

BODY IMAGE AND EATING DISTRESS IN A CULTURE UNDERGOING
RAPID SOCIO-CULTURAL TRANSITION:
THE CASE OF URBAN BULGARIAN WOMEN

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by

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BODY IMAGE AND EATING DISTRESS IN A CULTURE UNDERGOING
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In Bulgaria—a former Eastern Bloc state rapidly transitioning to democracy—the incidence of eating disorders seems to be on the rise. The emergence of eating disorders in transitional cultures is often seen as a reaction to the spread of the Western thinness-obsessed culture—a culture-reactive behavior. However not all women with disordered eating are motivated by a desire for thinness; rather, motivations for dietary restraint may be culture-specific. Culture-reactive and culture-specific factors affecting restrictive dietary behaviors were explored in a population recently exposed to the Western thin ideal.

A survey sample of 205 women ages 18-81 in Sofia, Bulgaria, concerning their Western media consumption, adoption of the thin-beauty ideal, body image dissatisfaction, engagement in dietary restraint behaviors (dieting and fasting), and having faith, defined as not being either atheist or agnostic. CART analysis was used to uncover factors influencing dietary restraint. Grounded theory was used to analyze interviews with 13 women to deepen the understanding of fasting behavior.

Disordered eating (EAT-40) scores predicted thin-ideal awareness and internalization, and dietary restraint (all $p < 0.05$), but not body dissatisfaction. Women

with higher body dissatisfaction exhibited higher dietary restraint ($p < 0.05$). Exposure to Western media was weakly related to awareness and internalization, suggesting that the media influence was filtered through local cultural norms. Dietary restraint—dieting and/or fasting—correlated positively with faith ($p < 0.05$). Qualitative analyses showed that fasting was linked to an overwhelming desire to attain physical purity and health. Weight control was seen only as a consequence of bodily purification.

In sum, Western media influences explain some, but not all, body image and eating problems in this sample. Faith seemed to affect dietary restraint via a culture-specific pathway. Fasting was universally accepted as a healthy and morally superior dietary behavior when compared to regular dieting. Fasting is a form of dietary restraint that differs from regular dieting only in its motivation. If taken to an extreme, fasting may present with the clinical consequences of a Western style eating disorder. This idea requires further investigation: if corroborated, it could have implications for the way eating pathology is diagnosed, treated, or prevented in Bulgarian populations.

BIOGRAPHICAL SKETCH

Rosa Angelova was born on November 24, 1980 in Sofia, Bulgaria. Majoring in biology and chemistry, she graduated at the top of her class from the “Georgy S. Rakovski” Sofia Secondary School No. 22 in May 1998.

After scoring highest on the entrance exam, she was accepted into the Ecology and Environmental Protection program at the Biological Faculty of Sofia University “St. Kliment Ohridski,” where she enrolled in October 1998. She graduated from Sofia University “St. Kliment Ohridski” with a B. S. and M. S. in ecology and environmental protection in 2002 and 2004, respectively. After winning a green card in the United States Department of State’s Diversity Immigrant Visa (DV) program (i.e., Visa Lottery), she came to the United States in March 2003, and worked as an environmental consultant in the San Francisco Bay Area. In August 2006, she entered Cornell University as a PhD candidate in the Department of Nutritional Sciences. Her concentration is Human Nutrition, with minors in Community Nutrition and Human Development. During her time at Cornell University she gained invaluable experience as a researcher, scientist and teaching assistant, has presented aspects of her research at national conferences, and formed close working relationships with her classmates and professors. In March 2009 she became an American citizen.

Upon graduation she hopes to continue working in areas related to her research, specializing in nutrition-related disease prevention and promoting a healthy body image in young women (and men) in Bulgaria and elsewhere.

From a Chicken to a Bear!

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CHAPTER 1

GENERAL INTRODUCTION

1.1. STATEMENT OF PROBLEM

Over the past two decades, Bulgaria has been going through a major transition from authoritarian communist rule with a planned economy to democratic governance and a free-market economy. This transition has often been hard on the Bulgarian population, bringing with it political and economic instability. Anecdotal reports claim that the transition was also accompanied by notable incidence of eating disorders, especially among young women (Kerekovska, 2006). Bulgaria has had difficulties tackling this problem. During communist rule, the existence of eating disorders was ignored or denied for ideological reasons (Boyadjieva & Steinhausen, 1996) and consequently the country was ill-prepared to deal with the phenomenon when it became manifest and, as some clinicians suggest, aggravated after communism's fall (Boyadjieva, 2008; Kerekovska, 2006). To date there is an absence of a coherent national strategy or central institution for combating eating disorders, while lack of funding and dearth of expertise have hampered treatment efforts and largely prevented in depth studies dealing with the issue from being undertaken (Kerekovska, 2006). To the best of my knowledge, little research has been done on the subject of body image and disordered eating anywhere in the post-communist Balkans.

In other regions, the rise of eating disorders in countries in transition has often been associated with Westernization and modernization, and the adoption of Western beauty ideals (Gordon, 2001). Bulgaria too has been undergoing the processes of Westernization and modernization, e.g. via the influx of Western media, but, as I intend to show, Bulgaria's case is unique due to its distinctive cultural and religious traditions, and calls for a separate investigation. It is valuable to learn to what extent Bulgarians have internalized the Western beauty ideal and how this might have impacted their eating behavior, as well as how that impact is influenced by local

socio-cultural norms—a process known as the “glocalization” of disordered eating attitudes and behaviors (Ritzer, 2003). Answering these questions could help in formulating hypotheses for future studies and in the development of culturally relevant and therefore more effective approaches to treating and preventing eating disorders in the Bulgarian population. The issue has been garnering more attention in recent years, and the number of Bulgarian specialists and organizations focusing on eating disorders has purportedly grown (Boyadjieva, 2008). There is thus a greater chance for novel findings on the subject to be used by practitioners and other potential researchers, making the time ripe, so to speak, to conduct this study.

1.2. OVERALL PURPOSE OF THIS RESEARCH

The primary purpose of this dissertation research was to explore the ways in which external forces of Westernization (via media) and local socio-cultural factors (faith and fasting) interact with each other to affect body image and eating disturbances in a sample of urban Bulgarian women. Specifically, this research addressed the following questions:

1.2.1. RESEARCH QUESTIONS

- A. Role of Westernization on body image and eating distress (culture-reactive idioms of distress):
 - Do Bulgarian women desire thinness and act on that desire?
 - Are Bulgarian women disordered eaters?
 - Does a socio-cultural model for body dissatisfaction and disordered eating based on Western media’s thin images apply to the Bulgarian context?
- B. Role of local cultural factors on body image and eating distress (culture-specific idioms of distress):
 - What is the role of faith and fasting in the schema of body dissatisfaction and disordered eating among Bulgarian women?
 - How do Bulgarian women define, view, and explain fasting behavior?

1.2.2. CONCEPTUAL FRAMEWORK

The core concepts addressed by the above research questions can be organized in the following framework. This conceptual framework has been informed by a review of the existing literature, as well as by findings from data analyses.

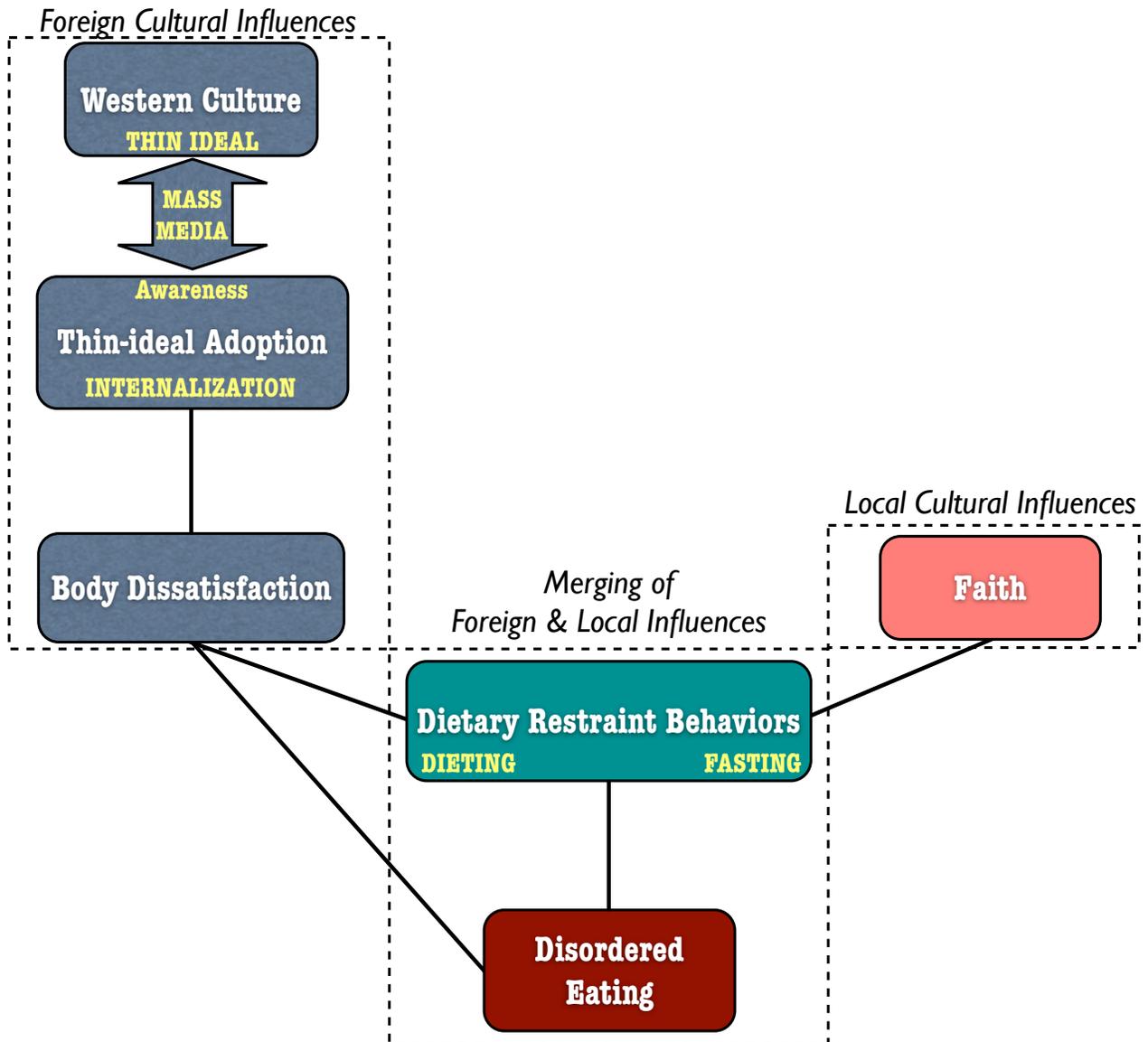


Figure 1.1. Conceptual framework for the overall dissertation study.

1.3. ORGANIZATION OF THIS DISSERTATION

This Dissertation is organized as follows:

In Chapter 2, I briefly introduce to Bulgaria, the location for the current research, and provide an overview of the country's historical, geographic, political, economic, and socio-demographic background.

A literature review relevant for the current research is presented in Chapter 3, while an overview of the general research design and methods for data collection and analysis are presented in Chapter 4.

The following three chapters (Chapters 5, 6, and 7) are organized in the form of research papers, which report on the three major parts of this research. Each of these chapters consists of a review of relevant literature and sections on methodology, results, discussion, and conclusions. Since these chapters represent self-contained papers, they contain repetitions from other chapters as necessary.

Chapter 5 (the first paper) presents data on disordered eating attitudes and behaviors as measured by the long version of the Eating Attitudes Test (Garner & Garfinkel, 1979) in a sample of urban Bulgarians. Although this chapter provides some data on males, it focuses on the female portion of the sample. Chapter 6 (the second study paper) and Chapter 7 (the third study paper) focus only females.

Chapter 6 reports on the interplay between foreign (Western) and local cultural influences on body image and eating distress among urban Bulgarian women.

In turn, Chapter 7 builds an understanding of the culture-specific fasting behavior among urban Bulgarian women.

Finally, in Chapter 8 I provide a general discussion of this Dissertation study's research overall aims, methodology, findings, strengths and limitations, conclusions, and implications for future research and practice.

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CHAPTER 2

INTRODUCTION TO BULGARIA

2.1. GENERAL INTRODUCTION

The Republic Bulgaria is a small, independent, democratic state located in Southeastern Europe. It borders Turkey to the Southeast, Greece to the South, Macedonia to the Southwest, Serbia to the West, Romania to the North, and the Black Sea to the East. At an area of 110,879 square kilometers, the country is slightly larger than the US state of Tennessee, which makes it 104th in the world (out of 249 countries) in terms of territory (The CIA Fact Worldbook, 2011). A contemporary political map of Bulgaria is presented in Figure 2.1.

A brief summary of the country's historical, geographic, political, economic, and socio-demographic characteristics is presented in Table 2.1 (adapted from the CIA World Factbook, 2011).



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Figure 2.1. Contemporary political map of Bulgaria.

Table 2.1. Summary of country characteristics.

GEOGRAPHY	Strategic location near Turkish Straits; Controls key land routes from Europe to Middle East and Asia
CLIMATE	Temperate—cold, damp winters and hot, dry summers
PEOPLE	
Population	7,093,635 (July 2011 est.), 99 th in the world (out of 247 countries)
Age Structure (2011 est.)	0-14 years: 13.9% (male 506,403/female 480,935) 15-64 years: 67.9% (male 2,367,680/female 2,446,799) 65 years and over: 18.2% (male 522,343/female 769,475)
Median Age (2011 est.)	Total: 41.9 years, Male: 39.6 years, Female: 44 years
Population Growth Rate (2011 est.)	-0.781%, 228 th in the world (out of 231 countries)
Net migration rate (2011 est.)	-2.82 migrant(s)/1,000 population, 174 th in the world (out of 220 countries)
Urbanization (2010)	Urban population: 71% of total population
Ethnic Groups (2001 census)	Bulgarian: 83.9%, Turk: 9.4%, Roma: 4.7%, other: 2% (including Macedonian, Armenian, Tatar, Circassian)
Religions (2001 census)	Bulgarian Orthodox: 82.6%, Muslim: 12.2%, other Christian: 1.2%, other 4%
Languages (2001 census)	Bulgarian (official): 84.5%, Turkish: 9.6%, Roma: 4.1%, other and unspecified: 1.8%
ECONOMY	
Economic Synopsys	Bulgaria, a former Communist country that entered the EU on 1 January 2007, averaged more than 6% annual growth from 2004 to 2008, driven by significant amounts of foreign direct investment and consumption. Successive governments have demonstrated a commitment to economic reforms and responsible fiscal planning, but the global downturn sharply reduced domestic demand, exports, capital inflows, and industrial production. GDP contracted by approximately 5% in 2009, and stagnated in 2010, despite a significant recovery in exports. The economy is expected to grow modestly in 2011, however. Corruption in the public administration, a weak judiciary, and the presence of organized crime remain significant challenges.
Labor force (2008 est.)	2.56 million
Labor force - by occupation (2nd qtr. 2006 est.)	Agriculture: 8.5%, Industry: 33.6%, Services: 57.9%
Unemployment rate (2010)	9.2%, 102 ^d in the world (out of 200 countries)
Population below poverty line (2008)	21.8%
GDP - per capita (PPP) (2010 est.)	\$13,500, 89 th in the world (out of 228 countries) <i>Note:</i> Data are in 2010 US dollars
Distribution of family income—Gini index (2008)	33.5, 94 th in the world (out of 136 countries)
Inflation rate (consumer prices) (2010)	4.4%, 124 th in the world (out of 223 countries)
COMMUNICATIONS	
Broadcast media (2010)	4 national terrestrial television stations with 1 state-owned and 3 privately-owned; a vast array of TV stations are available from cable and satellite TV providers; state-owned national radio broadcasts over 3 networks; large number of private radio stations broadcasting, especially in urban areas.
Internet hosts (2010)	785,546, 46 th in the world (out of 231 countries)
Internet users (2009)	3.395 million, 63 rd in the world (out of 216 countries) Approximately 48% of the total population

2.2. HISTORICAL OVERVIEW (adapted from Crampton, 2005)

Starting when the Bulgars, a Central Asian Turkic tribe, merged with the local Slavic inhabitants in the Balkans in the late 7th century to form the Bulgarian state and ending nowadays, the Bulgarian people have had a long 14-century history spanning periods of clan society, feudalism, free peasantry (during the First Bulgarian Empire), followed by emergence of agriculture and later appearance of indentured individuals (during the Second Bulgarian Empire). With only brief periods of peace and relative wealth, the heavy taxation during the Middle Ages, the half a millennium of stagnation under the Ottoman yoke (starting in the late 14th century), the inclusion into capitalist economy after Liberation (1878) replaced by an embrace of the Soviet socio-political mold after the Second World War (starting in 1946) and followed by a period of turbulent socio-economic transition after the fall of the Berlin Wall (starting in 1990), as well as the constant warfare throughout the centuries, have all inevitably influenced the ways in which Bulgarians view the world, their way of living, their belief system and survival strategies, and their uniqueness as a people and a nation. Thus, to be able to fully understand contemporary Bulgarians' beliefs, attitudes, and behaviors in any aspect of life, including those related to body image and food, one needs to look not only to the present, but also to the past. Therefore, a brief overview of Bulgarian history is presented.

2.2.1. THE BULGARIAN LANDS BEFORE THE FIRST BULGARIAN EMPIRE

The land, which is now called Bulgaria, was among the first in Europe to have an organized social life. The earliest settlements in these territories date back to the middle Paleolithic period. In Neolithic times the populations gradually moved out of their caves to work the land. By the third millennium the local population was also cultivating non-food crops (such as flax) and was beginning to demonstrate mastery in metalworking.

By the end of the 3rd millennium BC the lands to the east of the Morava-Vardar valleys were falling under the cultural influence of the Thracians, who lived in a loosely organized society. An Indo-European people, the Thracians were renowned for their metalworking skills, horsemanship, and musicality. The Thracians showed little inclination towards political cohesion and it was external pressures, namely from the neighboring Greeks, rather than internal disposition that united Thracians into a political union during the Ninth-Sixth Centuries BC. During the 1st century AD the Thracians fell under the Roman rule. By the 4th century AD the Roman rule was weakening and internal problems were exacerbated when Asiatic tribes from the steppes began raiding the North-East Balkans. The fabled wealth of Byzantium lured many invaders, including the Alani, the Goths, and the Huns, who soon moved out of the Balkans in search of fresh plunder. However, the Slavs, who first appeared in the Balkans during the 5th century AD, came there to settle. In the 5th century AD the Thracians became part of the Eastern Roman Empire (Byzantium) centered around Constantinople. Gradually, during 6th century AD the Thracians were melted into the newly settled Slavic tribes who came to dominate the population numerically as well as linguistically.

2.2.2. THE PROTO-BULGARIANS: THE "OLD GREAT BULGARIA"

The state referred to by medieval authors as “Old Great Bulgaria” was founded between 630 and 635 AD by the Proto-Bulgarian (i.e., Bulgar) Khan¹ Kubrat, after he successfully united two of the major Pontine Proto-Bulgarian tribes—Kutrigur and Onogondur—under his single rule. The new state emerged to the north of the Caucasian mountains, between the Caspian Sea and the Black Sea, and more precisely between the rivers Don and Volga. Around 654 AD after the death of Khan Kubrat, the Old Great Bulgaria split into three parts. Khan Asparuh, one of Kubrat’s heirs, headed Southwest to the lands in the East part of the Balkan peninsula between Lower Danube, the

¹ “Khan” is a monarchical title originating in Central Asia and used mainly by Mongolic and Turkic tribes. Also used by the Proto-Bulgarian rulers prior to the adoption of Christianity.

