning:

> I want to share it with my sorority but I am such a new member still that it's harder for me to have an influence. I want to do something with it, but I want to wait until I know the girls better.

This excerpt demonstrates Leah's hesitancy to share what she learned in The Body Project, largely because she fears she will not be found credible because she is a new member in her organization.

Similarly, other women who have been members of their organizations for two years or more reported not sharing it with their organizations. Four women attended The Body Project from the same organization and each of them reported not sharing it at length with their sorority. Jocelyn, a member of that organization, said "It was something I was able to bring back individually but as a collective, none of us have really discussed what we've learned." Ria, also a member of that organization, commented that she was not sure if she was supposed to share the specifics of what she learned. She commented:

> I bonded with those 12 people and we're all in the same page, but I don't know what page everybody else is on. So, I really haven't gone into depth with anyone else. *Just because nobody wants to hear about it* [emphasis added].

Nobody wanting to hear about the training was a similar feeling participants shared when commenting about who they shared the information with. Celia, for example, said she shared information about the training with both her mother and her boyfriend and both individuals seemed disinterested:

> He just didn't want to talk about it and I am not sure why. It was interesting because I know that men experience problems with that, too, and I think that in some ways, he probably has, and maybe that's why it was uncomfortable for him. When I went back the second day, I saw him later that night and I was so enriched and I was ready to talk about everything and he was just like… yeah, cool. He didn't ask me anything about it which was something that I did my own mental tracking with. I also told my mom and she had the same reaction as my boyfriend. She didn't want to pry too much.

Celia's quote recalls an attempt to share information from The Body Project with a male, something the other participants did not recall. In addition, her tried, and somewhat failed, attempt of sharing this information with her mother emphasizes the feeling that those who did not participate in the training are hesitant to learn about it, perhaps indicating resistance in discussing body image. Similarly, Ella tried to share the information with others, but repeated instances of listener disinterest caused her to keep the information to herself.

> I tried to. She didn't really seem that interested. Yeah. I can't believe I didn't tell anyone. Like, people asked how it was and I said it was great. I think the only thing I really said was that I felt really empowered to create change. But I didn't go into depth.

Here, Ella echoes the sentiments expressed by other participants. However, she also indicates not knowing what she should have or could have shared, suggesting that she was not properly prepared to share information with outside parties once she completed the training.

To be sure, participants thought about the information they learned in The Body Project after the training, but whether they shared the information in depth with others depended on

individual preferences. Some did not share in-depth information about the training because, according to Ella, the topic is taboo and she was "nervous of ridicule and backlash" from those she shared it with. Regardless, the information presented here suggests that participants may have benefited from discussing how to talk about the training after it was complete.

The results of this study indicate that participants qualitatively reported feeling an increased sense of self-worth, confidence, and empowerment. Self-esteem scores, however, decreased one month after the workshop. In the discussion chapter that follows, I will detail the implications of these results, ultimately synthesizing how this information contributes to additional research about The Body Project and contributes to memorable messaging and peer health education research at large.

Discussion and Conclusion

Societal pressures to be thin can take their toll on collegiate sorority women, a population that makes up more than 325,000 undergraduate students across the United States and Canada (National Panhellenic Conference, 2014). As a result, peer health education programs have been created that attempt to relieve collegiate women of pressures to pursue the thin ideal. This study illuminates how one health intervention, The Body Project, contributes to communication research about peer health education, narrative sharing, and memorable messages. The theoretical and practical implications of each are discussed below.

Peer Health Education

This study has built upon previous peer health education research (Klein & Sondag, 1994; Mellanby et al., 2000) by indicating that peer health educators benefit from not only the program itself, but from having the perspective of being a facilitator. Several theoretical and practical considerations about peer health education come from the current study.

First, health communication research indicates that social support helps people deal with social "incongruities" such as being physically or mentally different from others in some way (Albrecht & Goldsmith, 2008). Social support is fundamental for communication behaviors such as informing, persuading, or teaching. According to Albrecht and Goldsmith (2008), greater group diversity leads to increased social comparison which can model improved health behaviors. This may provide support for why participants ultimately reported that they benefited from being exposed to the narratives from women with body types different than their own, resulting in feelings of not being alone in their struggle with body image or eating habits. Thus, it may be beneficial to intentionally include a variety of body types when recruiting both peer health educators and The Body Project program participants.

Next, opportunities for follow up and facilitation should be identified before the peer health educators participate in workshop training. Social support literature also provides insight into the benefits of consistent and intentional communication. Regular communication and follow up can reduce stress felt by individuals (Albrecht & Goldsmith, 2008). During follow up interviews, it became clear that participants were not given opportunities to discuss the workshop with their sorority chapters. While some participants did share brief information about what they learned with their close friends or family members, participants often reported that those parties were disinterested or unengaged in those conversations (e.g., Ria commenting that "nobody wants to hear about it"). In addition, the sorority chapter at large was not made aware of the training their peers had received. This is problematic because the message of body positivity and rejecting the thin ideal ended with those who participated in the training. Thus, it would be beneficial to discuss next steps at the end of The Body Project training in order to identify how participants would inform their sorority chapters about what they learned. For example, requesting that participants contact their chapter leaders and ask to be permitted to provide a brief synopsis of what they learned and how others can participate in the training would allow participants to be recognized by their chapters and also serve as a recruitment tool to promote participation in The Body Project. Participants' inability to discuss the workshop with their chapters ultimately hindered the sorority community's exposure to The Body Project's message, a primary goal of the Office of Fraternity and Sorority Life.

In addition, participants expressed frustration and sadness about not being contacted to facilitate the workshop to an outside group. The Office of Fraternity and Sorority Life did not contact the facilitators about The Body Project until December 2014, approximately two months after the workshop. According to Bandura (1977), when choices are made that lead to positive

outcomes (e.g., choosing to run consistently which in turn improves mile times) self-efficacy and confidence improve (e.g., becoming more confident in one's athletic ability). The peer health educators made a choice to participate in The Body Project training, a choice that lead to positive outcomes in the way that was initially promised (i.e., the opportunity to facilitate to outside groups). Thus, training peer health educators on a program without having identified a market for future facilitation opportunities may impact the peer health educators' self-esteem and commitment to the program. Not being contacted by the Office of Fraternity and Sorority Life to facilitate the program may have resulted in feelings of neglect or lack of program interest, neither of which lend to future interest in growing the program or promote self-esteem. A future comparative study would be beneficial in order to compare the self-esteem of those who facilitate the program to an outside group and those who do not.

Peer health education program organizers should consider the role participant similarity and difference plays in peer health education workshops. In The Body Project, the peer health educators highly identified with one another. That is, being female college students from the same university, affiliated with sororities, and identifying as Caucasian allowed them to feel similar to others in the group and relate to each other's actions (e.g., Ella said, "It helped that we were all white, went to CSU, and were part of sororities. It made it easier to feel comfortable.") In turn, this resulted in higher reinforcement, or a greater ability to learn from other people's behaviors (e.g., Leah said, "Chandra was a huge feminist and she made me realize what it meant also.") However, while participants revealed that the homogeneity of the group was beneficial to learning, it was also suggested that the range and similarity of thin body types may have been unsatisfactory. For example, participants with higher BMIs reported initial fear about being spotlighted by the group and anticipated difficulty connecting with participants who more closely

adhered to the thin ideal (e.g., Celia said "It's kind of ironic because I feel like everyone here looks like what the thin ideal is… I was kind of nervous because I thought, is this going to be bulls eye on me?") Similarly, the influence of male professional facilitators may have been problematic and frustrating to some participants. For example, Ella shared that the male professional facilitators did not "have any idea what we go through." Ella's comment suggests that female professional facilitators may be the most relatable demographic to provide feedback.

While previous research suggests that individuals are more likely to learn from peer health educators who are the same gender, race, and skill level to themselves, results from this study suggest that diversity in body type and age or year in school may be beneficial. Similarly, recruiting students who vary in age and year in school may result in higher program success. Previous research suggests that peer health educators who are admired by their peers often serve as opinion leaders and are received well by the groups they facilitate to (Buller, et al., 1999). Those who were remembered most by other women in The Body Project were upperclassmen and also well-respected by their individual organizations. That being said, freshman and sophomore participants expressed concerns about not having the clout necessary to influence other sorority members. Considering these two factors, it may be beneficial to recruit a variety of women who are different ages and years in school in order to positively influence both the other peer health educators and the participants of the group they are facilitating to.

Finally, expectations of a peer health education program should be clearly communicated before students are selected to participate. Previous research indicates that students typically become peer health educators for altruistic, egoistic, or self-efficacy reasons (Sondag, 1994). However, the participants in this study did not know The Body Project was intended to train them to become peer health educators in the first place. Therefore, their expectations of what The

Body Project would entail was not related to peer health educator training, and some expressed resentment for being selected to participate without understanding the full details of what the program entailed (e.g., time commitments, facilitation expectations). It is imperative that recruitment materials clearly identify the purpose of the workshop, disclosing that The Body Project facilitator training is intended for students interested in both learning more about body image and becoming peer health educators.