Balkan Range and the Black Sea. The historical events that followed marked the beginning of a Bulgarian state in the Balkans where current day Bulgaria still resides.

2.2.3. FIRST BULGARIAN EMPIRE (681-1393 AD)

2.2.3.1. Formation

In the 7th century AD, after the split of the Old Great Bulgaria, the Proto-Bulgarians of Khan Asparuh combined with some of the local Slavic tribes to launch an assault into the Balkans across the Danube. In the summer of 680 AD the Byzantines lead by Emperor Konstantin IV were completely defeated resulting in a peace treaty in 681 AD with which an internationally recognized Bulgarian state appeared in the Balkans.

The new Bulgarian state was faced by two immediate problems central to its political survival: 1) the need to establish clearly defined and secure borders, and 2) the need to fuse the two main human components of the state—the minority of Proto-Bulgarians with highly developed sense of political cohesion and a formidable military reputation, and the predominant Slavs living in loosely organized family clans.

2.2.3.2. Bulgaria Under the Khans (681-852 AD)

After its formation Bulgaria enjoyed almost a century of continuous growth due to quickly contained initial conflicts and mutual economic interests with Byzantium. Under Khan Tervel (700-718 AD) Bulgaria expanded its territory and became a very important political power in the Balkan region. Due to the lack of navy, expansion to the East (the Black Sea) was virtually impossible in the face of Byzantium's maritime dominance. Expansion to the North of Danube was geopolitically and economically disadvantageous for the newly formed state due to lack of natural shield in the open steppe against the constant intrusion of Asiatic tribes migrating to the West. Thus, if Bulgarian rulers wanted to acquire new territories, they had to look to the West and South.

During the rule of Khan Krum (803 – 814 AD), the Bulgarians from east and the Franks from the northwest together finally brought to an end the Avar Khaganate with which Bulgaria became one of the three most powerful countries in Europe extending in the West to the river of Tisza and in the east to the river of Dniestr (now in modern Ukraine). Expansion to the South and Southwest, however, was a formidable task. In 811 AD in a characteristically vicious war Khan Krum took the fortified Sredets (now Sofia) from the Byzantines, seized Nesebur on the Black Sea coast and then marched as far as the walls of Constantinople. The Byzantine Emperor Nicephorus became the first of his rank for almost 500 years to literally lose his head at the battlefield. Krum encrusted his skull in silver and used it as a drinking goblet.

In 814 AD Krum's successor Khan Omurtag (814-831 AD) secured a treaty that gave Bulgaria territory in the Tundja valley further south. Later during his reign, Omurtag was able to add Belgrade to Bulgaria and expanded the state into Macedonia, a predominantly Slav area, and as far as Southern Albania, by taking advantage of Byzantium's internal and external problems. Omurtag, however, was not merely a warrior. He continued Krum's work in introducing a proper legal system into Bulgaria and he was also an avid builder.

2.2.3.3. Conversion to Christianity and the Reign of Boris I (852-888 AD)

The reign of Boris I² was marked by one of the most significant acts in the formation of the Bulgarian nation—the adoption of Christianity. Although Boris I was no less of a warrior than his predecessors, he was also a visionary ruler. There were multiple, long-standing issues (both domestic and external) behind his decision, including: 1) the relief of Byzantine military pressure, 2) the desire for acceptance into the cultural and religious community of the predominantly Christian European states (much of the civilized world at the time), and 3) the closing of gaps between Proto-Bulgarians and Slavs who, despite already speaking a Slavo-Bulgarian language, still experienced

² It was during the rule of Boris I (following the adoption of Christianity) that the use of the monarchical title “Khan” for a ruler was discontinued.

differences. In fact the Slavs had largely adopted the Christian religion of the Romans once they colonized the Balkans, whereas Proto-Bulgarians, especially the nobility and rulers, had remained pagan. Boris I recognized that the difference between the Christian and pagan could provide dividing lines that might be exploited by an external enemy and that might deepen dangerously in times of internal difficulty. Furthermore, Byzantine Christianity was associated with a centralized, autocratic state, which appealed to Boris I's desire to centralize the Bulgarian state. All of these factors led to the adoption of Christianity in 864 AD.

The conversion did not produce entirely satisfactory results for Boris I. Initially, Bulgaria was made part of the Byzantine church and was denied the right to have its own Bulgarian patriarch or to appoint its own bishops. This strengthened fears within the country that the church in Bulgaria could become an arm of Byzantium and could be used as a vehicle for Byzantine influence on the political and cultural affairs of the Bulgarian state. Additional difficulties came by the fact that the Bulgarian population had to be educated into their new faith. However, the Greek missionaries sent by Byzantium were too few for the task and, on top of that, were generally regarded with distrust and suspicion by Slavs and Proto-Bulgarians, who were accustomed to thinking of Greeks as "cunning" and "relentless" enemies. Furthermore, the Bulgarian population was instructed into Christianity in Greek, a language that they could not understand. As a result of all of that, suspicion and ignorance of the new doctrines prevailed within the masses, thus it was not surprising that heresies took a rapid and strong hold in the Bulgarian lands. Some of these heresies were to play a seminal role in the history of the region. Despite its many difficulties, however, the conversion managed to iron out the dissimilarities between Slavs and Proto-Bulgarians and by the 10th century the Bulgarians emerged as a uniform people.

In the mid to late 9th century a second event occurred, which had an equally important formative impact over Bulgaria as an independent nation, namely the adoption of the Cyrillic

alphabet. The latter was based on an older Slavic Glagolitic alphabet created by the Greek brothers St. Cyril and St. Methodius who taught Christianity to the Southern Slavs. Although this topic is a source of debate, several authors contend that although the Glagolitic alphabet was codified and expanded by St. Cyril and St. Methodius, it was their students at the Preslav Literary School in the First Bulgarian Empire who developed the Cyrillic alphabet from Greek in the 890s as a more suitable script for church literature (Cubberley, 1996). Not only did it prevent the absorption of the Bulgarians by foreigners (mostly Greeks or Franks), but the new alphabet also allowed for the rapid development of Bulgaria's own literature and rich culture. It facilitated the development of thriving centers of learning (e.g., Ohrid, Preslav and Pliska literary schools), enabled the production of important secular texts such as a legal code, as well as provided a foundation for carrying out an independent administrative system for the young state. Above all, however, the alphabet enabled the Bulgarian church to use a Slavo-Bulgarian language in liturgy, which was understandable for the population, thereby escaping Greek domination. Bulgarian was officially pronounced as the language of the Bulgarian state and church in 893 AD. Stemming from Bulgaria the Slavic alphabet and writing spread out into other Slavic countries like Serbia and Russia. Ohrid, Pliska and later also the new Bulgarian capital Great Preslav, became centres not only of Bulgarian but also of Slavic culture.

2.2.3.4. The Golden Age—Reign of Simeon The Great (893-927 AD)

Tsar³ Simeon I created the Bulgarian Patriarchy, which established independence of the Bulgarian church from Byzantine influence. Furthermore, during Simeon's rule Bulgaria became one of the most powerful countries in Europe spreading out over the vast majority of the Balkan Peninsula. After a successful military campaign Simeon was crowned by the Byzantine patriarch as "Emperor of the Bulgars and the Romans," a title that was quickly recognized by the then Pope

³ "Tsar" is a monarchical title used primarily by the Bulgarian and Russian rulers in the 9-20 century. This title is equivalent to the Western monarchical title "King."

Formosus. Simeon made another significant step by moving the Bulgarian capital from Pliska to the nearby Preslav. In the new capital the pagan traditions would be less strong. Preslav saw the flowering of Bulgarian art and literature, which was helped by twenty years of peace and prosperity following a treaty in 896 with Constantinople. The prosperity of those golden years was largely based on the close and healthy relations between Simeon, who grew up and was educated in Constantinople, and the empire.

2.2.3.5. The End of the First Empire (896-1018 AD)

Simeon died in 927 AD having nominated his second son Petur as his successor. Even though the reign of Tsar Petur I was of exceptional duration (nearly 40 years) it was marked by a gradual decline in for Bulgaria. There were both external and internal forces driving the decline of the state. The constant warfare with the empire to the South and the Magyars to the North inevitably weakened the state—wars were becoming rather defensive than offensive. Additionally, the Bulgarian court was turning increasingly Byzantified, while the disappointed nobility mourned for the golden days of prosperity and peace. Meanwhile the church turned into corruption and self-enrichment, which profoundly impacted the majority of the population. Due to the weakening of the centralized state, individual landowners gained tremendous economic and social power, while the poor grew poorer, discontented and alienated. As previously mentioned, since conversion the Bulgarian peasantry was left largely undereducated in their new religion, which halted the development of strong adherence to the official Christian doctrine. Hence, the unbearable living conditions, the profound corruption of the state and Church, and the weak adherence to religious dogmas pushed the masses of Bulgarians into heresy as a way of coping with and escaping the surrounding reality.

These heresies were markedly ascetic in nature and were characterized by a willingness to withdraw from the world and its problems. Such heresies provided a route for internal migration

and dissociation from the temporal world, which was otherwise extremely difficult to navigate. One of the greatest and longest lasting of these heresies—Bogomilism—entered the Bulgarian lands circa 928 AD. Because Bogomilism was very much a reaction to escalating social pressures, its popularity increased in times of hardship. Thus, it remained strong despite fierce persecution until the fall of Bulgaria under the Ottoman Empire in the end of the 14th century. In declaring all institutions evil and in rejecting authority, Bogomilism did nothing to prevent the downfall of the Bulgarian state. Despite providing an escape for Bulgarians, Bogomilism was essentially negative for Bulgaria as an organized state, since it did not stimulate the development of reformist movements or of an intellectual revolution, which the questioning of the Catholic Church produced in the West.

As a consequence, the decline of Bulgaria accelerated throughout the reign of Petur's successors. During 971 AD Byzantium occupied eastern Bulgaria and the capital was consecutively moved westward to Sredets, Skopie, Prespa, Bitolia, and eventually Ohrid. After a long struggle during 1018 AD Bulgaria was conquered by Byzantium after the defeat of Tsar Samuil's army in 1014 AD and the doom of Tsar Ivan-Vladislav in 1018 AD.

2.2.4. BULGARIA UNDER BYZANTINE RULE (1018-1185 AD)

Bulgaria remained an integral part of the Byzantium until the late 12th century. Ironically, Bogomilism—which was instrumental in the decline of the Bulgarian state—was in fact a key reason for the survival of Bulgarian cultural identity and separateness. Interestingly, Bogomilism was absorbed more easily by the Bulgarians than by the Greeks, which hindered assimilation of the former by the latter. It also prevented any commitment of the Bulgarians to the rule of the state and Church.

2.2.5. SECOND BULGARIAN EMPIRE (1186-1393 AD)

Almost immediately the struggle for the liberation from Byzantine domination started in the Bulgarian lands. The first uprising was lead by Peter II Delyan (1040 – 1041 AD). The taxation and

humiliation of Bulgarian nobility by the Byzantines was growing unbearable. In 1186 AD an uprising led by two landowners from Turnovo, the brothers Asen and Petur, who finally ended the domination of Byzantium. The Second Bulgarian Kingdom was founded with Turnovo as its capital and it was seldom free of crippling external or internal conflicts.

During 12th century the Bulgarian state was stabilized and strengthened due to the successful military campaigns of Tsar Kaloyan (1197-1207 AD) against the crusaders. During one of these campaigns Baldwin I of Constantinople, the emperor of the Latin Empire—a Crusader state formed on land taken from the Byzantium during the Fourth Crusade—was captured by Kaloyan and kept a prisoner in Turnovo until his death.

Under Tsar Ivan-Asen II (1218 – 1241 AD), Kaloyan’s successor, the Second Bulgarian Kingdom reached its zenith—enforced full political hegemony over southeast Europe, spread out its borders to the Black Sea, the Aegean Sea and the Adriatic Sea, developed a rich economy and culture. Furthermore, Ivan-Asen II successfully negotiated for the complete restoration of the independence of the Bulgarian Church from Crusaders, Byzantium, and Rome. In 1235 the head of the Bulgarian Church received the title Patriarch.

The period 1241-1280 AD Bulgaria survived invasions of the Tatars, decay during the reign of Tsar Konstantin-Asen *Tib* (“Quiet”) and severe discontent among the peasantry, which culminated in a massive uprising in 1277 AD headed by the swineherd-turned-king Ivailo (1278-1279 AD). The lack of a strong monarch by the end of the 13th century produced incessant bickering among the nobility. Additionally, another debilitating heresy, Hesychism, beset the kingdom. Those devoted to Hesychia called for inward retrieval and denouncement of the senses, for rejection of all social activity and a life devoted to silent contemplation and prayer. The latter, of course, did nothing to repel invaders. In short, Hesychism, like Bogomilism, was another

manifestation of the continuing theme of asceticism as a reaction to hardship among the Bulgarian people.

In the 14th century two new invaders added to Bulgaria's difficulties: the Serbs from the West and the Ottomans from the South. The constant warfare demanded an increase in taxation, and preoccupation with external affairs prevented the tsar from paying attention to the movement of political power from the center to the landowning nobility. Once again the main victims were the peasantry. During the reign of Tsar Theodor Svetoslav in the 14th century there was a period of consolidation, but later the ambitions of the nobility to disengage from the central authorities increased resulting in the separation of Dobrudja to the North-East. During 1371 AD Bulgaria was split between the heirs of Tsar Ivan Alexander into the Kingdom of Turnovo, led by Tsar Ivan Shishman, and the Kingdom of Vidin, led by Ivan Sratsimir. This split weakened the state still further and turned it into an easy prey for conquerors. Inevitably in 1393 AD Turnovo capitulated under the Ottoman Turks: the patriarch was shut up in a monastery, the dynasty deposed, the great nobility dispossessed and the state dissolved. In 1396 AD Vidin also capitulated and Bulgaria was finally conquered by the Ottoman Empire. Bulgaria as a state was not to exist again for nearly five hundred years.

2.2.6. OTTOMAN YOKE (1396-1878 AD)

The Ottoman Empire was a theocracy. Even though under Ottoman rule Christians at times enjoyed relative peace and prosperity, they were never given an equal status with Muslims. Non-Muslims were discriminated against in a variety of ways: they were given higher and various taxes; churches could not be higher than mosques; Christians could not wear the sacred green color, had to get off their horses when a Muslim passed the other way and could not carry arms, etc. The administrative organization of the Ottoman Empire was such that the empire's population was separated by religious creed, not by ethnicity. The religious groups, or millets, were allowed to

regulate their internal affairs. Since the Ottomans did not discriminate by ethnicity, the Bulgarians within the Orthodox millet—being non-Greeks—were in effect second-class citizens in a second-class millet.

The population of Bulgaria under the Ottoman rule declined dramatically. By the 16th century Bulgarians were only about 8% of the total population of the empire. There were four main reasons for this decline: 1) the empire expanded into the remainder of the Balkans and into Hungary, thus increasing its total population, 2) Bulgarians were persecuted, especially after major outbreaks of social and political discontent, 3) disease and pestilence at the time were overabundant, and 4) some Bulgarians converted to Islam. It can be argued that because Bulgarian lands were at the center of the Ottoman Empire, the Bulgarian population carried the strongest and longest burden of Ottoman dominance. The Ottoman rule was undoubtedly a cultural as well as political disaster for the Bulgarian nation. Not only did the state disappear and the Church fall under the domination of Istanbul, but Bulgarian language and literature also seemed to die. Yet the language and culture remained alive during the 14th to 19th centuries primarily because Bulgarians escaped Ottoman settlements for the hard-to-reach mountainous regions where they formed small, isolated and usually ethnically homogeneous villages. In such communities there was no need to adopt Greek for economic or commercial purposes, nor use Turkish when dealing with government officials. The villages earned relative autonomy from the Ottomans by doing favors for them and/or paying taxes, including a “blood tax” (providing young male children for the elite Ottoman army) every few years. In other words Bulgarian cultural identity in the form of Bulgarian language, Bulgarian names, Bulgarian folk tales, songs, and legends, Bulgarian forms of family organization, and Bulgarian festivals and holidays was kept alive by the Bulgarian village and therefore preserved.

The period from the 15th to the 17th century was filled with sporadically and badly organized attempts to throw off the Ottoman rule. As the Ottoman Empire began to grow more corrupt and

disorganized toward the Eighteenth Century, the Bulgarian Renaissance began in earnest, blessed with bright personalities like Paisii Hilendarski and Sofronii Vrachanski. From the decline of the empire eventually emerged the seeds of the Bulgarian national revival. Another uprising followed during the war of Ottoman Empire against Austria and the Russian-Ottoman war from 1768-1774. During the Crimean War (1854-1856) the Secret Community and the Goodact Company were founded. In 1860 Ilarion Makariopolski announced the split of the Bulgarian Church from the Universal Patriarchy in Istanbul, to which it had been subordinate until then. On 27 February 1870 the Sultan acknowledged the foundation of the Bulgarian Exarchy and in 1872 Antim I was chosen for Exarch. Thus, the first step towards national independence—autonomy of the Church—was achieved.

The years 1860-1878 were a period of organized national liberation movements. Georgy Rakovsky founded the Secret Central Bulgarian Committee, while national heroes such as Ljuben Karavelov, Christo Botev and Vasil Levski founded the Bulgarian Revolutionary Central Committee. The Stara Zagora (1875) and the April (1876) uprisings followed. The biggest uprising was the April one, which was lead by Georgi Benkovsky, Panaiot Volov, Todor Kableshkov and Zahari Stoyanov. On 12 April 1877 the Russian-Ottoman Liberation War began, which finished on 19 January 1878 with a victory for Russia and the liberation of Bulgaria.

2.2.7. NEW BULGARIAN HISTORY (1878-PRESENT)

With the treaty of San Stefano (March 3, 1878) Bulgaria was restored as a vast new state stretching from the Danube in the North to the Rhodopes in the South, and from the Black Sea to the East to the Morave and Vardar valleys in the West. Bulgarian territories included parts of the Aegean coast and the inland cities of Skopje, Ohrid, Bitola, and Seres. In terms of territorial claims this was as much as any Bulgarian nationalist could dream of. However, the San Stefano Bulgaria proved to be a short-lived happiness for Bulgarians. The new large Bulgarian state was seen by

Britain and Austria-Hungary as a tremendous entryway for Russian influence in the region. Thus, in July of 1878 in Berlin, Bulgaria was split into three parts: Kingdom of Bulgaria headed by Kniaz⁴ Alexander Battenberg—a German nobleman, nephew of Russia’s Tsar Alexander II who was advanced by the Tsar as the first prince of modern day Bulgaria; East Romelia with a Bulgarian governor nominated by the Sultan; and Thrace and Macedonia which remained under Ottoman domination.

The treaty of Berlin was a devastating event in the history of the newly established Bulgarian state. Ever since Berlin, Bulgarian history has been marked by the drive for consolidation of Bulgarian territories into a unified, independent state. Protests about the decision of the Berlin Congress, resulted in the Kresna-Razlog uprising (1878 - 1879), which in 1885 lead to the union of the Kingdom of Bulgaria and East Romelia. The Bulgarian Kniaz Ferdinand of Saxe-Coburg and Gotha proclaimed independence from the Ottoman Empire in 1908 and became the first “King” (or “Tsar”) of contemporary Bulgaria. Bulgaria took part in the Balkan war (1912) together with Serbia and Greece, fighting for the freedom of Thrace and Macedonia. Even though Bulgaria won this war, the consequent war between the ex-allies resulted in a defeat of Bulgarians by Romania, Turkey and their allies, which cost Bulgaria territorial losses.