To summarize, this study contributes to overarching peer health education theory and practice. Social support literature is useful in explaining the importance of varying participant body types and also the importance of follow up. Similarly, peer health education program organizers should intentionally select facilitators, being mindful of how varying body types, years in school, and race affiliations may impact the group's productivity and identification. Finally, expectations of the peer health education program should be clearly communicated before students are selected to participate and various opportunities for follow up and facilitation should be identified before workshop training takes place. Previous research has indicated that peer health education can be an effective way to initiate behavior change, affecting not only the participant, but the peer health educator as well. The following section addresses how research on health interventions has been extended due to investigating the role of peer health education in a dissonance based, narrative sharing program.

Health Interventions

A primary aim of this study was to contribute to research addressing communication and health interventions. This study does so by suggesting the necessity of co-creating the message, inclusion of narrative sharing, and addressing the impact of self-efficacy and self-esteem on peer

health education programs. Theoretical and practical implications for communication and health interventions are discussed here.

The necessity of co-creating the message. Previous research has indicated the importance of creating interactive, intrinsically motivated workshops in order to have a lasting impact on participants (Conley et al,. 2013; Lockwood & Wohl, 2012). This study extends health intervention research by examining what messages or moments were most memorable to participants, thereby revealing what was most influential to them. Two themes emerged that have pedagogical and social implications for health interventions.

First, participants benefit from the opportunity to co-create a message. That is, instead of being told exactly what they needed to know, participants benefited from being able to construct their own reality of what pursuit of the thin ideal looked like to them. Participating in situated learning—that is, engaging in different approaches to learning, such as activities (Rambusch & Ziemke, 2005)—helped a message be beneficial to each person. For example, instead of being told what the thin ideal was, they were guided there and permitted to generate their own interpretation of it (e.g., blonde, white, flat abs, large breasts, etc.) Participants had the opportunity to generate these conversations because of activity prompts within the script. The combination of completing the activity and having the opportunity to hear narratives shared by other participants resulted in more instances of participants recalling those specific activities (e.g., critiquing the thin ideal, the mirror exercise, etc.). Activity based conversations allowed participants to discover why the topic was important versus someone instructing them on why it was important. To summarize, in addition to being told information to remember, it is beneficial for participants to co-create important messages, providing further support for the benefits of situational learning (Rambusch & Ziemke, 2005). While there is evidence in the education

literature that co-creation of meaning facilitates learning, this has not been studied in the health message context. This finding suggests that additional research should examine the co-creation of messages in health interventions.

Second, the interactions participants observed during both The Body Project training and break times were not inconsequential. Instead of remembering a specific activity or instance, participants remembered an overall "feeling" after the workshop. For example, participants used break time to discuss frustrating moments during the workshop, an act that resulted in higher identification and greater trust between participants. Research indicates that the relationship between trust and group performance is strong (Dirks, 1999). If trust is not established, team effectiveness decreases (Costa, 2003). Thus, strong bonds between peer health educators are ideal, as future facilitation opportunities require that peer health educators facilitate in groups. Creating opportunities for casual conversation can increase trust and result in unexpected friendships that may ultimately benefit the peer health education experience.

Narrative sharing. This study affirmed that meaningful communication comes from storytelling and that it has the potential to influence future behaviors. According to Sowards and Renegar (2004), "personal testimony can connect the lives of individuals who share the same set of circumstances," serving as moments of catharsis (p. 542). Narrative sharing interventions contribute to generating cognitive dissonance and allow participants to learn from the experiences of others, in turn shaping their own health behaviors. This became evident in several ways.

First, narrative sharing allowed participant stories to emerge as models for behavior change. This finding aligns with previous narrative research (Green, 2006; Larkey & Hecht, 2010) and suggests that it is beneficial for participants to have role models during peer health

education training. As participants began to self-disclose information, the group became more united and willing to share additional stories. Intentional narrative sharing—that is, stories that are appropriate for the peer health education atmosphere—allowed for conversations to emerge that resulted in a more comfortable environment. In addition, narrative sharing contributed to the training's use of cognitive dissonance. Recall, dissonance theory states that "the possession of inconsistent cognitions creates psychological discomfort, which motivates people to alter their cognitions to restore consistency" (Stice et al., 2001, p. 249). On several occasions, participants reported psychological discomfort in learning that their pursuit of the thin ideal was counter to what the training suggested is most healthy for body image (e.g., Jocelyn sharing with her friend that "You just gotta learn how to be happy in your own skin" as opposed to comparing herself to others as she had done previously—a behavior supporting pursuit of the thin ideal). This psychological discomfort allowed participants to question their own thoughts and behaviors and mindfully critique the thin ideal.

Next, narrative sharing allowed participants to care more deeply about one another by providing a space for them to share personal, genuine stories. This can be explained by transportation theory which suggests that people may identify with narratives because of the opportunity for increased identification and role modeling (Green, 2006). High perceived identification allowed participants to become friends and generate more social support, an outcome they did not anticipate when participating in The Body Project. For example, about the support system she and another participant made, Jocelyn said "It's about addressing the challenges we face and acknowledging that nobody's perfect." Friendship and social support are important, as they allow for participants to feel comfortable asking for feedback and continuing

their pursuit of behavior change, such as not pursuing the thin ideal as Jocelyn's example demonstrates.

Finally, narratives allowed participants to generate a greater sense of self and empowerment. Narrative sharing during The Body Project allowed participants to gain a glimpse into the life of a peer—someone the participant highly identified with and perceived as similar. This produced several outcomes. First, research suggests that a narrative may be more realistic to an individual if it aligns with his or her cultural practices and values (Larkey & Hecht, 2010). The participants in this study were each part of a subculture at Colorado State. That is, sorority life contains its own vocabulary, rituals, and events—practices that contribute to the sorority community existing as a subculture. I argue that narratives shared by the participants were more realistic because of the common sub-culture affiliation, something that may have been similarly achieved if all participants were athletes or part of a club with a similar level of commitment and membership requirements. Next, gaining a glimpse into a peer's life—especially when that person is respected and admired—can make the participant feel as if she is not alone in her struggle with body image. For example, Sofia was highly respected and admired by the rest of the group, and her self-disclosure about dissatisfaction with her arms influenced others to feel comforted and understand that their struggle with body image was not unique. Second, narrative sharing can also inform someone of how their journey with body image compares to others. For example, after hearing the stories shared by other participants, Leah learned that her sense of self was more positive than what she perceived from her friends. That is, she learned that she was more confident and had *less* body image concerns than her peer group. Thus, in addition to serving as a means to create friendships in the group, narrative sharing can benchmark growth and encourage progression.

Dissonance-based intervention and self-efficacy. Previous Body Project research has demonstrated that the program is an effective dissonance-based intervention and has long-term potential to reduce eating disorder behavior in its participants. However, as I have reiterated throughout, this thesis seeks to extend the conversation beyond The Body Project's participants and focus on the impact of its peer health educators. This study illuminates the complicated relationship between dissonance-based interventions, self-efficacy, and self-esteem and suggests that poor or inconsistent follow up after the peer health education training can have unintended consequences.

Self-esteem, or an individual's sense of self-worth and value, is a different construct than self-efficacy, though research suggests that the two are related (Lane, Lane, & Kyprianou, 2004). The greater a participant's perceived ability to successfully change a behavior, the higher his or her self-efficacy (Bandura, 1977). Thus, self-efficacy focuses on outcomes, or one's perceived ability to successfully accomplish a task, and these outcomes may or may not have an impact on self-esteem. If one has invested significant self-worth in a task—for example, the desire to spread body positivity and facilitate The Body Project curriculum—then she is more likely to connect this task to self-esteem, whereas investing little self-worth into a task is unlikely to be related to self-esteem. An additional way to explain this relationship is through attribution theory (Weiner, 1986). Attribution theory suggests that past performances have implications for future efforts. However, when failure is attributed to lack of effort versus lack of ability, self-esteem is not likely to be as highly related and may not impact self-efficacy levels (Bandura, 1982). Thus, one's sense of self-efficacy and self-esteem is weighted on performance and varies depending on the individual.

When relating self-efficacy and self-esteem to The Body Project, it is clear that this relationship is complicated. The pre- and post-test data suggest that self-esteem decreased over the one month period. However, participants' interview responses suggested that they experienced an increased sense of self-confidence, empowerment, and desire to be involved. I present three potential explanations for this below.

First, participants commented that they thought both the program and the other participants were highly relatable, relevant, and that they had the desire to facilitate the program to outside groups. This suggests that participants were invested in serving as peer health educators for The Body Project, despite not initially knowing what the expectations were. Because self-efficacy is derived from previous performance, and because self-esteem is related to one's perceived self-worth, I argue that self-esteem was negatively impacted because participants did not have the opportunity to spread this information to others, either through brief conversations with their sorority chapters or through facilitating the program to an outside group (Neff, 2011). To reiterate, participant interviews suggest that outside parties often did not express interest in The Body Project experience and were not interested in hearing about it in detail (e.g., Ria commenting that "Just because nobody wants to hear about it.") Therefore, a space was not created to share this information.

Second, The Body Project was a workshop intended to help participants critique the thin ideal and develop an understanding as to why they did not need to look a certain way. To do so, they had to identify all of the qualities of the thin ideal and simultaneously recognize that they, in fact, did not look that way. Dittmar and Howard (2004) found that a woman's tendency to make social comparisons (be it to a professional model or to another person in her personal life) predicted that woman's body-focused anxiety. Thus, while attempting to critique the thin ideal,

participants were inevitably expected to realize that they did not adhere to a desired societal norm, which may have contributed to lower self-esteem.

Finally, after observing individuals perform facilitation tasks in front of small groups, Bond (1982) suggests that individuals lose self-esteem if they engage in a difficult task and do not perform it well. The presence of an observer impaired the learning of the task, especially if the task was perceived as challenging by the participant. Using the explanation from Bond's study provides another explanation for the decrease in self-esteem of the current study's participants after The Body Project training. Each participant in the current study was asked to facilitate curriculum they were not familiar with and with exception of two individuals, none of the participants had previous facilitation experience. Thus, it is possible that, before engaging in The Body Project training, participants were confident in their facilitation ability, but once exposed to the task and the nuances of facilitation, participants may have gained more self-awareness of how difficult the task of facilitation truly is and they may have also noted deficiencies in their own facilitation skills. Thus, considering Bond (1982), it is possible that participants experienced decreases in self-esteem due to the challenge of performing a difficult task (facilitation) well. Future research should examine participants' perceived feelings of facilitation competency prior to engaging in the workshop training and then again after the training to further determine the validity of this claim.

The relationship between self-efficacy and self-esteem has implications for both health interventions and peer health education. The score on the ideal body stereotype scale did increase, suggesting that the participants did listen during the workshop, took the information seriously, and thereby invested significant self-worth. If a participant learns information that she finds highly valuable and has the intention of sharing it with others, but then is never able to

share it, this may result in the perception that others are not interested in also learning about this topic, perhaps resulting in feelings of neglect and defeat. Body image is a personal and often sensitive topic for humans, and bodies are one of our primary tools for communication. If peer health educators are not validated and supported in their pursuit of social change, then both their self-esteem and the effectiveness of the program they are facilitating can suffer.

Previous Body Project research has already indicated that the program is an effective dissonance-based intervention approach. In addition, however, this study emphasizes the importance of follow up and that neglecting to do so may harm a peer health educator's personal self-efficacy and self-esteem. It is crucial that participants feel competent when facilitating the workshop and that they feel motivated to approach the task of helping other women feel more positive about their own bodies. If support is not gathered from organizers at the university, and if the peer health educators do not feel able to organize their own facilitation opportunities, there may be consequences for the program's ability to initiate social change.

To summarize, this study make several contributions to health intervention and peer health education research, including emphasizing the importance of co-creating program messages, sharing narratives in order to increase identification and relatability of the program, and the importance of follow up to maintain peer health educator self-efficacy and self-esteem. What hinges on all of the information presented so far is the impact of what messages were most memorable to The Body Project peer health educator participants. Thus, the next section discusses theoretical and practical contributions to memorable message research.

Memorable Messages: Embodiment and Em*body*ment.

To recall, a memorable message is a meaningful unit of communication that guides sense-making processes and has the potential to influence behavior long after initial exposure

(Knapp et al., 1981). This study was modeled after other memorable messages scholarship that identifies messages being recalled by their source, content, and context (Holladay, 2002; Knapp et al., 1981; Shiner, 1999). However, after using a grounded theory approach to analyze the data, messages not easily categorized by source, content, and context emerged. Thus, because participants often remembered the activities they participated in, I turned to the study of embodiment to make sense of what participants remembered. Additionally, participants' increased knowledge of feminism, a message that was not explicitly included in The Body Project's curriculum, emerged through narrative sharing and support seeking behaviors. The section below discusses this and expands the theory and practice of memorable messages.

First, the content that makes messages memorable in a narrative sharing and dissonance-based health intervention for peer health educators is the message's ability to initiate change in the recipient. Participants remembered new information that built upon existing knowledge and ultimately led to thought and behavior transformation. For example, Jean reported critiquing the thin ideal to be the most memorable moment to her throughout the workshop. She also reported an increased ability to approach others about their fat talk statements and disclosed several examples about approaching her sorority sisters and her mother about curbing their negative self-talk. Thus, the most memorable message of the workshop for her was something that affected her personal life and transformed her behavior after the workshop.

Second, a message's ability to provide social support contributed to what made it memorable. Participants recalled instances of self-disclosure from other participants, including struggles with eating disorders or instances of sexual assault. This study provides support for previous research indicating that a believable personal testimony, a highly realistic story, and

"like self" storyteller identification are crucial components to creating not only a genuine training experience, but a memorable one.

Additionally, source and content seemed to be explicitly intertwined in messages recalled by participants. The context in which a message took place seemed, however, to be less relevant. For example, on several occasions, participants recalled the source of a message. Celia remembered that Chandra disclosed her eating disorder during The Body Project workshop, but the exact words Chandra used to disclose this information were not recalled by Celia. Thus, the source was readily recalled memorable messages emerged differently in this analysis than in previous studies (Knapp et al., 1981; Holladay, 2002). It appears that context did not influence which messages participants remembered. Participants recalled information from both the workshop and the breaks, though workshop messages were often revealed more frequently, perhaps because break time was limited to only two hours total. Previous memorable message research has demonstrated the role of source, content, and context. However, putting memorable messages in conversation with embodiment literature may aid in explaining why source, content, and context were less often recalled than instances in which participants were able to co-create their own messages.

Embodiment literature refers to the physical body as a medium for sense-making, a process often explored in learning environments (Latta & Buck, 2008). Embodiment research argues that the mind and body are inextricably intertwined and cannot be viewed in isolation. Placing both the mind and body in a situated learning environment allows for increased cognition and comprehension of learned concepts (Rambusch & Ziemke, 2005).

According to Latta and Buck (2008), "Embodied teaching/learning demands being in the moment, at the juncture between self and other" (p. 319). Indeed, The Body Project created a

space in which participants were required to not only be present, but also make connections between self-experiences and other-experiences. For example, participant narrative sharing required expression of self-experiences (e.g., "I have struggled with an eating disorder"). Simultaneously, other participants were prompted to empathize and perhaps self-identify with the speaker (e.g., "Chandra, someone I admire, struggled with an eating disorder. I'm not alone in struggling with body positivity" or "I also have struggled with an eating disorder. Chandra is someone I can talk to"). This results in not only embodiment of a message, but em*body*ment of a message. In The Body Project, a workshop specifically about body image, participants were asked not only to actively engage in the workshop by co-constructing messages, but were also asked to create a mind and *physical* body connection. Participants were required to speak *about* their body, *with* their body, *to* other bodies.

The practice of embodiment led to em*body*ment in which participants were able to better understand the experiences of self and others regarding body image. For example, the role play activity allowed participants to embrace the persona of another individual (i.e., em*body* that person) by acting out her qualities and actually respond to other participants' comments. In another example, several activities required that participants disclosed the ways in which they struggled with body image. Sofia disclosed that she was dissatisfied with her arms. As she did so, other participants were able to see her arms. By being able to discuss one's body through interactive activities that allowed participants to co-create their messages and reality, participants engaged in em*body*ment in which they used their bodies to inform others about their own (e.g., Sofia saying she was dissatisfied with her arms, yet choosing to wear a sleeveless shirt to demonstrate her body positivity).

Examining The Body Project allows us to examine the role of the body in learning and education. This study puts embodiment literature in conversation with peer health education, health intervention, and communication research. The Body Project served as an exploration of embodiment and em*body*ment, serving as a medium that influenced curriculum comprehension and facilitation abilities. Thus, The Body Project worked to free its participants of previous constraints they felt from outside pressures, such as thinking they were the only ones who struggled with body image, whereas exposure to new knowledge transformed their thoughts and behaviors into understanding that they are not alone.

To review, this research builds upon embodiment literature in organizational communication (e.g., Cheney & Ashcraft, 2007), and provides insight into memorable messages in a peer health education workshop. In this study, memorable messages did not appear as originally anticipated. Instead of source, content, and context playing a major role in what information was remembered, opportunities in which participants were able to embody/em*body* the material, gain new knowledge, and learn more about the perspectives of others were recalled most often. That is, it was not necessarily the source, content, or context of a message that made something memorable to participants as previous literature suggested it might be (Knapp et al., 1981). Instead, greater emphasis was placed on messages that resulted as a participant's ability to actively engage in the activities. Doing so may have led to increased social support, comprehension of the material, and an increased desire to serve as a peer health educator. In addition, participants also remembered messages of feminism and feminist ideal. The following section discusses how memorable messages may have impacted feelings of social support and served as a venue for contemporary consciousness-raising.

Consciousness-raising, feminism, and the thin ideal. A seemingly unexpected message for The Body Project participants was the connection made to feminism and feminist ideals. Consciousness-raising, a rhetorical strategy used to give voice to women's experiences, is a strategy that was "cultivated to enable women to share their own experiences of gender discrimination in conversations and meetings" (Sowards & Renegar, 2004, p. 535). Consciousness-raising typically occurs in small groups, with women often writing essays or delivering lectures, and has been said to be central in encouraging personal testimony. The Body Project, with its narrative sharing foundation, served as a contemporary consciousness-raising space that increased participants' articulateness of body image issues.