In another attempt to reunite its territories as well as in consequence of the state’s predominantly Germanic dynasty, Bulgaria intervened in the First World War on the side of the Central Powers. This intervention finished in a national catastrophe. In 1918 Ferdinand abdicated in favor of his son Boris III. The treaty of Neuilly-sur-Seine (1919) put some severe sanctions on Bulgaria, which led to the loss of the outlet on the White Sea. Furthermore, West Thrace became a part of Greece, southern Dobrudja became part of Romania and the regions of Strumitsa,

⁴ “Kniaz” is a monarchic title found in most Slavic languages denoting a royal nobility rank. It corresponds to the Western titles of “Prince” or less commonly Duke (and is therefore lower in rank than the title “King” or “Tsar”).

Bosilegrad and Tsaribrod were given to the Kingdom of Serbia-Croatia-Slovenia. With a Bulgarian-Romanian treaty in 1940 south Dobrudja was given back to Bulgaria.

At the beginning of the 1940s Bulgaria yet again made policy sympathetic towards Germany and the Axis in another futile effort to regain its lost territories. Despite his pro-German orientation, however, Tsar Boris III with the support of public opinion, did not agree to deport about 50,000 Bulgarian Jews to concentration camps. In August 1943 Tsar Boris III died and the regents of the young Tsar Simeon II formed a government. At the end of the WWII Bulgaria was once again on the losing side.

On 5 September 1944 the Soviet army entered Bulgaria and on 9 September instituted the government of the Fatherland Front lead by Kimion Georgiev, which marked the onset of the Communist era for Bulgaria. In 1946 Bulgaria was proclaimed a republic, the Bulgarian Communist Party came to power, and Bulgaria became part of the Eastern Bloc. All political parties except the members of the Fatherland Front were banned, the economy and banking were nationalized, all agricultural land was forcibly united in cooperatives. The Communist heads of state consecutively changed from Georgi Dimitrov (1946-1949), Vasil Kolarov (1949-1950), Valko Chervenkov (1950-1956), Anton Jugov (1956-1962) and Todor Givkov (1962-1989). Despite its relatively short duration, Bulgarian totalitarian rule unprecedentedly scarred Bulgarian national identity. Bulgarians had to adapt to a brand new form of political, social, and economic oppression and the process of adaptation was not necessarily a positive turn in the development of the mentality and psychology of Bulgarians as a people.

The events of November 10, 1989 brought about the democratic changes in Bulgaria, which signified the beginning of Bulgaria's social, economic and political transitional period from a communist to a free market society. A new constitution was developed, the rights of the political parties were restored, the property was returned to its prior owners and a privatization was started.

The country joined NATO in 2004. In January 1, 2007 Bulgaria became a member of European Union. As of August 2009, however, the Bulgarian transition had not yet been completed.

To bring the above historical discussion into perspective, it should be noted that the “personal life histories” of the respondents in the current Dissertation cover the historical time span from the early 1930s (when the oldest participant was born) until the present (data collection happened in the summer of 2009). Importantly, these participants came of age in the contexts of very different socio-economic and cultural environments during four key periods in Bulgarian history, namely: 1) before the rise of communism (and secularization) in the late 1940s and 1950s for the current Dissertation’s elderly participants, 2) during the height of communism and secularization that lasted until the late 1980s for the middle-aged participants, 3) during the peak of the socio-economic transition and Westernization in the 1990s for the young adult participants, and 4) after the peak of transition in the modernized and Westernized Bulgaria of the 21st century for the teenage participants.

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CHAPTER 3

LITERATURE REVIEW

3.1. ISSUES OF BEAUTY IDEAL, BODY DISSATISFACTION AND EATING BEHAVIOR IN WESTERN CULTURE

The past fifty years have seen a dramatic change in the Western, particularly the American, concept of the “ideal body” with a shift towards a body that is thinner and more muscular. Researchers have studied the anthropometric characteristics of Miss America Pageant contestants and *Playboy* centerfold models from 1959 to 1988 to demonstrate the “thinning” trend in American media-purveyed beauty standards and have attempted to link it to a rise in eating disorders (Garner et al., 1980; Irving, 2001; Seifert, 2006; Wiseman et al., 1992). Additionally, it has been shown that female models in magazines, from the 1950's through the beginning of the 1980's (Silverstein et al., 1986), and movie actresses from the 1940's to the 1970's (Snow & Harris, 1986) have gradually become leaner. At the close of the 20th century, ideals of physical beauty that equate virtue with thinness have replaced the concept of thinness as a measure of spiritual attainment (Brumberg, 2000). Women are encouraged to strive for an ultra-thin body, whereas men are pressured to cultivate a V-shaped, muscular body (Willinge et al., 2006). Since these body ideals are unrealistic and unobtainable for most, it can be argued that the gap between what is desired and what is obtainable contributes to the rise in body dissatisfaction. Silberstein et al. (1998) contend that body dissatisfaction is, in fact, becoming a normative behavior for both genders, with an estimated two thirds of young women and one third of young men experiencing significant disturbance in body image (Rabak-Wagner et al, 1998). Body dissatisfaction, in turn, has been implicated in the development of unhealthy attitudes and behaviors, including disordered eating in women (Stice et

al., 1994), and compulsive over-exercising and the use of chemical supplementation in men (Cahill & Mussap, 2007).

According to the socio-cultural models, the rise of disordered eating (and ultimately eating disorders) in the West (Western Europe and North America) has often been declared a modern epidemic or a culture-bound syndrome (not without considerable controversy regarding the validity of both claims). It is worth noting that the rise in eating disorders in Western societies has coincided with a number of profound changes in these societies, including the rise of the consumer economy and its emphasis on individual satisfaction versus collectivist goals, and the increasing fragmentation of the family due to growing intergenerational conflicts and sex role upheavals (Gordon, 2001). Conflicts between modern and traditional socio-cultural expectations may be at the heart of the development of eating disorders, because they lead to a sense of personal uncertainty, self-doubt, and powerlessness, particularly among young women (Gordon, 2001).

Due to the mass media's pervasiveness and reach, they have been most aggressive in transmitting this socio-cultural female and male body ideals (Groesz et al., 2002; Willinge et al., 2006). Because forming views about oneself and socio-cultural norms are central components of adolescent development, youth appear more susceptible than adults to physical appearance messages purveyed through mass media. Moreover, female bodily changes during puberty (e.g., increased adipose tissue) move teen girls further away from societal standards of female beauty in the West, making them extremely preoccupied with weight and eating, and therefore, most receptive to media's influence (Clay et al., 2005). Overall, the scientific consensus is that media exposure to idealized body images results in internalization of the "thin-beauty ideal" and increased body dissatisfaction in vulnerable youth (Stice et al., 2001; Trample et al., 2007). Deficits in perceived social support (e.g., peers, family, etc.) have also been linked to increased media vulnerability (Cahill & Mussap, 2007; Stice et al., 2001). Moreover, preexisting depression or anxiety, "low self-esteem in

childhood, a history of weight preoccupation, and/or genetic predispositions” can further sensitize vulnerable individuals to the increasingly stringent socio-cultural demands for thinness and athleticism (Bulik, 2001; Fairburn et al., 1997).

3.2. BEAUTY IDEAL, BODY DISSATISFACTION AND EATING BEHAVIOR IN CULTURES IN TRANSITION

Until the 1990s the issues of body image disturbance, eating disorders, and media’s role in the promotion of the thin-beauty ideal were considered unique to Western societies (Gordon, 2001; Prince, 1985). However, based on her review of internationally published research, Nasser (1997) proposed that these issues perhaps could no longer be ascribed solely to the West. The internalization of the thin-beauty ideal, the spread of body dissatisfaction, and the emergence of eating disorders around the globe have been attributed to the processes of Westernization and modernization as societies transition culturally and economically (Katzman & Lee, 1997; Rathner, 2001). The transitional processes expose societies to new cultural norms, which destabilize traditional norms and produce various ill effects on mental health, particularly among the younger population (Rathner, 2001). The latter complements the socio-cultural models in explaining the spread of eating disorders in non-Western cultures (Fallon, 1990). Under these circumstances eating disorders can be seen as a maladaptive socio-cultural coping mechanism against the stressors of an increasingly complicated and rapidly changing world.

3.3. BEAUTY IDEAL, BODY DISSATISFACTION AND EATING BEHAVIOR IN POST-COMMUNIST EUROPEAN SOCIETIES

It is difficult to determine whether body image and eating disturbances existed in non-Western societies prior to the 1990s due to the lack of recognition of such conditions and the virtual absence of formal epidemiological studies (Gordon, 2001). Research concerning body image, eating disorders, and media influence in European countries from the former “Eastern Bloc” appears to be particularly limited (Bilukha & Utermohlen, 2002). There are no general population data from these

countries revealing whether the prevalence rate of eating disorders is similar to that obtained in Western countries and whether eating disorders have increased since the socio-political changes of 1989/1990 in Central and Eastern Europe (Tolgyes & Nemessury, 2004). Additionally, for ideological reasons, during Communism eating disorders and related topics were considered taboo (Boyadjieva & Steinhousen, 1996). Thus, virtually no information is available from this period for comparison purposes (Bilukha & Utermohlen, 2002). Some evidence coming from the German Democratic Republic (East Berlin) and Hungary before the political changes of 1989 hints that eating attitudes and eating disorder prevalence may have been similar to those found in the West, but only among student populations (Rathner et al., 1995). This has been attributed to the similar levels of industrialization in these countries along with their close proximity to the West, allowing for easier infiltration and over-identification with Western ideals, including ideals of thin beauty (Rathner, 2001).

Nonetheless, the general belief is that disordered eating and related behaviors are less prevalent in most of post-communist Eastern Europe than in the West (Bilukha & Utermohlen, 2002; Szumska et al., 2005). However, recent studies from this area suggest that the prevalence of dieting, compensating behaviors, and disordered eating may be similar to that of Western countries (Tolgyes & Nemessury, 2004). Furthermore, since eating disorders are often seen as a sensitive barometer of culture change, the rapid social, economic, and cultural transformations in former communist countries could be posing a heightened risk for weight preoccupation and disordered eating in these countries' adolescent and young adult populations (Gordon, 2000; Rathner, 2001). For instance, Sarlio-Lähteenkorva et al. (2003) somewhat unexpectedly found that girls who grew up in non-Western countries were more weight dissatisfied than Western girls. The findings of Oleg Bilukha suggest an alarming rate of dieting in the Ukraine, where over half of the women desired a thinner figure, though only 16.4% were overweight or obese (Biloukha, 2000; Bilukha &

Utermohlen, 2002). Moreover, after comparing school samples in Bulgaria and East Berlin in 1992, Boyadjieva and Steinhausen (1996) concluded that Bulgarian girls—nearly half of whom attended Western-oriented schools—showed higher rates of eating disturbances (measured by Eating Attitudes Test scores) than their Berlin counterparts.

It is important to point out, however, that the concept of a unitary “Eastern Bloc culture” is problematic when discussing socio-cultural transitions. Former communist countries are by no means homogenous with respect to their level of Westernization, thin-ideal acceptance, and body image (either before or after the reforms): attitudinal and trans-cultural dissimilarities would cause significant differences in disordered eating trends (Tury et al., 2003). Social, moral, and biological factors in the local environment remodel individual experience, as a result of which individuals’ attributions for non-eating are often location-specific and more diverse than the globally accepted standards of fat phobia and the drive for thinness (Lee, 2001).

3.4. ISSUES OF BEAUTY IDEAL, BODY DISSATISFACTION AND EATING BEHAVIOR IN BULGARIA

As is the case for most of post-communist Europe, in-depth epidemiologic studies concerning the prevalence or alleged rise in eating disorders in the Balkans is at best scarce. Bulgaria, in particular, remains an essentially uncharted region. Until the late 1980s eating disorders (mainly anorexia nervosa) were mentioned in psychiatric manuals solely for didactic purposes (Boyadjieva, 1994). In her doctoral dissertation published in 1994, Boyadjieva—a Bulgarian clinical psychiatrist—speaks of a clear upward trend in the prevalence of anorexia nervosa and a drop in its onset age in the population. Her claims, though, are not backed by firm data. Based on a review of the available literature, there have been no studies in non-clinical settings dealing with issues of body image, body dissatisfaction and disordered eating attitudes and behaviors in Bulgaria. Similarly, relevant socio-cultural research is absent.

There have been some general indications that eating disorders may be a growing problem in Bulgaria. If asked today whether eating disorders are a worrisome health issue in the country, Bulgarians will likely respond that it is. Having grown up and lived in Bulgaria until the early 2000s, I can attest that this was not the case as recently as four or even three years ago. The media have been quick to pick up on these societal concerns and have subsequently saturated the media space with discourse regarding dieting, body image, and eating disorders. For instance in June of 2008, a popular magazine—*Diet and Beauty*—specializing, as its title implies, in methods for beautification and dieting, launched (somewhat ironically) a National Campaign against anorexia under the slogan “Beauty is in the Charm.” The campaign billed itself as the largest-scale preventive effort ever in addressing the problem of anorexia nervosa in young girls in Bulgaria (*Diet and Beauty*, 2008). It enjoyed extensive media coverage and provided information regarding disease symptomatology, methods for detection, and avenues for help. Bulgaria’s most prominent psychological, psychiatric, and medical specialists agreed to participate by providing free consultations to young girls believed to be suffering from the disease. These specialists also participated in the public debate by giving interviews in magazines and on television. According to one of most acclaimed of these clinicians—the president of the Bulgarian Scientific Society for Nutrition and Dietetics, Prof. Bojidar Popov, MD—in Bulgaria 4-5% of the female population suffers from anorexia nervosa, compared to 0.5-1% in Western Europe (National Center for Health Information, 2008). He went on to estimate that about 30% of the country’s roughly 450 000 12-18 year-old girls (i.e., the most vulnerable segment of the population) are at risk of underweight and anorexia (Popov, 2008). Additionally, a recent report prepared for the European Institute of Women's Health, *claims* that there are over 250,000 officially registered cases of anorexia nervosa among women in Bulgaria, and no certainty as to how many more have gone undetected (Kerekovska, 2006). These numbers are striking and hint at a serious problem—to put the number in perspective, in all of Bulgaria there is a total of about

750 000 women between 15 and 29, the group most vulnerable to the disease (National Statistical Institute of Bulgaria, 2008). Despite the public and professional acknowledgement of the problem's existence, however, most discussions of eating disorders are concerned primarily with clinical presentations (signs and symptoms) of anorexia nervosa, while minimal attention is paid to its etiology. Furthermore, eating disorders other than anorexia nervosa fail to attract attention. Perhaps most importantly, there is no comprehensive national program aimed at the prevention, treatment and rehabilitation of eating disorders (Kerekovska, 2006).

How can one make sense of Bulgaria's seemingly mushrooming eating disorder problem? Meehan and Katzman (2001) contend that difficulties stemming from transition, dislocation, and oppression often times produce solutions in the form of manipulations of weight, diet, and food. Therefore to fully understand the specific body image experiences and dietary behaviors of Bulgarians in the context of Westernization, and to begin to get at the root causes contributing to the purported rise of disordered eating in the Bulgarian population, one needs to understand the socio-cultural, political and economic biography of this country. Bulgaria's protracted period of transition presents a unique opportunity for studying the intersection of body and culture under social, political, and economic strain.

3.5. PROBLEMS OF TRANSITION AND DIETARY SOLUTIONS IN BULGARIA

3.5.1. ECONOMIC CRISIS

A number of studies have assessed dietary changes in countries undergoing major economic transformation. The majority of these have focused on changes following economic recovery, and limited information is available concerning dietary changes in societies impacted by acute economic crises and transitions outside of wartime (Jahns et al., 2003). Since the early 1990s Bulgaria has experienced a drastic shift from a planned to a market economy, a transition that has been slow and plagued by debt, corruption, and hyperinflation (World Bank, 2004). Access to food for the

majority of Bulgaria's population decreased in the initial years following Communism's collapse, because of the decrease in real income and increase in food prices, though it has since improved (Ivanova et al., 2006). While major changes in the macronutrient composition of the Bulgarian diet have not been observed for the population as a whole, there is evidence that overall access to high quality food products has diminished (Ivanova et al., 2006). Nonetheless, little to no research has been done to examine these changes within distinct population sub-strata (e.g. adolescents versus young adults versus older adults) or distinct geographic locales (e.g. urban versus rural populations). Similarly, no studies have been conducted focusing on the changes in eating attitudes and behaviors resulting from changes in food access and availability.

The financial strain in Bulgaria was especially palpable in the early to mid 1990s. For instance, in 1996 inflation rose to 310% and the value of the Bulgarian currency (the "lev") fell from 70 to the dollar to 645, leading to the collapse of several banks and the subsequent drop in average wages to 30 USD a month—the lowest of any European country (Cockerham, 1999). Having lived in the economic cocoon of communism, Bulgarians lacked experience in coping with stressors such as hyperinflation, high unemployment, and poverty. Even though Bulgaria's economy underwent marked improvement since the mid 1990s, in many ways Bulgarians continue to live under depressed economic conditions. The labor market situation remains bleak with unemployment high, quality of employment low and social assistance scarce (Kolev, 2005). In addition, economic disparity has grown, so that there is an increased gap between the lower and upper classes (Ivanova et al., 2006).

It is often the case that under circumstances of economic strain and unemployment the presence of women in the workforce becomes undesirable (Catina & Joja, 2001). Bulgaria is no exception in this regard. Research reveals that many Bulgarian women left the labor market due to lack of affordable childcare facilities, the offer of long maternal leave (though with meager maternal

allowance), allegedly higher labor costs of women, and their family status as a second income earner (Nesporova, 2002). Others remained in the workforce by opting for jobs that men would not compete for. These women were more willing to take up low-quality, low-paying, or risky jobs in the public sector; or in unprofitable enterprises; or in newly created small private firms offering mainly service positions (Nesporova, 2002).

In short, it appears that after the demise of communism Bulgarian women's ambitions for meaningful and rewarding self-realization have in large measure been denied. Living in a society where men's monetary and social power is weakened by curtailed economic opportunity, women have been, and must surely feel, even more disempowered. It seems reasonable to suppose as well that young women in Bulgaria would experience the greatest frustration, given that unemployment in the country is highest among the young (15-24 age group) (World Bank, 2008). Numerous authors have pointed to the presence of eating disorders during times of frustrated ambition (Nasser & Katzman, 1999). Hungry for success and independence but frustrated by limited opportunities, women—especially young women—may turn to food for comfort and to appearance for approval. The possibility of controlling the body may provide a sense of mastery and an economic incentive, increasing one's chances for finding employment. In the case of Bulgaria, research is needed in order to substantiate these claims. To the best of my knowledge, however, no one has studied the subjective experiences of Bulgarian women when it comes to body image and food. It is the purpose of this study to take a step in the direction of investigating these topics by providing data for forming future research hypotheses.