Campbell (1989) argued, "Because oppressed groups tend to develop passive personality traits, consciousness-raising is an attractive communication style to people working for social change" (p. 141). Campbell's research indicates that women often negotiate negative self-esteem and self-images because of their lack of voice and obvious societal subordination. The Body Project served as a space for participants to address this subordination by actively co-creating an idea of how to initiate social change around pursuit of the thin ideal. Thus, it is beneficial for women to have a space to discuss what needs to take place to pursue increased body positivity and female empowerment in general. The Body Project's platform for narrative sharing allowed women to voice oppression, particularly with their peers, and provided a space for women to gather social support.

However, The Body Project did more than promote body positivity and generate social support. In addition, the training generated an increased sense of what it means to be a woman. Participants reported thinking more about feminism after the workshop, something that was largely the catalyst of other participants sharing their feminist identification. Because body

positive health interventions are often presented as eating disorder prevention programs, it may be beneficial to fuse the practice of consciousness-raising with health interventions, resulting in a co-constructed conversation that critiques the thin ideal and generates a larger dialogue about what it means to be a woman. For females in their collegiate years, discussions of this topic are imperative, as next life-steps include future instances of having to not only negotiate the thin ideal, but also negotiate additional social situations (e.g., gender inequalities, salary negotiation, and family). During The Body Project training, participants expressed feeling supported and comforted by the rest of the group because they were each able to share their own stories of oppression and struggles with body-image. The elements of consciousness-raising and narrative sharing were a contributing factor to this.

To summarize, The Body Project served as a consciousness-raising space that allowed participants to not only co-create messages about the thin ideal, but also engage in a supportive environment that allowed them to co-create and investigate their definition of feminism and what it means to be a woman. Fusing the practice of consciousness-raising with health interventions may result in a combination that increases the overall success of body image focused peer health education programs. In the section that follows, I present practical contributions and recommendations for improvement to The Body Project and the host institution.

Practical Contributions to The Body Project and the Host Institution

Previous research on The Body Project has demonstrated its positive effects on participants on the program, not the peer health educators specifically. Thus, this study contributes to The Body Project by focusing on understanding how the program impacts its peer health educators. Here, I make several recommendations for growth for The Body Project.

First, it may be beneficial for The Body Project to build in several recommendations for peer health educators to develop the opportunity to share the information they learned with others who did not participate (e.g., developing structured time for peer health educators to discuss and commit to sharing the information with their sorority chapters). Equipping peer health educators with the tools necessary to effectively share this information with friends, family, or colleagues may help them feel more engaged with the material, especially if not given an immediate opportunity to facilitate.

Second, peer health educators commented on the presence of male professional facilitators, stating that they may have not been the best source for information about women's body image issues. Thus, it may be beneficial to investigate the impact of male professional facilitators in an environment in which women may feel vulnerable discussing sensitive women's issues. In addition, comments from professional facilitators were sometimes seen as distracting rather than helpful (e.g., Celia commenting that professional facilitator comments were "a little over the top"). Therefore, the program may benefit from coaching professional facilitators on what comments are most beneficial or appropriate.

Finally, participant observations and interviews suggested that it may be helpful for The Body Project to provide more of an overview of both the program and its overarching goals at the host institution. Peer health educators commented on being "blindsided" by the requirements of the program (i.e., facilitation requirements, having to run-through the material multiple times during the training, time commitments). More clearly stating both The Body Project and the host institution's goals may require collaboration between the two entities as they make public the reasons why it was brought specifically to the university. This may result in greater peer health educator engagement.

During participant observation, interviews, and my analysis of the data, it became clear that there are several improvements the host institution could make to help The Body Project have a larger impact on both the peer health educators and campus as a whole. First, care should be taken to ensure that the program is properly promoted. That is, participants should know in advance that The Body Project will train them to be peer health educators. Knowing this in advance may ensure that those recruited to participate are able to commit both the time and dedication necessary to facilitate the program to outside groups. In addition, it may be beneficial to include women from a variety of sorority chapters. Doing so not only strengthens relationships within the Panhellenic community but also provides an opportunity for the information to be shared with more chapters in the community.

Second, follow-up meetings should be scheduled shortly after the workshop weekend. During interviews, participants commented that they had not heard from the host institution and were disappointed by this lack of contact. Taking steps to have the peer health educators remain actively involved in The Body Project may increase facilitator retention rates, maintain their excitement for the program, and also ensure that core program information (e.g., how to facilitate it) is not forgotten.

Finally, facilitation opportunities should be identified prior to the peer health educators participating in The Body Project. Doing so may give the facilitators something to look forward to after the training and also ensure that The Body Project gains and maintains momentum on campus. Not having opportunities to facilitate the program soon after the training (e.g., within one month) may result in facilitators' reduced self-esteem, forgetting the material, choosing not to serve as a facilitator at all, especially if a woman was recruited without knowing about the post-workshop facilitation commitment.

This thesis and previous research on The Body Project clearly indicates the benefits of the program. However, this thesis points to specific areas to focus on improvement for the program, especially as it influences those that it relies on to disseminate information—the peer health educators. The section that follows presents limitations of this study and areas for future research.

Limitations and Future Directions

Each study has its limitations and those identified for this study are included here. First, this study examined the memorable messages of only one workshop with a small sample size (N = 11). The small and rather homogeneous sample size limits what generalizations can be made from the data collected. While this study does contribute to memorable message research at large, it is likely other workshops on a different topic, with a different method of instruction, and more diverse participant population would differ and may or may not have greater success. The personal nature of a dissonance-based body-positivity workshop may have influenced what and how participants remember information. Future research would benefit from expanding the sample size and including more diverse ethic/racial origins. Workshops with participants of varying demographics may or may not have similar feelings of community building as an outcome.

Next, it is possible that women felt a greater sense of community after the workshop because they reported seeing the other participants around campus and in other activities not related to The Body Project. This frequent exposure may have influenced how often participants were thinking about the other women in the workshop, potentially thinking more frequently about the sense of community they felt. However, the strong sense of community remained a significant memorable message one month after the workshop for many of the participants,

suggesting that frequent planned follow-up meetings to a workshop may increase the level of support participants feel in pursuing the messages delivered during the workshop.

Additionally, several women in this workshop knew each other before (i.e., only one participant attended the training without having previously met at least one other participant). Previously established relationships (and perhaps pre-existing respect or credibility) may have impacted what was most memorable to participants. Though the accounts shared in this study are those of mostly white women and their bodies, the discourse and practice of self-hate extends to many more demographics and cultures. Concerns for body image differ across races and cultures. The accounts I have included here are not reflective of the experiences of non-white women. Additional research is necessary to determine what approaches might be best to address the quest for identity and how it is concerned with body image in non-white cultures, such as Asian, Hispanic, or African American women.

This study begins to provide insight into what makes messages memorable in a body-positivity workshop. This information may be beneficial for use in health campaigns and health interventions, as we have learned that participants find messages most memorable when they are able to connect them to their daily lives, have personal stakes in the conversation, and identify with the message source. Thus, when writing program curriculum, it may be beneficial to allow time for narrative sharing, a process that can produce the messages that are most memorable and influential to participants. Without the narrative sharing foundation provided in The Body Project, peer health educators would not have been exposed to genuine stories that provided a sense of social support and comradery.

Additionally, future research should examine memorable messaging in a wide variety of workshops. The participants were not able to facilitate the workshop to an outside group during

the one month that passed between workshop and participant interviews. Thus, I was not able to identify how memorable messages translated or were strengthened when the workshop was facilitated to parties unfamiliar with The Body Project content. Therefore, it would be beneficial for future research to investigate how a peer health educator's self-confidence fluctuates because of facilitating the information to an outside group.

Finally, there are several limitations and areas of future research related to the survey instruments used in the data. First, the pre-test survey asked participants to identify how they felt about their body image and self-esteem *today* whereas the post-test survey asked participants to identify how they felt about their bodies *over the past month*. While this choice was initially made to ensure that participants thought about their body image and self-esteem since the workshop, the phrasing of the question may have been confusing and prompted participants to think about various points over the last month, complicating their responses. In the future, I recommend that survey instruments be pre-tested with similar demographic groups to ensure ease of readability and comprehension. In addition, it may have been useful to include a measure of self-efficacy, as opposed to only self-esteem, to more deeply contribute to self-efficacy literature. Self-esteem measures were intentionally chosen because previous research on The Body Project used these measures, but this study provided a strong opportunity to also gauge self-efficacy in relation to peer health education and facilitation opportunities.

The one-month period between The Body Project and the post-test and interviews was intentionally chosen to retain participants and provide more timely results. In addition, previous research on The Body Project follows up with participants in varying time periods ranging from six months to 2-3 years (Stice et al., 2007; Stice et al., 2011). I recommend that future research explore which messages were most memorable, in addition to any changes in body image and

self-esteem, at several different time points after the training.. Specifically, I recommend surveying and interviewing participants immediately following the workshop, again one month later, and once more after the workshop had been facilitated to an outside group. Doing so will provide insight to different results, including which messages were remembered, how body image and self-esteem may have changed after the training, and how facilitating the material may have impacted peer health educators.