3.5.2. ACCULTURATION

3.5.2.1. The External Culture—Influx of Western Values in Bulgaria

Cross-cultural literature has repeatedly pointed to Westernization (i.e., acculturation to Western values) as a major risk factor for the development of eating disorders (Katzman & Lee,

1997). Exposure to Western media influence is often seen as the primary avenue of Westernization (Rathner et al., 1995). In communist societies significant restrictions were imposed on the availability of Western, especially US, media (movies, TV and radio, newspapers and magazines, music etc.). In Bulgaria at the present time formal restrictions are gone, and people have free access to these products of Western culture (Deltcheva, 1996). For some, however, this access is limited by several factors, including cultural distance—many people had begun being exposed to substantial amounts of Western media only after reaching maturity, thus making them less receptive to it; the language barrier—products of the Western mass media have to be translated to be understandable to much of the population; and finally unfamiliarity with newer technologies—many people have had no opportunity to learn the use of relatively new and expensive media outlets like computers and the Internet. However, these limitations may not apply to adolescents and young adults, who came of age since the beginning of the socioeconomic transition, who may have some knowledge of English, who have grown up using the Internet, and who have been absorbing media from the US and Western Europe since early childhood (Deltcheva, 1996). However, the effects of Western type media—selling Western values including that of ultrathin beauty—on the beauty ideal, weight dissatisfaction and eating behavior of Bulgarians, whether young or old, remains largely unexplored. To begin to address this knowledge gap, my study will, among other things, attempt to assess urban Bulgarians' exposure to Western media and the degree to which they have internalized the ultrathin Western ideal.

3.5.2.2. The Native Culture—The Unique Tradition of Fasting in Bulgaria

It would be imprudent to assume that preoccupation with thinness, body dissatisfaction and disordered eating result merely from exposure to media portraying Western culture, despite the relative popularity of this theory among social scientists. When examining susceptibility to body image disturbance and eating pathology, a close look at a country's cultural biography is warranted

(Meehan & Katzman, 2001). Accounting for the country's social, religious, and political history is necessary to understand the unique ways in which external forces of Westernization may infiltrate and interact with the native environment to produce eating disturbances. Steinhausen (1985) has argued that the further East one moves the less the belief concerning an "ideal (i.e., thin) body" serves as the anorexics' (an eating disordered individual) explanation for their starvation behavior. Some researchers have suggested that certain religious beliefs and practices may encourage dieting and weight control behaviors (Banks, 1996; Bell, 1985; Bemporad, 1996; Brumberg, 2000; Bynum, 1988). Fasting is potentially one such practice.

Despite decades of secularization, fasting is widely popular in Bulgaria, largely as a result of it being a standard component of the country's dominant religion, Orthodox Christianity. Originally a part of religious doctrine, fasting has become deeply ingrained into the cultural traditions, customs, and way of life of Bulgarians. In general, relationships between religious practices and dieting are not clear (Kim, 2006). However, the socio-cultural endorsement of fasting is arguably a contributing factor in the great success and proliferation in Bulgaria of popular literature advocating fasting and food restriction as therapies and cure-alls, exemplified by such titles as *Hunger as a Medicine* (Gavrilova, 2007), *Hunger—Friend and Cure* (Kovacheva, 1998), and *Starving the Right Way* (Angelov, 1999), among others. Similarly, this openness to, and high level of acceptance of, fasting, a self-restraint behavior, may facilitate the adoption of an anorexic attitude. With self-restraint behavior already a common cultural norm, it is reasonable to expect a body image, whose achievement is dependent on such behavior, to be assimilated more readily among Bulgarians than in a society where the behavior is discouraged or stigmatized. Alternatively, fasting may function as an additional dietary restraint strategy and/or a socially acceptable disguise for women with already existing disordered eating. What is more, Western socio-cultural influences (e.g. norms of thin beauty) may interact with local cultural peculiarities (e. g. traditional fasting behavior) to produce

completely novel and unique expressions of body image and eating concern among the Bulgarian population. Keeping these possibilities in mind, the current research attempts to develop an understanding of fasting behavior (its meaning, motivation, perceived benefits, etc.) in a sample of urban Bulgarians.

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CHAPTER 4

GENERAL RESEARCH DESIGN AND METHODS

4.1. RESEARCH PARADIGM

The overarching philosophical stance governing this dissertation study is that of pragmatism, using the mixed-method approach to explore issues of beauty ideal, body dissatisfaction and eating behavior in modern urban Bulgarians.

Traditionally, social and behavioral scientific inquiry has been a reflection of and guided by two major opposing philosophical stances (or paradigms), those that are “positivist” or “empiricist” and those that are “naturalist” or “constructivist” (Sobal & Lee, 1997). The positivist/empiricist paradigm presumes that knowledge can be discovered through scrutiny of a real world situated outside of the researcher. Conversely, the constructivist paradigm sees knowledge as individually constructed by the researcher who exists within the complexity of multiple realities. Typically, quantitative research has been associated with positivism and qualitative research with constructivism. There is, however, a third approach—the mixed-method approach—which integrates research methods from both quantitative and qualitative traditions “in a fashion that best addresses the given research questions” (Armitage, 2007). The mixed-method approach is situated, therefore, within a pluralistic paradigm, which rejects the “forced choice between positivism and constructivism” (Creswell, 2003). This paradigm is known as the pragmatic paradigm.

4.2. RESEARCH DESIGN

The overall study design is one of mixed methods, in which mixed (i.e., both quantitative and qualitative) data were gathered as part of the same project. Quantitative data took the form of surveys administered in the first phase of research, whereas qualitative data in the form of in two

consecutive in-depth interviews were collected during the second phase. The quantitative phase of research was used to guide and narrow the scope of the qualitative. “Qualitative” here refers to data that can be characterized in terms of their quality and that typically appear in the form of words (as part of extended text) or images. Such data require some processing and are not immediately available for analysis (Miles & Huberman, 1994). On the flip side, “quantitative” data are described in terms of quantity, that is, usually in some numerical form. It is important to mention, however, that the distinction between qualitative and quantitative data is “not unambiguous, nor are the two classes mutually exclusive” (Rosenthal & Rosnow, 2008). For instance, in mixed-method designs data may be converted (i.e., “qualitized” or “quantitized”) from one kind into the other (Bazeley, 2003).

The mixed-method approach of this study implies the use of a combination of qualitative and quantitative techniques for data collection, analysis, and interpretation. When describing research methodology, however, the terms “qualitative” and “quantitative” are used in a broader sense. That is, “quantitative” refers to methods dealing with the quantitative properties of the phenomena under investigation and the relationships between these properties, whereas “qualitative” denotes methods striving for an in-depth understanding of the phenomena under investigation. In other words, “quantitative” methods answer the “what,” “where” and “when,” while “qualitative” methods investigate the “why” and “how” of the studied phenomena.

The results of the quantitative and qualitative analyses were compared, and to the extent possible, integrated by using data triangulation (Creswell, 2003). Triangulation is the procedure of combining and comparing multiple data sources, data collection and analysis procedures, research methods, or inferences that occur at the end of the study (Tashakkori & Teddlie, 2003). Quantitative results provided the opportunity to “generalize specific observations, correct monolithic judgments about a case,” and “verify or cast new light on qualitative findings” (Miles &

Huberman, 1994). Conversely, qualitative results served to “provide richer detail and help validate, interpret, clarify, and illustrate quantitative findings”, as well as to expand on quantitative findings to “build, strengthen, and revise theory” emerging from raw data (Miles & Huberman, 1994). Due to the advantages it offers as well as to the nature of the collected data, the mixed-method approach was seen as the best choice for this study.

4.3. PILOT STUDY SUMMARY REPORT (SUMMER 2008)

A pilot study was conducted in the summer of 2008 with a sample of urban Bulgarians of both genders living in the city of Sofia. Participants were recruited through personal and professional contacts at institutions of higher learning, high schools, exercise studios, spa centers, and cosmetic studios. Interested individuals participated in one semi-structured interview at a time and place of their choosing.

In the course of the interview, questions from about five major areas were pre-tested, using an interview guide approved by the IRB in April of 2008: 1) Food consumption frequency and a 24-hour dietary recall; 2) Eating attitudes and behavior using the Eating Motivation Trait Inventory (EMTI) by Horner (1998); 3) Degree of adoption of Western ideal body standards using the Social Attitudes Towards Appearance Questionnaire (SATAQ) by Heinberg et al. (1995); 4) Assessment of issues related to the perceptions of ideal body ("ideal body image") using Stunkard's Figure Rating Scale (Stunkard et al., 1983); and 5) Exposure to and interest in Western media using items found useful by Biloukha (2000) for the Ukraine.

In addition to conducting interviews, I examined print media such as books, magazines, newspapers and catalogues, viewed popular TV shows, collected movie theater listings, explored popular web portals, and surveyed grocery stores and other places where food is sold to determine the degree of exposure to western media and the availability and cost of food items.

The interviews addressed how well the respondents understood the questions asked, whether they felt the questions were relevant to their life, whether they were interesting, whether there were other questions pertaining to the subject that they would have liked to see added, whether they thought any of the questions to be too personal, etc. Based on their feedback, as well as observations of their behavior during and after the interviews, participants responded to the questionnaire very well. Questions were comprehensible and getting at the desired information without difficulty. Interviewees showed interest and excitement, and were engaged in the interview process. These data, along with participant's comments and translation suggestions, were taken into account when refining translations of study materials for the dissertation research. Interviews were partially transcribed and data from interviews was analyzed for content, in order to develop a culturally relevant questionnaire to be administered in summer 2009.

Forty-seven semi-structured interviews were taken between the months of May and August, 2008. Individual interviews lasted from about 50 min to 2 hours, with an average duration of 1h and 15 min. Participants were of both genders, aged 18 to 69 (only one participant was 69 at the time of interviewing, all others were 65 or younger).

Over the course of Fall 2008 and Spring 2009: 1) pilot data were analysed using a combination of qualitative and quantitative techniques; 2) results from these analyses were used to narrow the scope of the dissertation study, focus its research questions, and developing a culturally relevant questionnaire and an interview guide to address these questions.

4.4. THE CURRENT DISSERTATION STUDY (SUMMER 2009)

4.4.1. SETTING

This study's site was selected and its participants recruited to ensure sufficient diversity of the phenomena under investigation (Lincoln & Guba, 1985), namely the beauty ideal, body dissatisfaction, and eating behavior of urban Bulgarians.

4.4.2. SITE SELECTION

Sofia, Bulgaria's capital and largest city, was selected as the site for this study due to the city's modernity, large population, and multiple opportunities for data collection. As a native of Sofia I have familiarity with the city and no serious cultural or language problems. I had also amassed a number of personal and professional contacts with members of the local community. Furthermore, Sofia's status as a metropolis, and hence a major gate for Western influences, make it particularly appropriate for studying the processes of Westernization and modernization.

4.4.2. PARTICIPANT SELECTION

This project utilized three non-probability sampling techniques—convenience and snowball sampling (in the quantitative phase of research), and purposive sampling (in the qualitative phase of research) to recruit and select members of the population of interest.

4.4.2.1. Quantitative Phase of Research

Convenience sampling is a type of non-probability sampling in which the participants are selected at the convenience of the researcher (Stangor, 2007). A convenience sample of survey participants, intended to provide a cross-section of ages, was recruited through personal and professional contacts (i.e. intermediaries) at institutions of higher learning, secondary schools, and other places of employment (e.g. sports clubs, exercise studios, spa and cosmetic centers, hospitals, state-owned and private companies) where was likely to find individuals with desirable characteristics (e.g., varied age, religious beliefs, and media consumption).

Snowball sampling is a procedure in which one or more key individuals from the population are contacted and used to lead the researcher to other members of the population (Stangor, 2007). Business cards and brochures (see Appendix 1) describing the study and giving my contact information were given to key individuals (professors, teachers, instructors, beauticians, etc.) from

the aforementioned locations, to distribute to potential participants. Additionally, a number of the surveyed participants offered to help with recruitment by distributing materials (brochures and/or business cards) and talking to friends and acquaintances likely to become participants. The recruitment process was greatly advanced by the efforts of these key persons (i.e. intermediaries) who provided invaluable assistance in contacting and/or arranging appointments with interested individuals. Interested individuals who contacted the investigator either directly or indirectly (via an intermediary) were given a questionnaire booklet to fill out. To assure quality of translation, brochures were translated and back translated by two independent bilingual individuals other than myself and their feedback was used to produce the final materials.

4.4.2.2. Qualitative Phase of Research

Purposive sampling is a naturalistic sampling technique in which researchers seek out groups, settings, or individuals where and for whom the processes being studied are most likely to occur (Denzin & Lincoln, 1998). As Lincoln and Guba (1985) content, the purpose of such sampling is to maximize information, not to facilitate generalization. There are no a priori specifications of the sample as the latter is determined “on the go” by study circumstances until reaching a point of information redundancy. In the current research purposive sampling was used to recruit a sub-sample of interviewees (of both genders) from the larger sample of survey participants. Survey participants were invited to leave their contact information on the front or back of the 10-page survey booklet if they wished to volunteer for the qualitative interview process as part of the second phase of research. Based on information provided by volunteers in their surveys, I selected interviewees for maximum variation in a set of desirable characteristics (e.g., age group, media consumption habits, spiritual beliefs, and fasting experiences).

4.4.3. SAMPLE SIZE CONSIDERATIONS

4.4.3.1. Quantitative Phase of Research

Of the 327 booklets distributed (to participants of both genders), 321 were returned with the consent form on top signed. Of these returned questionnaires, 2 were excluded due to being nearly blank. Thus, 319 questionnaires were used in the analyses, resulting in a final overall response rate of approximately 98%. A total of 235 females and 84 males aged 18-82 years made up the final survey sample. Considering the explorative nature of this research this survey sample size was considered sufficient.

4.4.3.2. Qualitative Phase of Research

In qualitative research the question of appropriate sample size is answered by the concept of “theoretical saturation” described by Glaser and Strauss (1967) and Corbin and Strauss (2008). Theoretical saturation occurs when no new or relevant data seem to emerge and information from interviews becomes somewhat redundant (Douglas, 2003; Goulding, 2002; Locke, 2001). However, there is no set number of interviews at which theoretical saturation will occur. The sample size is dependent upon the scope of the research questions (Morse, 2000; Sobal, 2001). A broader research scope requires more data collection, i.e. more interviews and/or interviewees, sometimes even alternative data sources.

Analyses of pilot data allowed me to clarify and narrow the scope of the research questions. This, as well as the limited time for data collection—about 3 months between May and August of 2009, with July and August being summer vacation months during which tracking down participants was more difficult—prompted me to aim for two consecutive interviews from a smaller number of participants. Keeping the aims of my research in mind, I came to believe that theoretical saturation was reached at 23 interviews (with 13 female and 10 male participants aged 18-81 years). This number falls within the mode recommended range of 20 to 30 informants (Safman & Sobal, 2004).

Alternative information sources were also utilized to deepen my understanding of the phenomena of interest (see “Participant Observation” below).

4.5. DATA SOURCES AND COLLECTION

4.5.1. QUANTITATIVE PHASE OF RESEARCH

4.5.1.1. Survey

4.5.1.1.1. Procedure

A survey was conducted over a period of approximately 3 months from May through August 2009, with the majority of surveys collected in May and early June. Participants were given a questionnaire booklet to fill out either at home, or in the office or classroom, or another location providing an adequately disturbance-free environment. The goal of the survey was to collect quantitative data on a larger sample of Bulgarians, as well as to screen for individuals with desirable characteristics for the purposes of maximum variation qualitative sampling via interviews.

The survey was devised to take up to 30 minutes to complete, however secondary students were given a full school hour (with a 10-minute intermission) or a total of 50 minutes to work on the booklet. Similarly, university students had about an hour to complete the survey. The rest of the participants were not limited in terms of time (they could work on the questionnaire on their own time at a location of their convenience).

4.5.1.1.2. Questionnaire Booklet

The survey questionnaire was designed as a 10-page booklet entitled “Food and Eating Habits of Modern Bulgarians” (see Appendix 2). It contained questions covering the following 5 main topics:

- 1) Relevant anthropometric and socio-demographic data, including questions on spiritual belief (level of faith) and fasting behavior (frequency), were collected using a country specific questionnaire developed using pilot data from summer 2008;
- 2) Western media exposure and consumption were assessed by using a measure derived from the work of Biloukha (2000) in the Ukraine. Analysis of pilot data confirmed the appropriateness of this measure for the Bulgarian situation. Items were regrouped and only slightly modified to facilitate readability and comprehension in the Bulgarian language;
- 3) A realistic figure set, which corresponds closely to Bulgarians' idea of an average female and male silhouette, was used for the assessment of body image perceptions and attitudes (including body dissatisfaction). This figure set was the Contour Drawing Rating Scale (CDRS) developed by Thompson and Gray (1995). Due to extensive critique of the Stunkard Figure Rating Scale (Stunkard et al., 1983) by participants in the pilot study in summer 2008, I decided to discontinue using these figures. Questions associated with the figures were regrouped and their wording modified to facilitate readability and comprehension in the Bulgarian language;
- 4) The degree of adoption of Western ideal body standards was assessed by employing questions from the Social Attitudes Toward Appearance Questionnaire (SATAQ) by Heinberg et al. (1995). Analysis of pilot data confirmed the appropriateness of this scale for the Bulgarian situation. Items were only slightly modified to facilitate readability and comprehension in the Bulgarian language;
- 5) Disordered eating attitudes and behaviors were evaluated using the 40-item Eating Attitudes Test (EAT-40) developed by Garner and Garfinkel (1979). A version of the EAT-40, which had been previously translated and used with Bulgarian samples by Boyadjieva (1994), a

psychiatrist, was used in the present research. The EAT-40 is a widely used, non-diagnostic, screening tool for the assessment of disordered eating attitudes and behaviors.

4.5.2. QUALITATIVE PHASE OF RESEARCH

Two qualitative techniques—participant observation and interviews—were employed for data collection, and multiple information sources were used to examine the study’s research questions.

4.5.2.1. Participant Observation

Across the social sciences, participant observation is a method in which the researcher observes and takes part in the daily activities, rituals, interactions, etc. of the people being studied in order to learn more about the explicit and tacit aspects of their culture (Dewalt et al., 1998). In my study I practiced participant observation by living in the community, taking part in usual activities, talking and spending time with local people, and making conscious observations. Highlights of all relevant observations were recorded as field notes (either in the form of voice or written records).

4.5.2.1.1. Observations of Language

I employed a discourse-centered approach to conduct informal conversations with some of the study participants as well as with younger teens, senior citizens, high-school teachers, college professors, undergraduate and graduate students, and anyone who was willing to discuss their everyday lives, health and nutrition related concerns, or the media environment. Discourse-oriented approaches are used in participant observation to elicit deeper understanding of the culture under investigation. Within these approaches, speech and socially situated discourse are seen as constitutive of culture and therefore close attention is paid to the specifics of language—particularly “naturally occurring discourse”—used in different social situations (Farnell & Graham, 1998).

4.5.2.1.2. Observations of the Media and Food Environments

During my stay in Bulgaria I examined written and visual media such as books, magazines, newspapers, TV programs and movies, and surveyed grocery stores and other places where food is sold to determine the degree of exposure to Western values, and the availability and cost of food items.

4.5.2.1.2.1. Media Observations

➤ *Assessment of the availability of Western magazines and catalogues:*

Western magazines available to the general public in stores were recorded along with their prices; fashion and entertainment magazines and newspapers were collected and read throughout my entire stay in Bulgaria, and more systematically over the course of a month, or when supplied by certain participants; questions about frequency of reading Western magazines and catalogues were included in the interview.

➤ *Assessment of Western content accessible via the web:*

Western media content made available through Bulgarian-based web portals (e.g., abv.bg, dir.bg, vbox.bg) was evaluated; questions about entertainment and media websites visited online were included in the interview.

➤ *Sampling of TV programs and movies:*

TV programs and movies were watched and scrutinized; TV and theater listings were collected to assess the type and number of Western programs and movies being shown as well as the amount and type of commercials (especially food and fitness-related); questions about frequency of watching different kinds of Western programs and films were included in the interview.

4.5.2.1.2.2. Food Observations

Food shops, farmer's markets, supermarkets, local food stands, and other food sources (e.g., supermarket brochures) were surveyed for content and price. Particular attention was paid to those foods that are considered "healthy" and "unhealthy" by the US population based on recommendations from the USDA Food Guide Pyramid (mypyramid.gov).

4.5.2.1.2.3. Additional Observations

Photographs were taken of food markets and stands, road advertisements and billboards, and cosmetic and beauty aisles of pharmacies.

4.5.2.2. Interviews

Interviews are widely used across the social sciences as a method of collecting self-report data from a group of people. Interviews provide a "snapshot" of people's thoughts, beliefs, and behaviors at a given place and time (Stangor, 2007). Because interviews allow the participants to express their own views relatively freely without being too constrained by the preconceived notions of the researcher, this method was selected as the primary method of investigation for this project.

In my study I employed face-to-face interviews to explore issues of body image, body dissatisfaction, and eating behavior in modern urban Bulgarians. Interested individuals were interviewed at a time and place of their choosing. All interactions took place at the participants' home, office, or another location providing an adequately disturbance-free and private environment, depending on participant preference. Individual interviews lasted from about 50 to 180 min for the initial interview and about 30 to 60 min for the follow-up interview, with an average duration of 1h and 30 min, which falls within the recommended duration range of 60 to 90 minutes (Safman & Sobal, 2004). Along with digitally recording the on-going conversation, in the course of interviewing I took brief notes of any relevant non-verbal phenomena such as quality and pitch of voice, facial

expression, body posture and movements, etc. Additionally, briefly after each field contact I wrote up a note summarizing the highlights of the interview.

4.5.2.2.1. Interview Protocol

Each interview appointment began with a brief introduction session followed by a recorded session. During the introduction I explained the overall topic and purpose of the interview, and prompted the interviewees to read and sign the Informed Consent Form (see Appendix 3). I also assured the interviewees of confidentiality, asked their permission to tape-record the interview, and answered questions as necessary.

After the introduction was completed, the digital recorder was turned on and interviewing began. During the recorded session of the initial interview I followed a semi-structured interview schedule (see Appendix 4), which covered ten main topics of conversation: 1) friendships; 2) physical activity; 3) media, social, and cultural environment; 4) attractiveness; 5) religion, faith, and fasting beliefs; 6) food rules and eating habits; 7) healthy eating; 8) weight history; 9) body image; 10) pursuit of pleasure and impulsivity. This interview guide was developed based on pilot data from summer 2008, as well as advice from experienced qualitative researchers who reviewed the script to assure quality and comprehensiveness. Their suggestions and corrections were incorporated into the script.

Initial interviews usually started with questions related to eating behavior and ended with checking socio-demographic data on surveys for completeness and accuracy, however, the sequence of interview parts was kept flexible to keep participants interested. Only topics seen as relevant to the study were included in the interview, that is, topics implicated by theory or mentioned in the literature, and topics that might potentially affect the results (Weller, 1998).

The goal of the initial interview was to gather rich qualitative data on the phenomena under investigation. At the end of this initial interview participants were asked permission to be contacted

for a follow-up interview within a few weeks of the first one. The goal of the second interview was to follow up on issues, as well as confirm and clarify concepts, categories, and themes that emerged during the first interview, as part of a process known as member checking (Lincoln and Guba, 1985). The second interview's questions and probes were unique depending on each particular interviewee, but all questions were based on those in the initial interview.

4.5.2.2.2. Interview Schedule

4.5.2.2.2.1. Item Generation

The interview schedule—the specific set of instructions and items (e. g., questions)—was prepared by generating items relevant to the research objectives, as well as drawing on items already available in the literature. The use of existing interview materials is justified, because it allows the researcher to take advantage of the large amount of work that goes into the development of such materials, and facilitates communication with a larger group of scholars (Weller, 1998). In this particular study, several items (related to a few subjects of conversation) were adapted from the literature sources shown in Table 4.1.

Table 4.1. Interview schedule items (shown by subject) adapted from literature sources.

Subject of Items	Literature Source
Healthy eating attitudes, barriers and information sources	Adapted from the Pan-EU Survey of consumer attitudes to food, nutrition, and health as presented in the work of Utermohlen and Biloukha in the Ukraine (Biloukha, 2000).
Media environment; Attractiveness	Adapted from the work of Utermohlen and Biloukha in the Ukraine (Biloukha, 2000).
Pursuit of pleasure and impulsivity	Adapted from the Asceticism and Impulse Regulation sub-scales of the Eating Disorders Inventory (EDI-2) by Garner (1991) in its Bulgarian version by Boyadjieva (1994).

4.5.2.2.2. Item Format

My study made use of the semi-structured interview approach to elicit information from interviewees. Semi-structured interviews—also referred to as “guided conversations” (Massey, 2000 as cited in Rosenthal & Rosnow, 2008)—are a hybrid instrument, combining open-ended and structured (fixed-response) question formats to bring out both deeper and more comparable responses respectively.

In my study I generally used open-ended questions to explore topics—such as the meaning of fasting in Bulgaria—about which little is known. I employed a more structured approach—e.g., provided interviewees with specified ranges of responses—to obtain better comparable data on less obscure issues. By varying the question format I successfully maintained participants’ interest throughout the somewhat lengthy interview process. Additionally, I varied the question format with the intention of eliciting more relevant replies and also to simplify future data coding and analysis (Rosenthal & Rosnow, 2008).

4.6. DATA ANALYSIS

The following section details methods that were used in the analytical stage of this research. I employed both qualitative and quantitative techniques for data analysis as implied by the mixed-method nature of this study. Data collected with both methods were compared and to the extent possible integrated via data triangulation in order to provide a better understanding of the results in light of the research questions (Creswell, 2005).

In the course of the study data will be continually “selected, focused, simplified, abstracted, and transformed” as part of a process known as data reduction (Miles & Huberman, 1994). Data reduction is in fact “analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that final conclusions can be drawn and verified” (Miles & Huberman, 1994). In this particular project, the results from quantitative data analysis contributed to data reduction by narrowing down

the scope of the qualitative phase of research and refining its research questions. Consequently, not all collected qualitative data, but only data relevant to these research questions, were processed in analyses. During the preparatory stages of analysis available materials were scrutinized for relevance to the research questions. All survey data were entered manually by me and double-checked for accuracy. Documents and field notes were read (to enhance qualitative analyses), and interview recordings transcribed by myself, as well as a team of paid Bulgarian transcribers (to speed up the transcription process) who had no way of knowing and identifying the interviewees as all personal identifiers had been removed.

Raw textual data were handled in Bulgarian (with the exception of one interview transcript, which was translated into English by myself). I translated into English only the codes, themes, categories, and concepts that emerged from qualitative data analyses, as well as the excerpts of text or quotations to be used to illustrate findings from my research. Quality of translation was assured by means of debriefing sessions with another bilingual individual who assisted me in selecting the most semantically appropriate English equivalents of Bulgarian words, phrases, and expressions. This person did not have access to the actual text or the identity of the interviewees involved.

Data management methods for both quantitative and qualitative leg of the dissertation study (sorted by data collection technique and source) selected for this study are presented in Table 4.2 below.

Table 4.2. Data management methods by data type, collection technique, and source.

Technique	Source	Management
A. Quantitative		
Surveys	Questionnaire booklet	Statistical data analysis
B. Qualitative		
Participant Observation	Documents Photographs Field Notes	Used to inform and complement grounded theory
Interviews	Interview Transcripts Field Notes	Grounded theory

4.6.1. QUANTITATIVE METHODS

Data from questionnaires were analyzed quantitatively using a variety of statistical techniques and software packages. Descriptive statistics, paired t-tests, Student's t-tests for pairwise comparison of means, Analysis of Variance (ANOVA), univariate and multivariate linear regression, Principal Components Analysis (PCA), and Classification and Regression Trees (CART)/recursive partitioning analysis were performed using JMP (JMP, Versions 7 & 8, SAS Institute Inc., Cary, NC, 1989-2007). Partial correlations among variables were calculated using PASW Statistics 18, Release Version 18.0.0 (SPSS, Inc., 2009, Chicago, IL, www.SPSS.com). Fisher's exact test was computed with StatXact 9 (Cytel, Inc., Cambridge, MA).

4.6.2. QUALITATIVE METHODS

4.6.2.1. Grounded Theory

I handled qualitative data by employing a set of procedures known as grounded theory. As Bernard and Ryan (1998) and Strauss (1987) describe it, grounded theory provides the researcher with insight into participants' experiences; a sound methodology for identifying categories and concepts emerging from text; and the tools to link these concepts into substantive and formal theories.

Using grounded theory for this project was essential, because of the lack of previous research regarding the issues of beauty ideal, body dissatisfaction, and eating behavior in the context of Bulgaria. This method allowed for theory to arise directly from the data about how the phenomena under study actually worked (Bernard & Ryan, 1998).

I used two sources of textual data—field notes and interview transcripts—to build grounded theory.

4.6.2.1.1. Field Notes

Field notes are either brief or detailed scripts of observations and events made by the researcher in the course of fieldwork. They contain invaluable information but at the same time are a product constructed by the researcher (Dewalt & Dewalt, 1998). In other words, field notes are simultaneously data and analysis. In this study, raw field notes were generated in the course of participant observation, as well as during and after semi-structured interviewing. These notes were converted into “write-ups,” which were then read multiple times and used to further analysis, for instance, by suggesting new or revised codes and informing data interpretation.

4.5.2.1.2. Interviews Transcripts

Small sections of text from transcripts (the section of the interview dealing with issues of religion, faith, and fasting attitudes and beliefs) were read several times and viable themes and concepts were identified. Codes, concepts, and categories were generated, reviewed, and modified by using the constant comparison method (Charmaz, 2000; Glaser, 1992). In this method events such as participant’s views, experiences, behaviors, actions, etc. were constantly compared within individual cases, as well as across the entire sample; events were compared to emergent categories; and categories were compared to each other. The relationships among categories were then used to build theoretical models, constantly checking those models against the data (Bernard & Ryan, 1998).

The initial steps of data analysis were open (usually line-by-line) coding followed by axial coding. Open coding was used to generate provisional concepts or codes that seem to fit the data (Strauss, 1987). Axial coding involved a more intense analysis of data around single concepts in order to determine several core categories. This enabled selective coding, which involved coding systematically and concertedly for core categories (Strauss, 1987), and was used to saturate, integrate, and refine categories. As the analysis proceeded, there was a shift from descriptive to more abstract, higher-level categories, allowing for theory to lift off from the data.

I used several techniques to further integrate and refine the coding process. First, field notes from participant observations and interviews were reviewed. Similarly, I read records of my research-related thoughts, decisions, questions, and insights, collected throughout the study as part of a reflexive journal. Furthermore, during data analysis I took short notes (i.e., memos) about the codes, as well as about potential hypotheses and new directions for the research (Bernard & Ryan, 1998). Last but not least, I use additional data, e.g. from newly transcribed portions of interviews, written materials and/or photographs, to refine theory and fill in conceptual gaps. The emerging grounded theory informed decisions whether to use such data. This decision-making process is called theoretical sampling, in which the analyst decides on analytic grounds what data to collect next and where to find them (Strauss, 1987). Theoretical sampling occurred during data collection (as part of purposive sampling of interviewees), as well as in the form of “sampling of text” obtained from materials readily available.

4.6.2.2. Use of Qualitative Analysis Software

I used a software package, ATLAS.ti, (ATLAS.ti Version 6.2.12, Scientific Software Development, Berlin, DE, 2002-2011) to assist me in managing the large numbers of documents of this project. ATLAS.ti is a powerful yet easy-to-use software package for the qualitative analysis of large bodies of textual, graphical, audio, and video data. Access to all basic project components such as primary documents (text, graphical, audio and video materials), quotations, codes and memos is fast and comfortable. Findings and interpretations can be visualized in a digital mind map throughout analysis.

Some researchers have qualms about qualitative data analysis software programs on the grounds that they are difficult and time consuming to learn, on top of promoting a superficial view of grounded theory. They suggest that computer-assisted analysis may dehumanize data analysis (Charmaz, 2000). On the other hand, many other authors argue that learning to use software

analytical tools is recommended, because these tools facilitate creative, systematic, and thorough research (Rubin & Rubin, 2005). I believe I was able to effectively use the selected software tool to gain a more holistic feel of the emerging grounded theory, as well as to assemble its parts.

4.6.2.3. Trustworthiness

Several practical standards and evaluative tactics were followed to assure the quality of qualitative research. Terms used to denote standards vary depending on the research paradigm being used. The standards and tactics deal with underlying issues of trustworthiness, authenticity, and quality of the research data and conclusions. Below is a table describing the standards, their underlying issues, and the specific tactics that were employed to assure the highest possible quality of qualitative research. These standards and tactics, shown in Table 4.3, are adopted from Erlandson et al. (1993), and Lincoln and Guba (1985).

Table 4.3. Standards and tactics for assuring trustworthiness of qualitative research.

Underlying Issue	Positivist (Conventional) Term	Naturalistic Term	Tactic
Truth-Value	Internal Validity	Credibility	Prolonged Engagement Member checks Reflexive Journal Triangulation
Applicability	External Validity	Transferability	Thick Description Purposive Sampling Reflexive Journal
Consistency	Reliability	Dependability	Reflexive Journal Audit Trail
Neutrality	Objectivity	Confirmability	Reflexive Journal Audit Trail Triangulation

To minimize bias stemming from my presence on-site and to heighten credibility, I sustained “prolonged engagement” (Lincoln & Guba, 1985) with the research participants to the point of data saturation. Indeed, the I was involved with participants in all phases of research—during the initial

survey, the lengthy (50 to 180 min) first interview, and the relatively long (30 to 60 min) follow-up interview, which encouraged rapport with interviewees and promoted more honest responses. Similarly, many of the interviews took place in congenial social environments such as cafes, restaurants, or the informant's home, which reduced both the researcher's threat and her exoticism (Miles & Huberman, 1994). My familiarity with the studied community, with its people, language and culture—being a native of Sofia—allowed me to fit into the landscape and keep a low profile. Having frequented the city over the last five years—three of which were research-focused visits—allowed me to also engage in multiple participant observations, thereby building trust with the members of the studied culture, and facilitating social and cultural insight, which resulted in stronger rapport with interviewees despite the relatively short duration of the study.

To address possible bias arising from my involvement with the research participants and ensure credibility, I used a reflexive journal where I recorded matters of importance to the project.

To further boost research credibility, I used the technique of member checking (Lincoln & Guba, 1985). Member checking in the sense of the interviewer paraphrasing, summarizing, and restating information received during a conversation to make sure that it is heard or understood correctly, was done throughout both interviews. Additionally, the second interview was used to formally follow up on questions and topics from the first interview, as well as ask interviewees to confirm, clarify, and comment on emerging concepts and themes, and the links between them. Nevertheless, special effort was made to refrain from the dangers of “romanticizing respondents' accounts” (Barbour, 2001; Atkinson, 1997).

To minimize bias stemming from use of data collection techniques, I sought data from multiple sources and recorded these data carefully. By scrutinizing and constantly comparing data from multiple sources (e.g., interview recordings, observations, written documents, field notes, etc.) and by integrating results obtained with different analytical methods (qualitative and quantitative) I

triangulated data in order to validate and confirm the findings from my research, thereby ensuring its quality.

To minimize bias related to abusive generalizing, I used my reflexive journal to record thick descriptions of my field experiences as a means of achieving research transferability (Lincoln & Guba, 1985; Miles & Huberman, 1994). Similarly, in the write-up of my research I continued to provide a sufficiently detailed account of research participants, settings, and processes, so that readers can assess the extent to which my research conclusions are transferable to other times, settings, situations, and people. Additionally, to minimize elite bias and to increase transferability, I looked for diverse (to the extent possible) participants within the population of interest—from both genders, various age groups, and different socio-economic backgrounds. This technique is known as purposive sampling.

To minimize distortions stemming from researcher bias and the use of data analysis methods (Miles & Huberman, 1994), I have kept clear records of methodological changes and decisions since the beginning of this project. I continued to do so until the development and reporting of findings. Furthermore, to ensure the credibility and confirmability of my findings, I will allow public access to research related documents that are not subject to ethical concerns. These may include parts of my reflexive journal, as well as the interview schedule, field notes, and other documents. All these documents are part of the audit trail for this study (Erlandson et al., 1993).

4.6. CULTURAL AND LINGUISTIC COMPETENCE

One has to know enough of a language to comprehend its peculiar or significant linguistic nuances (Levy & Hollan, 1998). The variations of standard speech that interviewees use in discourse usually convey meaningful personal information. Hence, cross-cultural interviewing depends on the adequate linguistic competence of the interviewer. Similarly, a researcher should have considerable

knowledge about a place and its people in order to understand the presence and significance of private variants and transformations of local cultural and social norms (Levy & Hollan, 1998).

As a native of Bulgaria and Sofia (the city where all interviews took place) I did not have serious cultural or language problems. In fact, I was able to easily “blend in” and gain participants’ trust before, during, and after interviewing, which encouraged their frankness. At the same time, as a doctoral student and someone who had lived in a Western country for a relatively long time, I was perceived as ‘interesting’ by interviewees and was treated by them with more than the usual respect, which boosted their willingness to partake and commit to the study.

4.7. TRANSLATION CONSIDERATIONS

The cross-national nature of my project called for translation of all materials (survey booklet, interview guide, brochures, and consent forms) that were distributed to participants from the source (English) into the target (Bulgarian) language. All materials were originally developed in English for, among other reasons, the convenience of my graduate advisor.

The questionnaire booklet and interview schedule were translated into Bulgarian by me, and back translated into English by a second bilingual individual living in the United States. The study brochure and consent forms were translated and back translated by two separate bilingual individuals (one living in Bulgaria and one in the United States) other than myself (Osman & Sobal, 2006; Harkness et al., 2004). All translators are fluent in Bulgarian and English and familiar with Bulgarian and Western cultures, which ensured cultural validity. Moreover, a third independent bilingual individual reviewed all translated materials and reconciled any translation differences to guarantee translation quality.

Additionally, translation quality was assured by my intimate familiarity with the survey and interview schedule’s measurement components and design (Harkness et al., 2004). Most questions

from the questionnaire (except the EAT-40 questions), as well as some of the items from the interview schedule, were piloted during summer 2008 with a sample of 47 Bulgarians, whose translation suggestions and comments were taken into account by the investigator during translations. I had available the Bulgarian version of the EAT-40, which I reviewed and modified only minimally to match the purposes of this study, assuring that questions were comprehensible and got at the desired information. The entire survey booklet and interview schedule were also piloted with one American (English original) and one Bulgarian (Bulgarian translation) woman living in the United States whose technical and linguistic feedback was incorporated into the final research materials.

Translation quality assurance was carried on until the end of the study. Comprehension of items or formulations was probed after each survey collection session (especially at the beginning of data collection) when responses were reviewed for errors and participant comments (whenever provided) were taken into account. Comprehension was assessed also after each interview in debriefing sessions and necessary adjustments were made before the next interview. Probes addressed how well the respondents understood the questions asked, whether they felt the questions were relevant to their life, whether they were interesting, whether there were other questions pertaining to the subject that they would have liked to see added, whether they thought any of the questions to be too personal, etc. Judging by their feedback, as well as my observations of their behavior during and after the interviews, participants seemed to respond to questions without strain. Questions were easily comprehensible and got at the desired information. Interviewees showed interest and excitement, and were engaged in the interview process.