Conclusion

The Body Project served the peer health educators in unexpected ways. The women in this study decided to participate because of reasons other than wanting to serve as peer health educators, but emerged as those who felt confident in their ability to positively impact the lives of others. This study contributes to peer health education, health intervention, and memorable message research in several ways. The research presented here demonstrates the necessity for peer health educators to truly embody/*body* the activities in the workshop by co-creating messages and personalizing the space to make it their own. Additionally, this study demonstrates the complicated relationship between dissonance-based interventions, self-esteem, peer health education, and self-efficacy. Regular follow up, access to facilitation opportunities, and the tools necessary to help peer health educators talk about their experiences can prevent unintended consequences, such as diminished self-esteem.

Perhaps the most important contribution of all, however, is this study's ability to continue the conversation about the challenges women face in their collegiate years. Though this study primarily focused on sorority women as the researched demographic, what was learned here can be applied to many other young women as they experience early adulthood. Discussions about body image, feminism, consciousness-raising, social support, and factors that influence self-

esteem are critical for ensuring that young women are able to navigate some of life's biggest steps while maintaining resiliency, confidence, and strong character.

References

Albrecht, T. L., & Goldsmith, D. J. (2008). Social support, social networks, and health. In T. L. Thompson, A. Dorsey, K. I. Miller, & R. Parrott (Eds.), *The Routledge Handbook of Health Communication* (pp. 263-284). Mahwah, NJ: Lawrence Earlbaum Associates.

Amar, A. L., & Gennaro, S. (2005). Dating violence in college women: Associated physical injury, healthcare usage, and mental health symptoms. *Nursing Research,* 235-242.

American College Health Association. (2011). *American College Health Association - National College Health Assessment II: Reference Group Data Report Spring 2011.* Hanover, MD: American College Health Association.

Anderson, J., Bresnahan, M. J., & DeAngelis, B. N. (2014). The impact of personal metaphors and memorable interpersonal communication on body satisfaction. *Qualitative Health Research, 24*(6), 727-737.

Annis, L. F. (1983) The processes and effects of peer tutoring. *Journal of Practical Research & Applications, 2*(1), 39-47.

Arizona State University. (2014, July 25). *Program Effectiveness*. Retrieved from Arizona State University Southwest Interdisciplinary Research Center: http://sirc.asu.edu/keepinitreal/program-effectiveness

Bandura, A. (1972). *Social Learning Theory.* New York, NY: General Learning Press.

Bandura, A. (1977). Self-efficacy: Toward a Unifying Theory of Behavior Change. *Psychological Review, 84*(2), 191-215.

Becker, C., Smith, L. M., & Ciao, A. C. (2005). Reducing eating disorder risk factors in sorority members: A randomized trial. *Behavior Therapy, 36,* 245-253.

Bodie, G. D. (2011). The understudied nature of listening in interpersonal communication: Introduction to a special issue. *The International Journal of Listening, 25*, 1-9.

Bond, C. F. (1982). Social facilitation: A self-presentational view. *Journal of Personality and Social Psychology (42)*6, 1042-1050.

Boud, D., Cohen, R., & Sampson, J. (Eds.). (2014). *Peer learning in higher education: Learning from and with each other.* Routledge.

Brown, W. J., & Basil, M. D. (1995). Media celebrities and public health: Responses to "Magic" Johnson's HIV disclosure and its impact on AIDS risk and high-risk behaviors. *Health Communication, 7*(4), 345-370.

Buller, D. B., Morrill, C., Taren, D., Aickin, M., Sennott-Miller, L., Buller, M. K., . . . Wentzel, T. M. (1999). Randomized trail testing the effect of peer education at increasing fruit and vegetable intake. *Journal of the National Cancer Institute, 91*(17), 1491-1500.

Capone, C., Wood, M., Borsari, B., & Laird, R. (2007). Fraternity and sorority involvement, social influences, and alcohol use among college students: a prospective examination. *Psychology of Addictive Behaviors, 21*(3), 316.

Carlson, B. E., McNutt, L. A., & Choi, D. Y. (2003). Childhood and adult abuse among women in primary health care: Effects on mental health. *Journal of Interpersonal Violence*, 924-341.

Cheney, G., & Ashcraft, K. L. (2007). Considering "the professional" in communication studies: Implications for theory and research within and beyond the boundaries of organizational communication. *Communication Theory, 17*(2), 146-175.

Conley, C. S., Travers, L. V., & Bryant, F. B. (2013). Promoting psychosocial adjustment and stress management in first-year college students: The benefits of engagement in a psychosocial wellness seminar. *Journal of American College Health, 61*(2), 75-86.

Costa, A. C. (2003). Work team trust and effectiveness. *Personnel Revisew, 32*(5), 605-622.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA: Sage Publications.

Damon, W. (1984). Peer education: The untapped potential. *Journal of Applied Development Psychology, 5*(4), 331-334.

Dirks, K. T. (1999). The effects of interpersonal trust on work group performance. *Journal of Applied Psychology, 84*(3), 445-455.

Dittmar, H., & Howard, S. (2004). Thin-ideal internalization and social comparison tendency as moderators of media models' impact on women's body-focused anxiety. *Journal of Social and Clinical Psychology, 23*(6), 768-791.

Douglas, J. (1976). *Investigative social research.* Beverly Hills, CA: Sage.

Drummond, P., Mizan, A., Brocx, K., & Wright, B. (2011). Using peer education to increase sexual health knowledge among West African refugees in Western Australia. *Health Care for Women International, 32*(3), 190-205.

Earp, J., Eng., E., O'Malley, M., Altpeter , M., Rauscher, G., & Mayne, L. (2002). Increasing use of mammography among older, rual African American women: Results from a community trial. *American Journal of Public Health, 92*, 646-654.

Eating Disorders Review. (2010, June). *Sorority rush: Hazardous to body image?* Retrieved from Eating Disorders Review: http://eatingdisordersreview.com/nl/nl_edr_21_3_10.html

Eisenberg, D., Nicklett, E. J., Roeder, K., & Kirz, N. E. (2011). Eating disorder symptoms among college students: Prevalence, persistence, correlation, and treatment-seeking. *Journal of American College Health*, 700-707.

Fisher, W. R. (1984). Narration as a Human Communication Paradigm: The Case of Public Moral Argument. *Communication Monographs, 51*(1), 1-22.

Fox, J., & Bailenson, J. N. (2009). Virtual self-modeling: The effects of vicarious reinforcement and identification on exercise behaviors. *Media Psychology, 12*, 1-25.

Freijy, T., & Kothe, E. J. (2013). Dissonance-based interventions for health behaviour change: A systematic review. *British Journal of Health Psychology, 18*, 310-337.

Garnett, B. R., Buelow, R., Franko, D. L., Becker, C., Rodgers, R. F., & Austin, S. B. (2014). The importance of campaign sailency as a predictor of attitudes and behavior change: A pilot evaluation of social marketing campaign Fat Talk Free Week. *Health Communication, 29*, 984-995.

Glaser, B. G. (1965). The Constant Comparative Method of Qualitative Analysis. *Social Problems*, 436-445.

Goldman, L. (2010, March 10). *Kappa kappa skinny: Do sororites encourage eating disorders?* Retrieved from iVillage: http://www.ivillage.com/kappa-kappa-skinny-do-sororities-encourage-eating-disorders/4-a-122790

Gollust, S. E., Eisenberg, D., & Goldberstein, E. (2008). Prevalence and correlates of self-injust among university students. *Journal of American College Health*, 491-498.

Green, M. (2006). Narratives and cancer communication. *Journal of Communication, 56*, 163-183.

Green, M., Brock, T., & Kaufman, G. (2004). Understanding media enjoyment: The role of transportation into narrative worlds. *Communication Theory, 14*, 311-327.

Gregory, A., Walker, I., Mclaughlin, K., & Peets, A. D. (2011). Both preparing to teach and teaching positively impact learning outcomes for peer teachers. *Medical Teacher, 33*(8), e417-e422.

Helm, C., Knipmeyer, C., & Martin, M. (1972). Health aides: Student involvement in a universiy health center program. *Journal of American College Health, 20*(4), 248-251.

Holladay, S. (2002). "Have fun while you can," "You're only as old as you feel," and "Don't ever get old!": An examination of memorable messages about aging. *Journal of Communication, 52,* 681-697

Holladay, S., & Coombs, W. (1991). *"There are plenty of fish in the sea": An exploratory investigation of the exchange of memorable messages about dating.* Atlanta, Georgia: Paper presented at the annual conference of the Speech Communication Association.

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health,* 3-10.

Jennings, J., Howard, S., & Perotte, C. (2014). Effects of a school-based sexuality education program on peer educators: the Teen PEP model. *Health Education Research, 29*(2), 319-329.

Jorgensen, D. L. (1989). *Participant observation: A methodology for human studies.* Thousand Oaks, CA: SAGE Publications.

Keeley, M. P. (2004). Final conversations: Survivors' memorable messages concerning religious faith and spirituality. *Health Communication, 16*(1), 87-104.

Keenan, J. M., MacWhinney, B., & Mayhew, D. (1977). Pragmatics in memory: A study of natural conversation. *Journal of Verbal Learning and Verbal Behavior, 16,* 549-560.

Kim, H. S., Bigman, C. A., Leader, A. E., Lerman, C., & Capella, J. N. (2012). Narrative health communication and behavior change: The influence of exemplars in the news on intention to quit smoking. *Journal of Communication, 62*(3), 473-492.

Klein, N. A., & Sondag, K. A. (1994). Understanding volunteer peer health educators' motivations: Applying social learning theory. *Journal of American College Health, 43*(3).