4.8. ETHICAL CONSIDERATIONS

This study is guided by the traditional utilitarian approach of addressing ethical issues that may arise from work with human subjects. As Miles & Huberman (1994) contend: “a utilitarian,

pragmatic approach judges actions according to their specific consequences—benefits and costs—for various audiences: the researcher, the researched, colleagues, the public.” The ethical framework of this project is that of informed consent (during recruitment), avoidance of harm (during fieldwork), and confidentiality (during reporting) (Flinders, 1992 as cited in Miles & Huberman, 1994). The project was approved by Cornell University’s IRB (see Appendix 5).

4.8.1. INFORMED CONSENT

At the beginning of each survey or interview participants read and signed an informed consent form (see Appendix 3), which explained the purpose of the interview, as well as the way interview information would be used. To assure the quality of translation, the consent forms (three versions) were translated and back translated by two separate bilingual individuals different than myself (Osman & Sobal, 2006; Harkness et al., 2004). Furthermore, I assured participants of confidentiality with regard to personal information, asked permission to use a digital recorder during interviewing, and answered participants’ questions (if there were any).

4.8.2. BENEFITS AND RISKS

There were no direct and immediate benefits to study participants. I hope that the study will contribute to the research of disordered eating in Bulgaria and Eastern Europe, which has thus far been inadequately addressed, and be of use in future public policy decisions and disordered eating prevention efforts. The only risks to the study participants may have been the potential sensitivity of some of the questions I used in the survey or interview.

4.8.3. AVOIDANCE OF HARM

Participants were assured at appropriate intervals that they do not need to answer any question they do not wish to answer and that they can stop the survey or interview whenever they wish. By using questions from standardized survey tools, by amending survey or interview questions

based on respondent comments, and by paying careful attention to question wording, I kept the survey and interview as inoffensive and considerate of respondents' feelings as possible.

4.8.4. COMPENSATION

Study participants were monetarily compensated for partaking in the interview process—individuals who volunteered for the semi-structured interviews were paid per interview. While this compensation was sufficient enough, it was not so high as to create a financial participation bias. Survey participants (those who completed and returned only the questionnaire booklet) were not compensated.

4.8.5. CONFIDENTIALITY

Names were not recorded on any document that connects the name to the survey booklet or interview record. Signatures were obtained on the consent forms only. Since Bulgarians seldom spell out their names when signing, but rather use an illegible, yet creative composition of their names' initials as a signature, identification of the interviewee by his or her signature is practically impossible. To avoid students' influencing each other's answers, all surveys were completed simultaneously in the classroom in the presence of the researcher (myself) and a professor or a teacher, and collected directly by the researcher. It was made clear to students that participation was voluntary and that they could refuse to fill out the survey and leave the classroom at any time. Participants reached through a contact person were provided with sealable envelopes and given an additional option to staple closed their questionnaire booklet to keep it confidential. Participants selected for interviewing (out of the pool of survey participants) were given a code to hide their identity, which was used to identify their survey and interview, as well as their contact information. The code sheet with contact information was kept separately from the interviews and survey, and was destroyed once the interviews were complete. Digital voice recordings were downloaded to a

computer immediately after obtaining the recording, and the recordings on the device were erased in preparation for the next interview. The computer folder where participants' files were kept was locked and only I had access to the password. Interview transcriptions were carried by the researcher, as well as by paid transcribers who had no way of personally knowing or identifying the interviewees. Before and during interview transcriptions specific identifiers were removed to ensure individuals' anonymity. The recordings were destroyed after transcription of all interviews was completed.

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CHAPTER 5

DISORDERED EATING ATTITUDES AND BEHAVIORS AS MEASURED BY THE EAT-40 IN AN URBAN BULGARIAN SAMPLE

5.1. INTRODUCTION

For the past thirty or so years disordered eating has been the focus of a considerable amount of research, particularly in the West. The rise of disordered eating (and ultimately eating disorders) has often been declared a modern epidemic, as well as a culture-bound syndrome particular to Western societies. These views are part of the prevailing socio-cultural models for the development of disordered eating, in which Western society ideals are implicated as playing a central role (Bilukha & Utermohlen, 2002; Szabo & Allwood, 2004).

The rise in disordered eating in Western societies has coincided with a number of profound changes in these societies, including the rise of the consumer economy and its emphasis on individual satisfaction versus collectivist goals, and the increasing fragmentation of the family due to growing intergenerational conflicts and sex role upheavals (Gordon, 2001). Conflicts between modern and traditional socio-cultural expectations may be at the heart of the development of eating disorders, because they lead to a sense of personal uncertainty, self-doubt, and powerlessness, particularly among young women (Gordon, 2001).

On the whole, there has been no shortage of studies exploring these issues in the West. Indeed, until the 1990s eating disorders were considered unique to Western societies (Gordon, 2001; Prince, 1985). However, based on her review of internationally published research, Nasser (1997) proposed that this might not be the case. The processes of Westernization and modernization as societies transition culturally and economically, appear to have led to the emergence of disordered eating around the globe (Katzman & Lee, 1997; Rathner, 2001). These transitional processes expose

societies to new cultural norms, which destabilize traditional norms and produce various ill effects on mental health, particularly among the younger population (Rathner, 2001). Under these circumstances eating disorders can be seen as a maladaptive socio-cultural coping mechanism against the stressors of an increasingly complicated and rapidly changing world.

Due to the lack of recognition of such conditions and the virtual absence of formal epidemiological studies, it is difficult to determine whether eating disturbances existed in non-Western societies prior to the 1990s (Gordon, 2001). Research concerning disordered eating in European countries from the former “Eastern Bloc” appears to be particularly limited (Bilukha & Utermohlen, 2002). Nonetheless, the general belief has been that disordered eating and related behaviors are less prevalent in most of post-communist Eastern Europe than in the West (Bilukha & Utermohlen, 2002; Szumska et al., 2005). However, recent studies from this area suggest that the prevalence of dieting, compensating behaviors, and disordered eating may be similar to that of Western countries (Tolgyes & Nemessury, 2004). Furthermore, since eating disorders are often seen as a sensitive barometer of culture change, the rapid social, economic, and cultural transformations in former communist countries could be posing a heightened risk for weight preoccupation and disordered eating in these countries’ adolescent and young adult populations (Gordon, 2000; Rathner, 2001).

One such country is Bulgaria, a formerly communist Eastern European state that for the past two decades has been undergoing a drastic socio-cultural transition. As is the case for most of post-communist Europe, in-depth epidemiologic studies concerning the prevalence or alleged rise in eating disorders in the Balkans is at best scarce. Bulgaria, in particular, remains an essentially uncharted region with respect to eating disorders. In her 1994 dissertation, which as far as I know is the only study of its kind for Bulgaria, Boyadjieva focused exclusively on overt cases of eating disorders (Boyadjieva, 1994). Boyadjieva also conducted the only known study on disordered eating

among Bulgaria's non-clinical population. To the best of my knowledge there are no other studies dealing with issues of disordered eating attitudes and behaviors in non-clinical settings in Bulgaria. Similarly, relevant socio-cultural research is absent.

There have, however, been some general indications that eating disorders may be a growing problem in Bulgaria. According to one of Bulgaria's most acclaimed public health specialists—the president of the Bulgarian Scientific Society for Nutrition and Dietetics, Prof. Bojidar Popov, MD—4-5% of Bulgaria's female population suffers from anorexia nervosa (Popov, 2008), compared to 0.5-1% in Western Europe (National Center for Health Information, 2008). Additionally, a recent report prepared for the European Institute of Women's Health, *claims* that over 250,000 Bulgarian women suffer from anorexia nervosa, but there is no certainty as to how many more have gone undetected (Kerekovska, 2006). These numbers are striking and hint at a serious problem—to put the number in perspective, in all of Bulgaria there is a total of about 750 000 women between 15 and 29, the group most vulnerable to the disease (National Statistical Institute of Bulgaria, 2008). These data again suggest that the prevalence of disordered eating in Bulgaria may be unusually high, and may be higher than in the West. Most discussions of disordered eating in Bulgaria, however, are concerned primarily with clinical cases (overt eating disorders), while minimal attention is paid to the etiology of such disturbances. And it is precisely from this standpoint—that of etiology—that Bulgaria is interesting. Its protracted period of transition offers a unique opportunity for studying the intersection of body and culture under social, political, and economic strain.

Data reported in the current chapter (study 1) were collected as part of a larger study on body image, disordered eating attitudes and behaviors, and related media effects in a non-clinical sample subjected to socio-cultural transition in Bulgaria; I do not address the true prevalence of clinically diagnosable disorders such as anorexia nervosa or bulimia nervosa in the sample under investigation. I chose to employ the Eating Attitude Test (EAT) by (Garner & Garfinkel, 1979)—

one of the most widely used self-report questionnaires for the assessment of disordered eating attitudes and behaviors—because this would give the greatest latitude in comparing the current study’s results to those of studies previously carried out in the West. Indeed, the EAT has been used in both genders and across a variety of age groups and cultures (Garfinkel & Newman, 2001). However, the majority of studies that have employed this test relied on samples made up of adolescents and young women, gender and age groups for which the test was actually developed and validated. The EAT has not been similarly validated for other groups, such as older women and men, though it has occasionally been used with these groups for convenience and/or lack of an alternative psychometric tool (Alonso et al., 2005; Eagles et al., 2000). In seeking to investigate the effects of socio-cultural transition on disordered eating, I deliberately sought a cross-sectional sample of Bulgarians, anticipating cohort differences in eating attitudes and behaviors among the different age groups. By including older males and females in the sample, I obtained data that may also help illuminate the issue of the EAT’s utility for those groups.

In summary, the purpose of this study is: 1) to explore the prevalence of disordered eating in this Bulgarian sample from an under-researched, transitional, post-communist culture; 2) to compare the prevalence of disordered eating in this sample to those observed in Western societies; 3) to explore the effects of socio-cultural transition on the rates of disordered eating by studying age patterns; and 4) to illuminate the issue of applicability of the EAT to older individuals.

5.2. MATERIALS AND METHODS

5.2.1. SETTING

Sofia, Bulgaria’s capital and largest city (population of approximately 1.5 million), was selected as the site for this study. The sampling procedure used a convenience sample and was intended to provide a cross-section of ages. Participants were recruited through personal and professional contacts (i.e., intermediaries) established at various institutions of higher learning,

secondary schools, and other places of employment (e.g. sports clubs, exercise studios, spa and cosmetic centers, hospitals, state-owned and private companies).

5.2.2. PROCEDURE

The survey was conducted over a period of approximately 3 months from May through August, 2009, with the majority of surveys collected in May and early June. Participants were given a questionnaire booklet to fill out either at home, or in the office or classroom, or another location providing an adequately disturbance-free environment. Brochures or business cards with contact information for the researcher (myself) were made available to all persons contacted. Additionally, a number of the surveyed participants offered to help with recruitment by distributing materials and talking to friends and acquaintances likely to become participants. Interested individuals who contacted the investigator either directly or indirectly (via an intermediary) were given a questionnaire booklet to fill out.

The survey was devised to take up to 30 minutes to complete, however secondary students were given a full school hour (with a 10-minute intermission) or a total of 50 minutes to work on the booklet. Similarly, university students had about an hour to complete the survey. The rest of the participants were not limited in terms of time (they could work on the questionnaire on their own time at a location of their convenience).

While it is impossible to know the exact number, very few individuals refused to partake in the survey. Of the 327 booklets distributed, 321 were returned with the consent form on top signed. Of these returned questionnaires, 2 were excluded due to being nearly blank. Thus, 319 questionnaires were used in the analyses, resulting in a final response rate of approximately 98%.

5.2.3. QUESTIONNAIRE BOOKLET

The questionnaire was designed as a 10-page booklet entitled “Food and Eating Habits of Modern Bulgarians.” It contained questions covering 5 topics: demographic information, disordered eating attitudes and behaviors; degree of adoption of Western ideal body standards; body image and dissatisfaction; and Western media exposure and consumption. All survey data were self-reported. Only data on sociodemographics, anthropometric information, and eating attitudes and behaviors are presented in the current chapter.

5.2.3.1. Socio-Demographic Information

The following information was asked of participants: gender; date and place of birth, and the location where they grew up; race; ethnicity; religious affiliation, spiritual beliefs (i.e., level of faith), and practices (i.e., frequency of engaging in traditional fasting behavior); language skills; legal marital status; employment status and professional category; current and highest achieved educational level; monthly household income and expenditure for food.

5.2.3.2. Anthropometric Information

Participants were asked to self-report their height (m) and current, lowest and highest weight (kg). Body Mass Index (BMI) was calculated as the ratio between each person’s current weight (kg) to height squared (m^2) (Garrow & Webster, 1985). Participants were subsequently divided into four categories—underweight ($BMI < 18.5 \text{ kg}/m^2$), normal weight ($18.5\text{-}24.99 \text{ kg}/m^2$), overweight ($25\text{-}29.99 \text{ kg}/m^2$), and obese ($BMI \geq 30 \text{ kg}/m^2$)—based on the WHO International Classification of adult underweight, overweight and obesity according to BMI (World Health Organization, 1995, 2000, and 2004). As data analysis progressed, for the purposes of simplicity and clarity, I combined the underweight and normal weight categories into a new, “light weight” category ($BMI < 25 \text{ kg}/m^2$),

and the overweight and obese categories were merged to create the “heavy weight” category ($BMI \geq 25 \text{ kg/m}^2$).

5.2.3.3. Disordered Eating Attitudes and Behaviors

Disordered eating attitudes and behaviors were measured using the Bulgarian version of the 40-question Eating Attitudes Test (EAT-40) originally developed by Garner and Garfinkel (1979). This version of the EAT-40 was used in clinical and non-clinical samples of Bulgarian adolescents ($M = 15.2$, $SD = 1.3$ years) by Boyadjieva and Steinhausen (1996). Translations of the 40 test items were performed by Dr. Svetlana Boyadjieva, a bilingual psychiatrist and a seasoned expert in the screening, diagnosis, and treatment of eating disorders in Bulgaria.

For each of the forty items participants rate their agreement or disagreement on a 6-point Likert scale and the severity of their responses is scored from 0 to 3 with only the most symptomatic responses given scores of 1, 2, and 3. All answers are then summed and respondents who score above a cutoff of 30 are considered at risk of an eating disorder and referred for clinical evaluation. The small scale and limited funding of the current study did not, however, allow for clinical determination of eating disorders in the sample under investigation.

5.2.4. TRANSLATION CONSIDERATIONS

The questionnaire booklet, recruitment brochure, and study consent form were developed in English by the researcher (myself). The questionnaire booklet was translated into Bulgarian by me, and back-translated into English by a second bilingual individual living in the United States. The study brochure and consent form were translated and back translated by two separate bilingual individuals (one living in Bulgaria and the other in the United States) other than myself (Osman & Sobal, 2006; Harkness et al., 2004). All translators were fluent in Bulgarian and English and familiar with Bulgarian and Western cultures. Most questions from the questionnaire (except the EAT-40

items) were piloted during summer 2008 with a sample of 47 Bulgarians, whose suggestions and comments were taken into account during translations. The researcher had available the Bulgarian version of the EAT-40, which she reviewed and modified only minimally to assure that items would be comprehensible and get at the desired information.

5.2.5. ETHICAL CONSIDERATIONS

All surveys were collected anonymously and participants were assured that their participation was voluntary and that their answers would be absolutely confidential. While it is impossible to know the exact number, very few individuals refused to partake in the survey. In each recruitment setting the study was briefly introduced as being about the food and eating habits of contemporary Bulgarians. Furthermore, all participants were required to read and sign a consent form, which was stapled on top of each questionnaire booklet. To avoid students' influencing each other's answers, all surveys were completed simultaneously in the classroom in the presence of the researcher and a professor or a teacher, and collected directly by the researcher. It was made clear to students that participation was voluntary and that they could refuse to fill out the survey and leave the classroom at any time. Participants reached through a contact person were provided with sealable envelopes and given an additional option to staple closed their questionnaire booklet to keep it confidential. This study was approved by the Cornell University Institutional Review Board.

5.2.6. DATA ENTRY AND ANALYSIS

All data were entered manually by the researcher and double-checked for accuracy. Data from questionnaires were analyzed quantitatively using a variety of techniques including descriptive statistics, Student's t-tests for pairwise comparison of means, Analysis of Variance (ANOVA), univariate and multivariate linear regression, and Principal Components Analysis (PCA), among others. The JMP 7 statistical software package (JMP, Version 7, SAS Institute Inc., Cary, NC, 1989-2007) was used for these analyses.

5.3. RESULTS

5.3.1. SOCIO-DEMOGRAPHIC INFORMATION

A total of 319 adults ranging in age from 18 to 82 years participated in this study. Of them 235 (74%) were women and 84 (26%) men. Women ranged in age from 18 to 81 years, with a median and mean age of 26 and 32.8 (SD=17.0) years, respectively. The 84 men who took part in the survey ranged in age from 18 to 82 years and had a median age of 25 and a mean age of 30.6 (SD=15.7) years. Participants were grouped into four age categories. Approximately 62% of the sample was made up of young people falling within the first ('youth') age category (18-29 years). Participants were evenly distributed in the second ('young adults') and third ('middle-aged adults') category—16% were between 30 and 44 years and 17% between 45 and 64 years of age. Only 6% of the sample was comprised of 'seniors' aged over 65 years. All participants were Caucasian and most of them—ethnically Bulgarian—with only 2.2% of mixed ethnicity (e.g., Bulgarian and Russian or Ukrainian) and just 1 non-Bulgarian (e.g., Turkish) participant. Only 15% of participants did not speak a foreign language. The majority could read and understand spoken English and a sizeable number (27%) were comfortable with at least one additional Western European language (e.g., French, German, Spanish, or Italian).

The majority of participants were born, grew up, or at the time of data collection were living in a large urban area—over 94% were born and grew up in large cities (e.g., Sofia, Plovdiv, Varna); 3% were born in a village, but grew up in a large city; 1% were born in a large city, but grew up in a village; and 1% were truly rural—born and grew up in a village (N missing = 9). Most participants were never married (67%), some were in a first and only marriage (24%), and very few were either remarried, or separated or divorced, or widowed (9%). High-school seniors and university students (5% of whom graduates) accounted for about half of the sample (52%), and the rest came from diverse occupational groups (e.g., university professors, researchers, school teachers, bank

employees, accountants, lawyers, medical doctors, nurses, psychologists, salespersons, architects, engineers, artists, etc). Unemployed and retired participants were only a small fraction of the sample. Most everyone had earned (or was in the process of earning) the equivalent of at least a high-school diploma. Close to half of the participants (44%) had earned the equivalent of a college or university degree with 33% of the study sample holding a graduate (master's and above) degree and 4% having completed more than one higher education degree. In summary, the sample consisted of mainly young, urban, highly educated people, most of whom were women. A detailed description of the entire sample is given in Table 5.1.

Table 5.1. Socio-demographic characteristics of the whole mixed sample (N=319).

	N	% Sample
AGE CATEGORIES		
18-29	196	61.4
30-44	53	16.6
45-64	51	16.0
65+	19	6.0
ETHNICITY		
Bulgarian	311	97.5
Mixed	7	2.2
Non-Bulgarian	1	0.3
FOREIGN LANGUAGE SKILLS		
English Only	173	54.2
English and Non-English*	86	27.0
Non-English*	11	3.5
<i>*French, German, Spanish, or Italian</i>		
MARITAL STATUS		
Never married	214	67.1
Married, first and only marriage	75	23.5
Remarried	10	3.1
Separated or divorced	13	4.1
Widowed	7	2.2
EMPLOYMENT STATUS		
Student	122	38.3
Working Student	45	14.1
Unemployed	3	0.9
Employed (including self-employed or freelance)	120	37.6
Retired	21	6.6
Working retired	8	2.5
EDUCATION STATUS		
A. CURRENT STUDENT		
Upper Secondary (9 th grade and above)	87	27.3
Semi-Higher (College or equivalent)	1	0.3
Higher (University or equivalent)	79	24.8
B. HIGHEST COMPLETED EDUCATION		
Lower Secondary (Up to 8 th grade inclusive)	87	27.3
Upper Secondary (9 th grade and above)	92	28.8
Semi-Higher (College or equivalent)	18	5.7
Higher (University or equivalent)	122	38.3

5.3.2. BODY MASS INDEX (BMI)

5.3.2.1. Women

BMI was not calculated for 11 women due to lack of sufficient information (these women did not provide either their current weight or height, or both). As shown in Table 5.2, all other women's BMI ranged from 14.9 (underweight) to 52.7 (obese) with a median of 20.8 and a mean of 22.1 (SD=4.9) kg/m², which are within the normal weight range using criteria adapted from the World Health Organization (1995, 2000, and 2004). Across the entire sample of women, the majority (61.2%) were of normal weight. However, a sizable proportion of women (21%) were underweight, whereas only 12.5% were overweight and even fewer (5.4%) obese. There were small but significant increases in BMI with increasing age— R^2 (224)=0.26, R^2 Adj. (224)=0.25, $p < 0.0001$. The distribution of BMI (continuous variable as well as categories) by age category is presented in Table 5.2.

Table 5.2. Distribution of BMI for women: BMI groups for the overall sample and by age category.

Age Category	Overall Sample (F)	18-29 years	30-44 years	45-64 years	65+ years
N (% of F sample)	224 (95.3%)	136 (60.1%)	34 (15.2%)	39 (17.4%)	15 (6.7%)
BMI, kg/m ² :					
Range	14.9-52.7	14.9-30.9	17.2-52.7	19.2-39.1	20.6-37.5
Median	20.8	19.7	21.4	24.9	26.7
Mean (SD)	22.1 (4.9)	20.1 (2.8)	24.0 (7.5)	25.7 (4.6)	25.9 (4.6)
N missing	11	6	4	1	0
Underweight (BMI<18.5)	47 (21%)	44 (32.4%)	3 (8.8%)	0 (0%)	0 (0%)
Normal (BMI=18.5-24.99)	137 (61.2%)	85 (62.5%)	24 (70.6%)	22 (56.4%)	6 (40.0%)
Overweight (BMI=25-29.99)	28 (12.5%)	6 (4.4%)	2 (5.9%)	13 (33.3%)	7 (46.7%)
Obese (BMI≥30)	12 (5.4%)	1 (0.7%)	5 (14.7%)	4 (10.3%)	2 (13.3%)

5.3.2.2. Men

Table 5.3 shows the distribution of BMI and BMI categories for the overall male sample, as well as by each of the four age categories. Three men were excluded from these analyses due to

insufficient data. Most men in the current study were of normal weight (72.8%) and very few were underweight (4.9%), virtually all of the latter falling within the 18 to 29 years of age category. There was a significant increase in BMI with increasing age— $R^2(81)=0.26$, $R^2 \text{ Adj.}(81)=0.25$, $p<0.0001$.

Table 5.3. Distribution of BMI for men: BMI groups for the overall sample and by age category.

Age Category	Overall Sample (M)	18-29 years	30-44 years	45-64 years	65+ years
N (% of M sample)	81 (96.4%)	52 (61.9%)	15 (17.9%)	10 (11.9%)	4 (4.8%)
BMI, kg/m ² :					
Range	18.0-41.5	18.0-31.8	20.8-29.2	21.9-30.7	23.7-41.5
Median	22.8	22.1	23.7	24.3	29.0
Mean (SD)	23.4 (3.6)	22.4 (2.9)	23.8 (2.3)	25.3 (2.9)	30.8 (7.7)
N missing	3	2	0	1	0
Underweight (BMI<18.5)	4 (4.9%)	4 (7.7%)	0 (0%)	0 (0%)	0 (0%)
Normal (BMI=18.5-24.99)	59 (72.8%)	41 (78.9%)	11 (73.3%)	6 (60.0%)	1 (25.0%)
Overweight (BMI=25-29.99)	14 (17.3%)	6 (11.5%)	4 (26.7%)	3 (30.0%)	1 (25.0%)
Obese (BMI≥30)	4 (4.9%)	1 (1.9%)	0 (0%)	1 (10.0%)	2 (50.0%)

5.3.3 DISORDERED EATING ATTITUDES AND BEHAVIORS IN WOMEN

Table 5.4 provides detailed information on EAT-40 for women. A total of 27 women, or 11.5%, in this sample scored 30 and above on the questionnaire. The mean score for the entire sample was 16.5 (SD=10) and the median 14. For the 27 women who scored 30 and above, the mean score was 37.2 (SD=7.8) and the median was 35. In contrast, women who scored below 30 (N=208) had a much lower mean of 13.9 (SD=6.5) and their median score was 13.

In addition to the total, mean, and median scores on the EAT-40, Table 5.4 shows the proportion of women who scored above four distinct cut-offs—30, 25, 20, and 10—on the test. Because of the way EAT-40 items are scored, only the most symptomatic responses are given values of 1 to 3 points, whereas less symptomatic responses are weighed as 0. Therefore, even if a person scores below 30 on the EAT-40, he or she may still endorse eating attitudes and behaviors that are disordered. The lower the score on the EAT-40, the less disturbed the eating behavior, until

dropping below a threshold where there are hypothetically no eating disturbances whatsoever. I set this threshold for subclinical eating disturbances at $EAT-40 \geq 10$ as has been suggested before in the literature (Babio et al., 2009; Schneider et al., 2008). Across all females, 18.7% and 28.9% scored above the 25 and 20 cut-offs, respectively. Interestingly, a substantial proportion of women (74.0%) displayed disordered eating attitudes and behaviors by scoring 10 or more points on the EAT-40.

Table 5.4. EAT (sum score and cutoffs) by age category for women.

Age Category	Overall Sample (F)	18-29 years	30-44 years	45-64 years	65+ years
N (% of F sample)	235 (74%)	142 (60.4%)	38 (16.2%)	40 (17.0%)	15 (6.4%)
Total EAT-40 Score:					
Range	1-56	1-49	4-56	3-48	4-36
Median	14	13.5	12.0	16.0	22.0
Mean (SD)	16.5 (10.0)	15.7 (9.4)	16.3 (12.3)	17.5 (9.4)	22.7 (9.2)
N missing	0	0	0	0	0
EAT-40>30	27 (11.5%)	13 (9.2%)	4 (10.5%)	5 (12.5%)	5 (33.3%)
EAT-40>25	44 (18.7%)	26 (18.3%)	6 (15.8%)	7 (17.5%)	5 (33.3%)
EAT-40>20	68 (28.9%)	37 (26.1%)	9 (23.7%)	12 (30.0%)	10 (66.7%)
EAT-20>10	174 (74.0%)	102 (71.8%)	27 (71.1%)	31 (77.5%)	14 (93.3%)

Since the sample contained a sizable number of older women, Item 23 (“Have regular menstrual periods”) on the questionnaire was not scored for postmenopausal women, giving rise to possible reductions in EAT-40 total scores. An additional reduction in total EAT-40 scores may have come from 23 women who skipped between 1 and 3 items on the test (however, these women were not excluded from the analysis, because they had answered most EAT-40 items). For some of these 23 women there could be a maximal possible reduction of 9 score points on the EAT-40, which may have caused them to be classified as ‘normal’ as opposed to ‘eating disordered’ based on a cut-off of 30 points.

5.3.4. RELATIONSHIP BETWEEN AGE AND DISORDERED EATING ATTITUDES AND BEHAVIORS FOR WOMEN

A small but significant positive correlation was found between women's age and their total EAT-40 scores— $R^2(235)=0.03$, $R^2\text{Adj.}(235)=0.03$, $p<0.05$ —making it seem as though disordered eating attitudes and behaviors increased across the age of the sample. Because a significant positive association between BMI and total EAT-40 scores was observed for the women in this sample— $R^2(224)=0.04$, $R^2\text{Adj.}(224)=0.04$, $p<0.05$ —it was necessary to investigate the relationship between age and total EAT-40 scores in light of the effects of BMI. The sample was split into “light weight” (underweight and normal weight) and ‘heavy weight’ (overweight and obese) women. For lighter women there was a significant positive correlation between age and total EAT-40 score, $R^2(184)=0.03$, $R^2\text{Adj.}(184)=0.03$, $p<0.05$, indicating an increase in disordered eating attitudes and behaviors as women got older. In contrast, there was no significant relationship between disordered eating and age among heavier women.

5.3.5. PRINCIPAL COMPONENTS ANALYSIS OF THE EAT-40 AND ASSIGNMENT OF ITEMS TO COMPONENTS FOR WOMEN

The full EAT-40 had a good internal consistency with a Cronbach's α of 0.81. Nevertheless, to further investigate the reasons behind this finding—in other words, to reveal the internal structure of the data in ways which would allow for its variance to be best explained—a Principal Components Analysis (PCA) of the 40-item EAT was performed and the results were compared across the four age categories for women. Please note that the term “component” was used instead of “factor” to emphasize the present study's use of PCA (Kim & Mueller, 1978).

Based on the meaning of the correlated EAT items, as well as a Scree Plot (see Figure 5.1), in which the slope of the line begins to level off after the 6th component, the following 6 components (together accounting for 47.3% of the variance in the data) were extracted:

- Component 1 explains 17.1% of the total variance and has a good internal consistency at $\alpha=0.7851$. The component contains 6 items, which deal with issues of meal-related anxiety, obsessive-compulsive thoughts and behavior towards food and eating. Therefore, this component was labeled “Food Preoccupation.”
- Component 2 explains 8.5% of the total variance, has a good internal consistency ($\alpha=0.8299$), and includes 9 items related to fat phobia and perceived overweight, desire to be thinner, and engaging in dieting and other behaviors conducive to energy expenditure. Thus this component was named “Drive for Thinness.”
- Component 3, labeled “Oral Control,” explains 7.6% of the total variance, has a good internal consistency at $\alpha=0.8225$, and contains 5 items that had to do with avoidance of “fattening” foods, concerns about calorie content of foods, and control over food intake.
- Component 4, labeled “Social Pressure to Eat”, explains 5.5% of the total variance, has a good internal consistency at $\alpha=0.8614$, and contains 3 items reflecting the pressure received from others to gain weight.
- Component 5, labeled “Food Exploration and Social Aspects of Eating,” explains 4.7% of the total variance, has an acceptable internal consistency at $\alpha=0.5672$, and is made up of 3 items reflecting interest in novel food items and feelings associated with eating in social settings.
- Component 6, labeled “Purging”, explains 3.8% of the total variance, has an acceptable internal consistency at $\alpha=0.5814$, and contains 2 items dealing with the impulse to purge after eating.

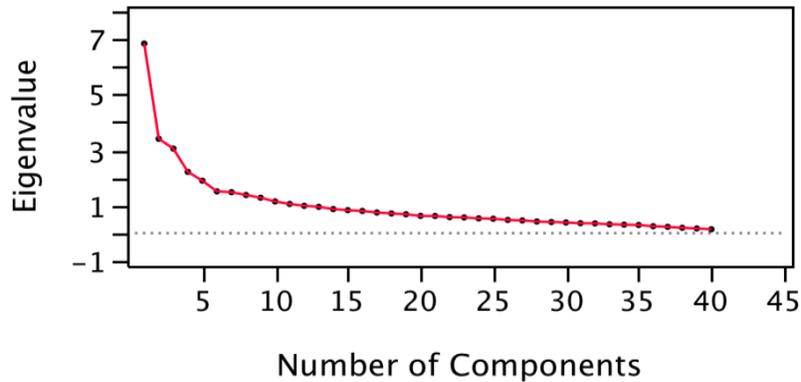


Figure 5.1. EAT-40 scree plot (female sample).

The 28 items comprising the 6 components, along with their associated eigenvalues, percent of variance, cumulative variance percent, component loadings, and Cronbach’s α coefficients are presented in Table 5.5. The eigenvalues of the first 6 components are 6.8, 3.4, 3.1, 2.2, 1.9, and 1.5, respectively. Within each component’s set of items, the Cronbach’s α coefficient excluding an item is smaller than the Cronbach’s α coefficient for the entire set.

Table 5.6 shows the component sum scores across the four age categories for “heavy weight” and “light weight” women (i.e., component sums by age controlling for BMI). Interestingly, within age groups the rationale behind scoring high on the full EAT-40—and thus displaying higher levels of disordered eating attitudes and behaviors—was quite dissimilar for heavy compared to thin women. Not surprisingly, heavier women’s eating was more disturbed due to a higher “Drive for Thinness” (i.e., they scored higher on Component 2), whereas thinner women’s disordered eating attitudes and behaviors were mostly related to higher levels of “Oral Control” (higher scores on Component 3).

Table 5.5. EAT-40 component structure for women.

Items by Components	Eigen-value	% Var	Cum %	Component Loading	Cronbach's α
COMPONENT 1: FOOD PREOCCUPATION:	6.8383	17.096	17.096	-	Entire Set: 0.7851
Q3 Become worried and tense immediately prior to eating	-	-	-	0.55	0.7841
Q6 Find myself preoccupied with thoughts about food	-	-	-	0.80	0.7123
Q7 Have gone on eating binges where I feel that I may not be able to stop	-	-	-	0.62	0.7724
Q14 Feel woeful (guilty, unhappy, sad) after eating	-	-	-	0.55	0.7671
Q31 Feel that food controls my life	-	-	-	0.68	0.7591
Q34 Food takes up too much of my time and thoughts	-	-	-	0.84	0.7094
COMPONENT 2: DRIVE FOR THINNESS:	3.4030	8.508	25.603	-	Entire Set: 0.8299
Q4 Am terrified about the prospect of being overweight	-	-	-	0.69	0.7987
Q5 Avoid eating every time when I feel hunger	-	-	-	0.53	0.8249
Q11 Feel bloated (puffed up) after meals	-	-	-	0.61	0.8151
Q15 Have a strong desire to be thinner	-	-	-	0.66	0.7902
Q22 Think about burning up calories when I move or do calisthenics	-	-	-	0.57	0.8177
Q25 Think that I have excess fat on my body	-	-	-	0.54	0.8129
Q28 Take laxative aids or medications	-	-	-	0.59	0.8247
Q37 Engage in dieting behavior	-	-	-	0.67	0.8025
Q38 Like my stomach to be empty	-	-	-	0.64	0.8216
COMPONENT 3: ORAL CONTROL:	3.0507	7.627	33.230	-	Entire Set: 0.8225
Q9 Pay attention to the calorie content of foods	-	-	-	0.73	0.7965
Q10 Avoid doughy foods	-	-	-	0.74	0.7693
Q29 Avoid foods containing a lot of sugar	-	-	-	0.65	0.7797
Q30 Eat diet foods	-	-	-	0.69	0.7787
Q32 Display self-control when it comes to eating	-	-	-	0.67	0.8114
COMPONENT 4: SOCIAL PRESSURE TO EAT:	2.2120	5.530	38.760	-	Entire Set: 0.8614
Q12 Think that others would want me to eat more	-	-	-	0.87	0.7685
Q24 Other people think that I am too thin	-	-	-	0.85	0.8295
Q33 Other people make me eat more	-	-	-	0.83	0.8159
COMPONENT 5: FOOD EXPLORATION AND SOCIAL ASPECTS OF EATING:	1.8910	4.727	43.487	-	Entire Set: 0.5672
Q1 Like eating with other people	-	-	-	0.62	0.4662
Q27 Enjoy eating at restaurants	-	-	-	0.63	0.3587
Q39 Enjoy trying new foods	-	-	-	0.51	0.5580
COMPONENT 6: PURGING:	1.5074	3.768	47.256	-	Entire Set: 0.5814
Q13 Vomit after I have eaten	-	-	-	0.53	-
Q40 Have the irresistible desire (impulse, need) to vomit after meals	-	-	-	0.66	-

Table 5.6. Component sums by age and weight category for women.

Age Category	18-29 years		30-44 years		45-64 years		65+ years	
Weight Category	BMI \geq 25	BMI<25						
N	7	129	7	27	17	22	9	6
% Sample (N=235)	3%	55%	3%	12%	7%	9%	4%	3%
N missing	6	0	4	0	1	0	0	0
Component 1: Food Preoccupation								
Range	0-8	0-8	0-15	0-5	0-5	0-7	0-7	0-3
Median	0	0	0	0	0	0	3	0
Mean	1.3	1.0	2.8	0.4	0.7	1.3	2.6	0.5
SD	2.3	1.8	5.4	1.2	1.4	2.2	2.2	1.2
Component 2: Drive for Thinness								
Range	0-14	0-18	0-17	0-24	0-9	0-18	0-8	0-11
Median	8	2	7	1	3	2.5	3	3
Mean	7	4.0	7.1	2.2	3.4	5.0	4.2	4.2
SD	5.0	4.6	5.9	4.7	2.3	5.4	3.1	3.9
Component 3: Oral Control								
Range	0-14	0-12	0-9	0-12	0-6	0-13	0-12	0-11
Median	0	2	2	2	0.5	4	0	3.5
Mean	2	2.6	2.6	3.6	1.3	4.7	3.4	4.3
SD	4.0	3.2	2.9	4.0	1.8	4.0	4.7	4.7
Component 4: Social Pressure to Eat								
Range	0-7	0-9	0-2	0-7	0-1	0-3	0-3	0-5
Median	0	0	0	0	0	0	0	2.5
Mean	0.8	1.3	0.2	0.8	0.1	0.4	0.4	2.5
SD	2.1	2.2	0.6	1.6	0.3	0.9	1.0	2.4
Component 5: Food Exploration & Social Aspects of Eating								
Range	0-3	0-4	0-6	0-4	0-6	0-4	0-7	0-4
Median	0	0	1	1	2	1	2	3
Mean	0.6	0.8	1.3	1.2	1.9	1.4	2.8	2.7
SD	1.0	1.0	1.7	1.5	1.8	1.3	2.0	1.4
Component 6: Purging								
Range	0-1	0-4	0	0	0-1	0	0	0
Median	0	0	0	0	0	0	0	0
Mean	0.1	0.1	0	0	0.1	0	0	0
SD	0.3	0.4	0	0	0.2	0	0	0

Among older individuals, heavy women displayed less “Drive for Thinness,” whereas thin women’s “Oral Control” intensified (refer to Figures 5.2 and 5.3 for the correlations’ R^2 , adjusted R^2 , and p-values; only the best fit line(s) is/are reported). These relationships seemed to be curvilinear rather than linear (a polynomial fit data better than a straight line)—with middle-aged women (between about 30 to 65 years of age) representing the nadir or the peak of the curve, respectively. A

significant relationship between age and component sum scores was observed also with respect to Component 5, “Food Exploration and Social Aspects of Eating” (refer to Figures 5.2 and 5.3 for correlations’ R^2 , adjusted R^2 , and p-values; only the best fit line(s) is/are reported). Both heavier and thinner women were less likely to explore novel foods or enjoy eating in social settings as they aged. In other words, the relationship between age and score on Component 5 was independent of women’s BMI status. Consequently, older women (regardless of weight category) tended to score higher on the full EAT-40 not because their eating was genuinely more disturbed, but likely because of a natural decline in their food-related curiosity and sociability with age.

All other relationships between age and component sum scores within the two BMI groups were insignificant ($p > 0.05$, NS). Component 1 (“Food Preoccupation”), Component 4 (“Social Pressure to Eat”), and Component 6 (“Purging”) were not correlated to either the age or BMI status of the women. That is, women of varying ages and weight categories displayed comparable levels of food preoccupation, and they perceived external pressure to eat in similar ways and did not differ in their attitudes towards postprandial purging.