Knapp, M. L., Stohl, C., & Reardon, K. K. (1981). "Memorable" messages. *Journal of Communication, 31,* 27-41.

Kranstuber, H., Carr, K., & Hosek, A. M. (2012). "If you can dream it, you can achieve it." Parent memorable messages as indcators of college student success. *Communication Education, 61*(1), 44-66.

Lane, J., Lane, A. M., & Kyprianou, A. (2004). Self-efficacy, self-esteem, and their impact on academic performance. *Social Behavior and Personality, 32*(3), 247-256.

Larimer, M., Turner, A., Mallett, K., & Geisner, I. (2004). Predicting drinking behavior and alcohol-related problems among fraternity and sorority members: examining the role of descriptive and injunctive norms. *Psychology of Addictive Behaviors, 19*(3), 203.

Larkey, L., & Hecht, M. (2010). A model of effects of narrative as culture-centric health promotion. *Journal of Health Communication, 15*(2), 114-135.

Latta, M. M., & Buck, G. (2008). Enfleshing emboiment: 'Falling into trust' with the body's role in teaching and learning. *Educational Philosophy and Theory, 40*(2), 315-329.

Levine, M., & Smolak, L. (2004). Body image development in adolescence. In T. Cash, & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 74-82). New York, NY: Guilford Press.

Lindlof, T. R., & Taylor, B. C. (2002). *Qualitative communication research methods -- 2nd ed.* Thousand Oaks, CA: Sage.

Lockwood, P., & Wohl, R. (2012). The impact of a 15-week lifetime wellness course on behavior change and self-efficacy in college students. *College Student Journal, 46*(3), 628-641.

Mackenzie, S., Weigel, J., Mundt, M., Brown, D., Saewyc, E., & Heidligenstein, E. (2011). Depression and suicide ideation among students accessing campus health care. *American Journal of Orthopsychiatry, 81*(1), 101-107.

Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation, 10*(2), 29-37.

Mellanby, A., Rees, J., & Tripp, J. (2000). Peer-led and adult-led school health education: A critical review of available comparative research. *Health Education Research, 15*(5), 533-545.

National Eating Disorders Association. (2006). *National Eating Disorders Association announces results of eating disorders poll on college campuses across the nation*. Retrieved from National Eating Disorders Association: http://findarticles.com/p/articles/mi pwwi/is /ai n16742451.

National Panhellenic Conference. (2014, July 29). *Annual Reports 20122013*. Retrieved from NPCwomen.org: https://www.npcwomen.org/resources/pdf/2013%20Annual%20Report%20Final.pdf

Nichter, M., & Vuckovic, N. (1994). Fat Talk. In N. Sault (Ed.), *Many mirrors: Body image and social relations* (pp. 109-132). New Brunswick, NJ: Rutgers University Press.

Neff, K. D. (2011). Self-compassion, self-esteem, and well-being. *Social and Personality Psychology Compass, 5*(1), 1-12).

Philis-Tsimikas, A., Walker, A., Rivard, L., Talavera, G., Reimann, J., Salmon, M., & Araujo, R. (2004). Improvement in diabeties care of underinsured patients enrolled in Project Dulce: A community-based, culturally appropriate, nurse case management and peer education diabetes care model. *Diabetes Care, 27*(1), 110-115.

Rambusch, J., & Ziemke, T. (2005). The role of embodiment in situated learning. *Conference of the Cognitive Science Society,* (pp. 1803-1808).

Reno, J. E., & McNamee, L. G. (2014). Do sororites promote members' health? A study of memorable messages regarding weight and appearance. *Health Communication,* 1-13.

Rimer, B., & Glassman, B. (1984). How do persuasive health messages work? A health education field study. *Health Education & Behavior, 11*(3), 313-321.

Rimer, B., & Kreuter, M. (2006). Advancing tailored health communication: A persuasion & message effects perspective. *Journal of Communication, 56,* 184-201.

Rolnik, A. M., Englen-Maddox, R., & Miller, S. A. (2010). Here's looking at you: Self-objectification, body image disturbance, and sorority rush. *Sex Roles, 63*(1-2), 6-17.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Schulken, E., Pinciaro, P., Sawyer, R., Jensen, J., & Hoban, M. (1997). Sorority women's body size perceptions and their weight-related attitudes and behaviors. *Journal of American College Health, 46*(2), 69-74.

Shapiro, D., Dundar, A., Ziskin, M., Yuan, X., & Harrell, A. (2013). *Completing college: A national view of student attainment rates - fall 2007 cohort.* Herndon, VA: National Student Clearinghouse Research Center. Retrieved from http://nscresearchcenter.org/signaturereport6/

Shiner, M. (1999). Defining peer education. *Journal of Adolescence, 22,* 555-566.

Sloane, B., & Zimmer, C. (1993). The power of peer health education. *Journal of American College Health, 41*, 241-245.

Smith, S. W., Nazione, S., Laplante, C., Kotowski, M. R., Atkin, C., Skubisz, C. M., & Stohl, C. (2009). Topics and sources of memorable breast cancer messages and their impact on prevention and detection behaviors. *Journal of Health Communication*(14), 293-307.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.

Sonenshein, S., DeCelles, K. A., & Dutton, J. E. (2014). It's not easy being green: The role of self-evaluations in explanining support of environmental issues. *Academy of Management Journal, 57*(1), 7-37.

Springston, J. (2005). Public health campaign. In R. Heath (Ed.), *Encyclopedia of Public Relations* (pp. 670-674). Thousand Oaks, CA: SAGE Publications.

Steimel, S. (2013). Memorable messages and volunteer identification. *Communication ResearchReports, 30*(1), 12-21.

Stice, E., & Shaw, H. (2002). Role of body dissatisfaction in the onset and maintenance of eating pathology: A synthesis of research findings. *Journal of Psychosomatic Research, 53*, 985-993.

Stice, E., Chase, A., Stomer, S., & Appel, A. (2001). A randomized trial of dissonance-based eating disorder prevention program. *International Journal of Eating Disorders, 29*, 247-262.

Stice, E., Fisher, M., & Martinez, E. (2004). Eating disorder diagnostic scale: Additional evidence of reliability and validity. *Psychological Assessment, 16*(1), 60.

Stice, E., Mazotti, L., Weibel, D., & Agras, W. (2000). Dissonance prevention program decreases thin-ideal internalization, body dissatisfaction, dieting, negative affect, and bulimic symptoms: A preliminary experiment. *International Journal of Eating Disorders, 27*, 206-217.

Stice, E., Presnell, K., Gau, J., & Shaw, H. (2007). Testing mediators of intervention effects in randomized controlled trials: An evaluation of two eating disorder prevention programs. *Journal of Consulting Clinical Psychology, 75*(1), 20-32.

Stice, E., Rhode, P., Durant, S., Shaw, H., & Wade, E. (2013). Effectiveness of peer-led dissonance-based eating disorder prevention groups: results from two randomized pilot trials. *Behaviour Research and Therapy, 51*(4), 197-206.

Stice, E., Rohde, P., Shaw, H., & Gau, J. (2011). An effectiveness trial of a selected dissonance-based eating disorder prevention program for female high school students: Long-term effects. *Journal for Consulting and Clinical Psychology, 79*(4), 500.

Stice, E., Shaw, H., & Rohde, P. (n.d.). *Body Acceptance Class Manual.* Retrieved from BodyProjectSupport.org: http://www.bodyprojectsupport.org/assets/pdf/materials/bp_4sess_script_handouts.pdf

Stice, E., Shaw, H., Becker, C. B., & Rhode, P. (2008). Dissonance-based interventions for the prevention of eating disorders: Using persuasion principles to promote health. *Prevention Science, 9*(2), 114-128.

Stice, E., Shaw, H., Burton, E., & Wade, E. (2006). Dissonance and healthy weight eating disorder prevention programs: A randomized efficacy trial. *Journal of Consulting and Clinical Psychology, 74*, 263.

Stice, E., Trost, A., & Chase, A. (2003). Healthy weight control and dissonance-based eating disorder prevention programs: Results from a controlled trial. *International Journal of Eating Disorders, 33*(1), 10-21.

Stohl, C. (1986). The role of memorable messages in the process of organizational socialization. *Communication Quarterly, 34*, 231-249.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CS: SAGE Publications.

Tedlock, B. (2003). Ethnography and ethnographic representation. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 165-213). Thousand Oaks, CA: SAGE Publications.

The Body Project Collaborative. (2014, July 28). *Body Project Collaborative Background*. Retrieved from TheBodyProjectCollaborative.com: http://www.bodyprojectcollaborative.com/

Theodorakis, Y., Weinberg, R., Natsis, P., Douma, I., & Kazakas, P. (2000). The effects of motivational and instructional self-talk on improving motor performance. *The Sport Psychologist, 14*, 253-271.

Turner, G., & Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion. *Health Education Research, 14*(2), 235-247.

Wagner, L. (1982). *Peer teaching: Historical perspectives.* Westport, CT: Greenwood.

Wechsler, H., Nelson, T. F., Lee, J. E., Seibring, M., Lewis, C., & Keeling, R. P. (2003). Perception and reality: A national evaluation of social norms marketing interventions to reduce college students' heavy alcohol use. *Journal of Studies on Alcohol and Drugs*, 484-494.

Weiner, B. (1986). *An attributional theory of motivation and emotion.* New York, NY: Springer Science & Business Media.

Weitzman, E. R. (2004). Poor mental health, depression, and associations with alcohol consumption, harm, and abuse in a national sample of young adults in college. *Journal of Nervous & Mental Disease*, 269-277.

Welch, S. L., & Fairburn, C. (1994). Sexual abuse and bulimia nervosa: Three integrated case control comparisons. *American Journal of Psychiatry, 151*, 402-408.

White, S. (1994). An overview of a peer health education program at a student health service. *Peer Facilitator Quarterly*, 24-28.

White, S., Park, Y. S., Israel, T., & Cordero, E. D. (2009). Longitudinal evaluation of peer health education on a college campus: Impact on health behaviors. *Journal of American College Health*, 497-506.

Wiist, W. H., & Snider, G. (1991). Peer education in friendship cliques: Prevention of adolescent smoking. *Health Education Research, 6*(1), 101-108.

Wiist, W. H., Jackson, R. H., & Jackson, K. W. (1995). Peer and community education to prevent youth violence. *American Journal of Preventative Medicine, 12*(5 Suppl), 56-64.

Williams, A. (2006, April 2). *Before spring break, the anorexic challenge*. Retrieved from The New York Times: http://www.nytimes.com/2006/04/02/fashion/sundaystyles/02BREAK.html?pagewanted=all&_r=0

Williams, E. A., & Connaughton, S. L. (2012). Expressions of identifications: The nature of talk and identity tensions among organizational members in a struggling organization. *Communication Studies, 63*(4), 457-481.

Wilson, W., & Pratt, C. (1987). The impact of diabetes education and peer support upon weight and glycemic control of elderly persons with noninsulin dependent diabetes mellitus (NIDDM). *American Journal of Public Health, 77*(5), 634-635.

World Health Organization. (2008). *Global burden of disease: 2004 update*. Geneva: World Health Organization.

Appendix A: Letter Confirming Participation
Office of Fraternity and Sorority Life, Colorado State University

Hi Shana!

Thank you for your email, and for your patience as we work on this.

We were just able to confirm the program dates for the training, which will be October 4th and 5th. In addition, our contact with the Body Project is more than happy to work with you on your research. He recommended reaching out directly to him to share more about what you are interested in doing, and then he would work with you on getting the materials for an expedited IRB protocol, as well as provided any necessary advice.

Here is a little information Alan shared with us about the program:

The Body Project is a dissonance-based body-acceptance program designed to help high school girls and college-age women resist cultural pressures to conform to the thin-ideal standard of female beauty and reduce their pursuit of unhealthy thinness. The Body Project is supported by more research than any other body image program and has been found to reduce onset of eating disorders. The Body Project has been implemented on over 100 campuses in North America (both under The Body Project brand and under a different name, Reflections: Body Image Program). You can learn more about The Body Project Collaborative at the following website: http://www. bodyprojectcollaborative. com. One of several preferred methods for implementing The Body Project on college campuses is utilizing trained undergraduate peer leaders. The Body Project Collaborative offers two day trainings for up to 8 campus professionals and 16 student trainees to begin implementation of the program. The training also provides full details and advice for implementation of the program on your campus. Normally, the cost of a two-day campus training is $2,500 plus the trainer's major travel expenses. ***Eating Recovery Center is offering your campus the chance to receive a grant that covers 90% of the training fee for the two-day training.*** *This grant means your campus can receive a two-day The Body Project training for just $250! Since I am located in Colorado, we will also waive any minimal travel expenses! Eating Recovery Center is committed to giving back to the communities we serve and to supporting the full spectrum of body image and eating disorders intervention, from prevention to treatment of the most complicated eating disorder diagnoses. Together, Eating Recovery Center and The Body Project Collaborative are committed to dissemination of The Body Project to as many young women as possible at minimal cost.*

Our contacts name is Alan Duffy and his email address is aduffy@eatingrecoverycenter. com. He will be expecting an email from you.

If there is anything else we can do right now, just let us know!

Thanks

Amy

Alan Duffy –The Body Project

I, Alan Duffy, give permission to researcher Shana Makos to survey, interview, and observe participants during Colorado State University's Body Project training on October 4-5, 2014.

Electronically signed on 09/23/2014,

Alan Duffy

Alan Duffy, MS

Case Manager

Partial Hospitalization Program

Eating Recovery Center

Outreach and Training Coordinator / Trainer

The Body Project Collaborative

Phone: 303-731-8914

Fax: 303-366-3082

Appendix B: Codebook

Variable Name	Description	Value Coding
Residence	Please indicate your current residence	1 = Sorority housing 2 = On-Campus (non-sorority housing) 3 = Off-Campus
Year	Please indicate your year in school	1 = Freshman 2 = Sophomore 3 = Junior 4 = Senior
Officer	Are you currently serving as an officer in your sorority?	1 = Yes 2 = No
PRE-TEST: *Ideal Body Stereotype Scale – revised / Stice, Fisher, & Martinez (2004)*		
SlenderA	***Please answer the questions below regarding your thoughts and behaviors today.*** Slender women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
ShapeA	Women who are in shape are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
TallA	Tall women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
TonedA	Women with toned (lean) bodies are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
ShapelyA	Shapely women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
LLegsA	Women with long legs are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree

		5 = Strongly agree
WeightA	***Today, how satisfied are you with your…?*** Weight	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
FigureA	Figure	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
StomachA	Appearance of stomach	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
BuildA	Body build	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
WaistA	Waist	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
ThighsA	Thighs	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
ButtA	Buttocks	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
HipsA	Hips	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
LegsA	Legs	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied

FatA	***Please respond to the following questions considering how you feel today:*** Have you felt fat?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
FearFatA	Have you had a definite fear that you might gain weight or become fat?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
WeightJudgeA	Has your weight influenced how you think about (judge) yourself as a person?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
ShapeJudgeA	Has your shape influenced how you think about (judge) yourself as a person?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
PRE-TEST: *Rosenberg Self-Esteem Scale / Rosenberg, 1965*		
SatisfiedA	***Please indicate how strongly you agree or disagree with each statement.***	4 = Strongly agree 3 = Agree 2 = Disagree

	On the whole, I am satisfied with myself.	1 = Strongly disagree
NoGoodA **REVERSE CODED**	At times, I think I am no good at all.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
QualitiesA	I feel that I have a number of good qualities.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
DoThingsA	I am able to do things as well as most other people.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
ProudA **REVERSE CODED**	I feel I do not have much to be proud of.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
UselessA **REVERSE CODED**	I certainly feel useless at times.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
WorthA	I feel that I'm a person of worth, or at least on an equal plane with others.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
RespectA	I wish I could have more	4 = Strongly agree

REVERSE CODED	respect for myself.	3 = Agree 2 = Disagree 1 = Strongly disagree
FailureA **REVERSE CODED**	All in all, I am inclined to feel that I am a failure.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
PositiveA	I take a positive attitude toward myself.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
POST-TEST: *Ideal Body Stereotype Scale – revised / Stice, Fisher, & Martinez (2004)*		
SlenderB	***Please answer the questions below regarding your thoughts and behaviors over the past month.*** Slender women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
ShapeB	Women who are in shape are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree

TallB	Tall women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
TonedB	Women with toned (lean) bodies are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
ShapelyB	Shapely women are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
LLegsB	Women with long legs are more attractive	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree
WeightB	***Over the past month, how satisfied have you been with your…?*** Weight	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied

		5 = Extremely satisfied
FigureB	Figure	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
StomachB	Appearance of stomach	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
BuildB	Body build	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
WaistB	Waist	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
ThighsB	Thighs	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral

		4 = Satisfied 5 = Extremely satisfied
ButtB	Buttocks	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
HipsB	Hips	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
LegsB	Legs	1 = Extremely dissatisfied 2 = Dissatisfied 3 = Neutral 4 = Satisfied 5 = Extremely satisfied
FatB	***Please respond to the following questions considering how you have felt over the past month:*** Have you felt fat?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all

		6 = Not at all
FearFatB	Have you had a definite fear that you might gain weight or become fat?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
WeightJudgeB	Has your weight influenced how you think about (judge) yourself as a person?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly 5 = between slightly & not at all 6 = Not at all
ShapeJudgeB	Has your shape influenced how you think about (judge) yourself as a person?	0 = Extremely 1 = between extreme & moderately 2 = Moderately 3 = between moderately & slightly 4 = Slightly

		5 = between slightly & not at all 6 = Not at all
POST-TEST: *Rosenberg Self-Esteem Scale / Rosenberg, 1965*		
SatisfiedB	***Please indicate how strongly you agree or disagree with each statement.*** On the whole, I am satisfied with myself.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
NoGoodB **REVERSE CODED**	At times, I think I am no good at all.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
QualitiesB	I feel that I have a number of good qualities.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
DoThingsB	I am able to do things as well as most other people.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
ProudB **REVERSE CODED**	I feel I do not have much to be proud of.	4 = Strongly agree 3 = Agree

		2 = Disagree 1 = Strongly disagree
UselessB	I certainly feel useless at times.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
WorthB	I feel that I'm a person of worth, or at least on an equal plane with others.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
RespectB **REVERSE CODED**	I wish I could have more respect for myself.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
FailureB **REVERSE CODED**	All in all, I am inclined to feel that I am a failure.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
PositiveB	I take a positive attitude toward myself.	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree

Appendix C: Pre-Test Survey Questions

ID: (last four digits of your telephone number and day of birth – e.g., 7058-06) _____

Age: _____

What is your ethnic origin?

American Indian/Alaskan Native
Hispanic
Asian/Pacific Islander
White (non-Hispanic)
Black (non-Hispanic)
Other

Please indicate your current residence:

Sorority housing
On-Campus (non-sorority housing)
Off-Campus

Year in school:

Freshman
Sophomore
Junior
Senior

Major: _____

What semester and year were you initiated into your sorority? (e. g. Fall 2010) _____

Are you currently serving as an officer in your sorority? If yes, please describe: _____

Please answer the questions below regarding your thoughts and behaviors **today**.

Ideal Body Stereotype Scale – revised / Stice, Fisher, & Martinez (2004)

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Slender women are more attractive	1	2	3	4	5
Women who are in shape are more attractive	1	2	3	4	5
Tall women are more attractive	1	2	3	4	5
Women with toned (lean) bodies are more attractive	1	2	3	4	5
Shapely women are more attractive	1	2	3	4	5
Women with long legs are more attractive	1	2	3	4	5

Today, how satisfied are you with your:

	Extremely dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely satisfied
Weight	1	2	3	4	5
Figure	1	2	3	4	5
Appearance of stomach	1	2	3	4	5
Body build	1	2	3	4	5
Waist	1	2	3	4	5
Thighs	1	2	3	4	5
Buttocks	1	2	3	4	5
Hips	1	2	3	4	5
Legs	1	2	3	4	5

Please respond to the following questions considering how you feel **today**:

	Extremely		Moderately		Slightly		Not at all
Have you felt fat?	0	1	2	3	4	5	6
Have you had a definite fear that you might gain weight or become fat?	0	1	2	3	4	5	6
Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6

Rosenberg Self-Esteem Scale / Rosenberg, 1965

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself.	4	3	2	1
At times, I think I am no good at all.	4	3	2	1
I feel that I have a number of good qualities.	4	3	2	1
I am able to do things as well as most other people.	4	3	2	1
I feel I do not have much to be proud of.	4	3	2	1
I certainly feel useless at times.	4	3	2	1
I feel that I'm a person of worth, or at least on an equal plane with others.	4	3	2	1
I wish I could have more respect for myself.	4	3	2	1
All in all, I am inclined to feel that I am a failure.	4	3	2	1
I take a positive attitude toward myself.	4	3	2	1

Appendix D: Post-Test Survey Questions

ID: (last four digits of your telephone number and day of birth – e.g., 7058-06) _____

Please answer the questions below regarding your thoughts and behaviors **over the past month**.

Ideal Body Stereotype Scale – revised / Stice, Fisher, & Martinez (2004)

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Slender women are more attractive	1	2	3	4	5
Women who are in shape are more attractive	1	2	3	4	5
Tall women are more attractive	1	2	3	4	5
Women with toned (lean) bodies are more attractive	1	2	3	4	5
Shapely women are more attractive	1	2	3	4	5
Women with long legs are more attractive	1	2	3	4	5

Over the past month, how satisfied were you with your:

	Extremely dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely satisfied
Weight	1	2	3	4	5
Figure	1	2	3	4	5
Appearance of stomach	1	2	3	4	5
Body build	1	2	3	4	5
Waist	1	2	3	4	5
Thighs	1	2	3	4	5
Buttocks	1	2	3	4	5
Hips	1	2	3	4	5
Legs	1	2	3	4	5

Please respond to the following questions considering how you felt over **past month.**

Over the past month…

	Extremely		Moderately		Slightly		Not at all
Have you felt fat?	0	1	2	3	4	5	6
Have you had a definite fear that you might gain weight or become fat?	0	1	2	3	4	5	6
Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6

Rosenberg Self-Esteem Scale / Rosenberg, 1965

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself.	4	3	2	1
At times, I think I am no good at all.	4	3	2	1
I feel that I have a number of good qualities.	4	3	2	1
I am able to do things as well as most other people.	4	3	2	1
I feel I do not have much to be proud of.	4	3	2	1
I certainly feel useless at times.	4	3	2	1
I feel that I'm a person of worth, or at least on an equal plane with others.	4	3	2	1
I wish I could have more respect for myself.	4	3	2	1
All in all, I am inclined to feel that I am a failure.	4	3	2	1
I take a positive attitude toward myself.	4	3	2	1

Appendix E: Verbal Recruitment Script

Hello and congratulations on being selected as a representative from your sorority to participate in The Body Project. My name is Shana Makos and I am a graduate student and researcher from Colorado State University in the Department of Communication Studies. I am also an alumna member of the Gamma Phi Beta Sorority and an active volunteer. I don't volunteer with the Gamma Phi Beta chapter here, but I do volunteer for the organization internationally.

I am here today because conducting a research study on peer health education and sorority women's body image. This research is separate from The Body Project and is in no way affiliated. I am doing this under the guidance of my advisor, Dr. Elizabeth Williams.

For the next two days, I will be observing this workshop from the back of the room. I'll be taking notes, but everything everyone shares will be kept private and anonymous. My observation is strictly for research purposes only.

There are three components of this study that relate directly to you. First, I would like you to complete a survey before the training workshop gets started that should take you no longer than 10 minutes. Second, I will send you an email approximately three weeks after this workshop that contains an electronic survey that should again take you no longer than 10 minutes. Lastly, I would like to conduct a one-hour one-on-one interview with each of you approximately one month from today. An interview sign-up sheet is located at the front of the room and I will pass it around during our first break. Interviews will take place Monday – Friday, 9 am – 8 pm from November 3-14, 2014.

Your participation in this research is voluntary and anonymous. When I report and share the data with others, I will combine the data from all participants. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

I hope to gain more knowledge on how to improve these types of peer health education training workshops so you can benefit as much from them as possible.

All of my contact information is provided on the sheet you received upon entering the workshop. I am happy to answer any questions you may have. Thank you for your time.

Appendix F: Participant Handout

The Body Project Training – Research Project

Congratulations on being selected as a representative from your sorority to participate in The Body Project!

My name is Shana Makos and I am conducting a study on peer health education and sorority women's body image. This research is not in conjunction with The Body Project, but instead an activity outside of The Body Project.

As a participant in this research, you will be asked to:

- Complete a 10 minute survey the first day of The Body Project training
- Complete a 10 minute follow-up survey approximately one month after completing The Body Project training. This will be sent via email.
- Complete an interview (60 minutes or less in length) approximately one month after completing The Body Project training. Please complete the follow-up survey prior to attending the interview.

Your follow-up interview date and time are: _____

Please write your interview information in a place where you will remember it!

Researcher contact information:
Shana Makos
Department of Communication, Colorado State University
Cell: (760) 408-7058
Email: smakos@rams.colostate.edu

If you have questions about your rights as a volunteer in this research, contact the CSU IRB at: RICRO_IRB@mail.colostate.edu or (970) 491-1553.

Appendix G: Post-Test Survey Email Script

Hello [insert participant name here],

I hope this email finds you well! I enjoyed meeting you during your training for The Body Project. Thank you again for your participation in this research concerning peer health education and sorority women's body image. This email includes information with next steps, including the follow-up survey link and interview information.

The follow-up survey can be found here: [insert survey link]. Please complete the survey ***before*** you arrive at your interview. The survey should take you no longer than 10 minutes.

Your interview is on [date] at [time] and will be held in room [building and room number] on CSU's campus.

Please do your best to arrive on time. During the interview, I will ask you about what you remember most from The Body Project training. You do not need to bring anything with you to the interview other than yourself. Our conversation will be relaxed and will last no longer than 60 minutes.

Please contact me with any questions. I will see you next week!

All my best,
Shana

Shana Makos
Department of Communication Studies, Colorado State University
Cell: (760) 408-7058
Email: smakos@rams.colostate.edu

Appendix H: Semi-Structured Interview Questions

Peer Health Education

- Why did you decide to apply for The Body Project training?
- What specific experiences in your life motivated you to become a peer health educator?
- Have you facilitated the training to an outside group yet? If so, which group? What was that experience like?

Memorable Messages

A memorable message is defined as "a piece of advice" or "some words of wisdom" (Stohl, 1986).

- What single message during the training was the most memorable to you? Why?
- Who did you receive the message from? Please indicate whether it was the (a) Body Project facilitator, (b) another participant, (c) another participant with which you had a substantial previous relationship – substantial defined as having more than one conversation and would greet when seen outside of class – and (d) other.
- Other than the most memorable message you just disclosed, what other messages were memorable to you and why?
- Which of the messages you just shared with me have you shared with someone else? Who did you share it with?
- How did your previous personal experiences play a role in your participation in the training?
- What messages would you take (or have you taken) from the training and share with a group you might facilitate this with?
- What important information have you learned from the other participants in the workshop about your body?
- Is there one instance or experience that stands out to you during the last month related to how you feel or what you think about your body?

Health Interventions

- What impact did the workshop have on you personally?
- What role did that information play after you completed the workshop?