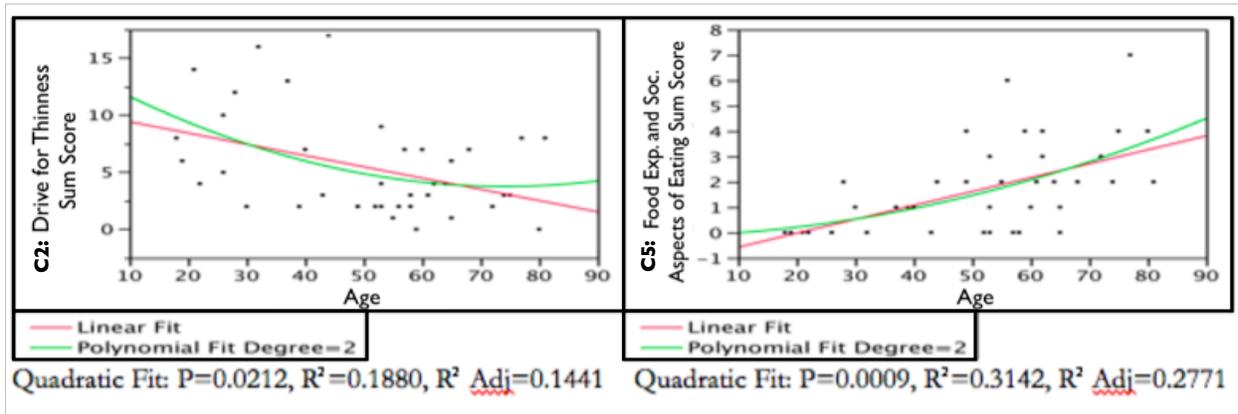


Figure 5.2. Relationship between age and component sum scores for women with BMI \geq 25, N=40.

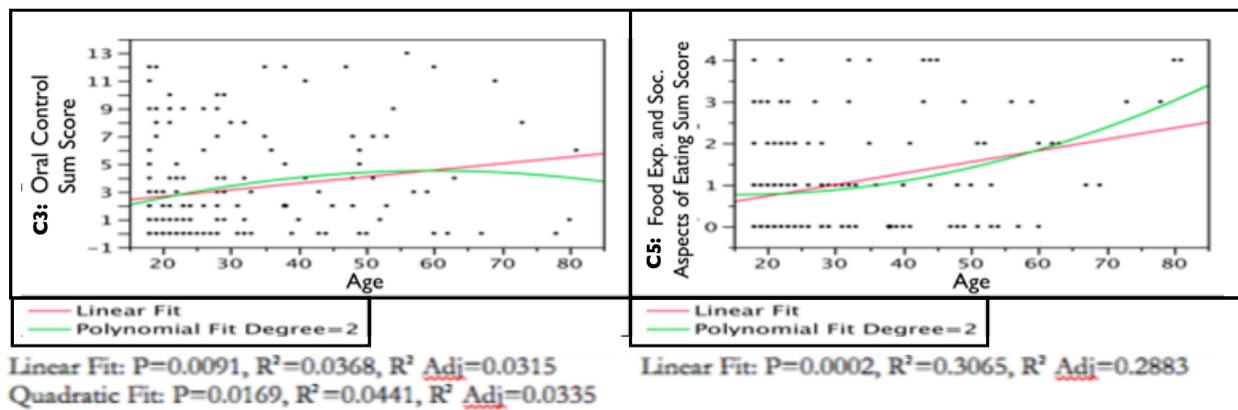


Figure 5.3. Relationship between age and component sum scores for women with BMI<25, N=184.

5.3.6. DISORDERED EATING ATTITUDES AND BEHAVIORS AND THEIR RELATIONSHIP TO AGE IN MEN

Men had lower levels of disordered eating attitudes and behaviors compared to women—only 1 (1.3%) of 77 men scored 30 and above on the EAT-40 indicating an increased risk for eating disorders. Within the subclinical range of eating attitudes and behaviors, fewer men than women displayed disordered eating attitudes and behaviors—62.3% scored above the cut-off of 10, 11.7% above 20, and 2.6% above 25 on the test. The median EAT-40 sum score was 10 and the mean 11.9 (SD=7.3, range: 3-56), again lower than what was observed for women.

Seven men were excluded from the above analyses due to failure to complete 3 or more items on the EAT-40 (in fact, these men missed more than 17 items on the questionnaire making their EAT data unusable). For obvious reasons, question 23 (“Have regular menstrual periods”) was not scored for men, leading to possible reductions in EAT-40 total scores, as was the case for postmenopausal women. One man skipped 1 and another skipped 2 items on the test, thus in these cases the possible reduction in total EAT-40 scores was negligible.

Table 5.7 shows EAT-40 sum scores and cut-offs by age category for men.

Table 5.7. EAT (sum score and cutoffs) by age category for men.

Age Category	Overall Sample (M)	18-29 years	30-44 years	45-64 years	65+ years
N (% of F sample)	77 (24.1%)	49 (63.6%)	14 (18.2%)	10 (13.0%)	4 (5.2%)
Total EAT-40 Score:					
Range	3-56	4-56	3-24	6-21	3-10
Median	10	11	9	10.5	7.5
Mean (SD)	11.9 (7.3)	12.6 (8.0)	10.6 (6.4)	12 (5.0)	7 (3.6)
N missing	7	5	1	1	0
EAT-40>30	1 (1.3%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)
EAT-40>25	2 (2.6%)	2 (4.1%)	0 (0%)	0 (0%)	0 (0%)
EAT-40>20	9 (11.7%)	5 (10.2%)	2 (14.3%)	2 (20.0%)	0 (0%)
EAT-20>10	48 (62.3%)	33 (67.4%)	6 (42.9%)	7 (70%)	2 (50%)

There was a negative but insignificant relationship ($p>0.05$, NS) between age and disordered eating attitudes and behaviors among men and men’s BMI did not correlate with total scores on the EAT-40 ($p>0.05$, NS). In short, the men in this sample displayed low levels of disordered eating attitudes and behaviors regardless of their BMI status or age category.

5.4. DISCUSSION

The purpose of this study was: 1) to explore the prevalence of disordered eating in this Bulgarian sample from an under-researched, transitional, post-communist culture; 2) to compare the prevalence of disordered eating in this sample to those observed in Western societies; 3) to explore

the effects of socio-cultural transition on the rates of disordered eating by studying age patterns; and 4) to illuminate the issue of applicability of the EAT to older individuals.

5.4.1. SELECTION OF STUDY SITE AND PARTICIPANTS

Data reported in the current chapter were collected as part of a larger study on body image, disordered eating, and related media effects in a non-clinical sample subjected to socio-cultural transition. I present only data on disordered eating attitudes and behavior as measured by the Eating Attitudes Test in the sample, however, I do not address the true prevalence of clinically diagnosable disorders such as anorexia nervosa or bulimia nervosa.

Sofia's status as a metropolis, and hence a major gate for Western influences, as well as the city's modernity, large population, and multiple avenues for data collection, make it a particularly appropriate site for studying the impact of Westernization on body image and eating behavior. It should be noted, however, that the findings from this study cannot be generalized to the entire population of Sofia (or Bulgaria) and cannot be extended to any population with a different socio-demographic makeup. The scope of this study along with its financial, time, and human resource constraints, did not allow for probability sampling among the population of interest. I did not have access to up-to-date census data and recruitment over the phone or through household visits was not feasible for this study. Due to the recent economic turmoil many Bulgarians have changed their living quarters or moved away to find employment. Sofia—being the country's largest industrial center—has attracted most of these economic migrants, resulting in an outdated or unreliable phone directory. Moreover, the rise in criminality associated with the transition has made Bulgarians wary of sharing personal information with strangers, especially over the phone, and of letting them into their homes. In addition, I did not have resources to hire and train phone or household recruiters. Similarly, the unavailability of recent census data, the unreliability of home address information, and the unwillingness of people to disclose personal information to strangers, along with a possible

unfamiliarity with the survey format (leading to confusion and inaccurate answers), made using mail-in surveys impractical.

As a result the recruitment procedure available to me was that of convenience and snowball sampling (i.e., via key intermediaries). I deliberately sought out individuals from diverse ages to explore the effects of socio-cultural transition on body image and eating behavior—participants' age was considered a suitable proxy for this transition. To the extent that the socio-cultural milieu impacts personal attitudes about physical appearance, growing up during a peak of pressures to look a certain way may instill values and beliefs about body image that last a lifetime (Keel, 1997). Research has repeatedly shown that adolescents and young adults, particularly women, are at the highest risk for developing body image and eating issues (Peat et al., 2008; Fernandez et al., 2007). Meehan and Katzman (2001) contend that difficulties stemming from transition, dislocation, and oppression oftentimes produce solutions in the form of manipulations of weight, diet, and food. When one adds the stress associated with coming of age to the difficulties of societal transformation, it may be that Bulgarians who lived through the transition in their youth would display the most body image and eating disturbances. Thus, it was important to obtain participants from diverse age cohorts, because their experiences of the transition may have been different depending on the developmental stage they were in while it lasted. The resulting sample consisted of participants who were adults at the onset of societal changes, participants who were adolescents or young adults as these changes occurred, as well as participants who were born after them. Despite my best effort to obtain a sample that was as diverse as possible, the final sample consisted of mainly young (high-school graduates and university students), urban (from Sofia), highly educated people (44% holding the equivalent of a college degree), most of whom (74%) were women. In addition, participation relied heavily on individuals' personal interest in the topic of the study leading to possible self-selection bias.

Nevertheless, the sampling procedure, while not random, was useful for the purposes of this study, because it provided a sample of urban, highly educated Bulgarians, who were: 1) more likely to be affected by the socio-cultural and economic changes in the country; 2) more likely to have had opportunities for exposure to western values and ideas, including media messages on nutrition, dieting, and beauty ideal; and 3) highly literate, therefore able to follow written instructions and complete a questionnaire of unfamiliar format with minimal errors. Moreover, the recruitment method had the advantages of establishing a personal contact between the survey collectors and participants. The latter met face-to-face with either the researcher (myself) or an intermediary and could clarify any uncertainties about completing the survey. Being acquainted with the survey collector also may have fostered more trust in participants that their personal information will be handled appropriately.

5.4.2. BODY MASS INDEX (BMI)

Overall, these participants were much lighter than the typical Bulgarian (and the typical citizen of Sofia). The proportion of obese women in the sample corresponds well with representative data on BMI among urban Bulgarians living in Sofia—5.4% vs. 4.7%, respectively (Ivanova et al., 2008). However, at 12.5%, the current study's data show a notably lower rate of overweight among women as compared to Ivanova et al. (2008) who determined the prevalence of overweight among females to be as high as 32.4%. Similar to the findings of Ivanova et al. (2008), men in the current sample were more overweight than women (17.3% vs. 12.5%). Unlike the findings of Ivanova et al. (2008), the proportion of overweight males was much lower—17.3% vs. 44.8%, respectively. However, obese men and women had a comparable prevalence (4.9% vs. 5.4%) in the current study, whereas the Ivanova et al. (2008) survey revealed a greater prevalence of obesity among men (6.0%) than women (4.7%). It could be argued that the prevalence of obesity among adult males in the current sample is similar to that reported by Ivanova et al. (2008). To the best of

my knowledge, the study by Ivanova et al. (2008) is the most recent cross-sectional survey on the prevalence of overweight and obesity among urban adults in Bulgaria that uses the same BMI cut-offs and a comparable participant age range (19 to 75+ years of age). Ivanova et al. (2008) also suggest that persons of lower income and older adults are more likely to have a higher BMI compared to those with higher income and younger adults—a finding that disagrees with current reports on obesity increasing with affluence in transitional Eastern European countries (Dobson, 2008). Although in the present study income data were collected, these data were incomplete (many participants did not provide the information) and biased due to possible over- or underestimation of income. Hence, I could not draw valid conclusions regarding the association of income with BMI in the studied sample.

Looking at recent data on the global prevalence of adult obesity, the current participants appear to have much lower rates of overweight and obesity than the average Western European or American. For instance across Western societies such as England, Belgium, France, Austria, Germany, and the United States, the rates of female overweight range from 23.8% in France to 32.4% in Austria, and female obesity is between 10.2% in Belgium and 35.5% in the US. In males overweight is lowest in the US (40.1%) and highest in Germany (45.5%), and obesity—lowest in Belgium (10.7%) and highest in the US (32.2%). These data come from a report by the International Association for the Study of Obesity (2011).

Overweight and obesity are well-known risk factors for eating disorders in vulnerable populations (Babio et al., 2009). Body dissatisfaction, the desire for thinness, and dieting—all of which have been linked to the development of body image and eating issues (Jacobi et al., 2004; Keel et al., 2007)—generally increase as a person's BMI increases (Schwartz & Brownell, 2004). BMI also increases with age of the population—people typically gain weight throughout their lives (Andres, 1989; Webster & Tiggemann, 2003)—which was confirmed for both the women and the

men in the current sample. Thus, to be able to draw valid conclusions regarding the relationship between age and disordered eating attitudes and behaviors among these participants, it was important to take into account the effects of BMI. I accomplished this by splitting the sample into “light weight” and “heavy weight” categories.

5.4.3. DISORDERED EATING ATTITUDES AND BEHAVIORS

When exploring little known phenomena, such as disordered eating in transitional societies, it is imperative to employ established psychometric tools to allow for meaningful cross-cultural comparisons. The original, English version of the EAT-40 by Garner et al. (1982) is one such tool that has an established validity and reliability, and is among the most widely used self-report screening tools for eating disorder symptomatology in a broad range of cultures and age groups (Garfinkel & Newman, 2001; Pereira et al., 2008). The Bulgarian version of the EAT-40 adapted from the original by Boyadjieva and Steinhausen (1996) was found to have an excellent discriminant validity. Based on their analyses these authors argued that the Bulgarian EAT-40 is an excellent screening tool for disordered eating attitudes and behaviors among adolescent populations in Bulgaria. I chose to use this version of the EAT in the current study, because it was deemed culturally appropriate.

The Principal Components Analysis (PCA) that was performed on the EAT corroborated this conclusion. Even though the characteristics of the sample, the type of rotation used, as well as the chosen criterion for assignment of items to components differed from study to study, there was a notable similarity between the currently obtained component pattern and the component patterns obtained by other authors studying Western and non-Western cultures (Garfinkel & Newman, 2001; Garner et al., 1982; Garner & Garfinkel, 1979; Pereira et al., 2008; Wells et al., 1985). Indeed the 6-component structure that I extracted was reminiscent of the component structure in the original study by Garner and Garfinkel (1979)—where items could be grouped on 7 components, reflecting:

1) food preoccupation; 2) body image for thinness; 3) vomiting and laxative use; 4) dieting; 5) slow eating; 6) clandestine eating; and 7) perceived social pressure to gain weight. Moreover, the current 28-item component structure resembled the component structure of EAT short forms developed for a number of English and non-English speaking populations. For instance, the initial English short form consists of 26 items that load on 3 components: 1) dieting; 2) bulimia and food preoccupation; and 3) oral control (Garner et al., 1982). A number of international short forms have retained an identical 3 component pattern, while others have added between one and 3 new components to the 3 originally reported (Garfinkel & Newman, 2001). The similarity between component structures—the fact that items intended to measure particular symptom areas correlate more highly with each other and form similar cluster patterns across diverse samples, including the current one—is a strong empirical support for the cross-cultural validity of the EAT in the current female sample.

Trans-cultural adaptations of questionnaires such as the EAT-40 require separate culture-specific norms and cut-offs for the identification of at risk individuals (Boyadjieva & Steinhausen, 1996). Italian researchers have demonstrated that the sensitivity of the questionnaire is very low if the originally proposed cut-off of 30 is used (Vetrone et al., 2006). In a study among young Spaniards by Babio et al. (2009), a cut-off score of 25 (as opposed to 30) was used to designate individuals at risk for eating disorders, because this cut-off provided the most balanced sensitivity to specificity ratio for their sample. Similarly, another Spanish study by Fernandez et al. (2007) proposed a cut-off as low as 20 on the EAT-40. Still, the cut-off score of 30 has been applied most frequently to a number of English and non-English speaking populations. Since I did not have access to clinical samples, I was not able to calculate sensitivity and specificity, and therefore determine the unique EAT-40 cut-off for this sample, so I picked the original cut-off of 30 to identify at risk individuals.

5.4.3.1. What are the Rates of Disordered Eating Attitudes and Behaviors in the Present Compared to Western Samples?

I compared the mean EAT-40 scores and the proportion of at risk individuals in the present study to previous reports in the literature coming from Western Europe (Portugal, Spain, Italy, and Germany), North America (Canada and the US), and Australia (see Table 5.8 below). Unlike the current study, most of these studies drew samples from high school and college students within a narrow age range (Alonso et al., 2005; Canals et al., 2002; Garner et al., 1982; Garner & Garfinkel, 1979; Griffiths et al., 2000; Neumarker et al., 1998; Pereira et al., 2008; Vetrone et al., 2006; Williams et al., 1986). Comparisons were therefore interpreted with caution due to differences in sample size, age, gender structure, and BMI between the current sample and the samples used by others. An additional obstacle was the lack of consistency in the way data were reported. Furthermore, trans-cultural research has demonstrated greater variability in the frequency of high EAT scores than in the prevalence of clinical eating disorders (Garfinkel & Newman, 2001). Lastly, the meaning of high scores on the EAT may differ when used in populations with different true prevalence of full-syndrome eating disorders (Garfinkel & Newman, 2001). Nevertheless, I contend that the disordered eating attitudes and behaviors found among female and male Bulgarians in the current study were at least of the same magnitude as those observed in Western cultures, if not higher, especially since the current sample excluded individuals at the height of eating disorders—those younger than 18 years (American Psychiatric Association, 2000; Preti et al., 2009). Furthermore, scoring any missing answers as “0” and dropping Item 23 for men and postmenopausal women may have resulted in even lower EAT-40 scores and consequently an additional underestimation of the degree of disordered eating in the current sample. While this choice of approach may underestimate the extent of disordered eating, it was made in order to be conservative (see Eagles et al., 2000).

Table 5.8. EAT-40 sum scores and proportion of at risk individuals (% EAT-40>30) in one Bulgarian and nine previously studied Western samples.

Study	Country	Population	Sample Characteristics	EAT-40 Sum Score	EAT-40 > 30
Boydjjeva and Steinhausen (1996)	Bulgaria	Transitional, European	Non-clinical Early to mid adolescents Mostly women (unclear) Normal weight	Mostly females (unclear): Mean (unclear)=17.5 approximately, SD not reported	Mostly females (unclear): 10.4%
Alonso et al. (2005)	Spain	Western, European	Non-clinical Early to late adolescents Mixed gender Normal weight	Females: Mean (Range)=16.2 (15.4-17.0) Males: Mean (Range)=13.4 (13.0-13.9)	Females: 7.8% Males: Not reported (unclear, may be reported together with women)
Canals et al., (2002)	Spain	Western, European	Non-clinical Late adolescents All women Normal weight	Females: Mean (SD)=15.7 (11.6)	Females: 9.3%
Garner and Garfinkel (1979)	Canada	Western, North American	Non-clinical Late adolescents to young adults Mixed gender Normal weight	Females (normal controls): Mean (SD)=15.6 (9.3) Males (normal controls): Mean (SD)=8.6 (5.3)	Females (normal controls): 7% Males (normal controls): Not reported (unclear, may be reported together with women)
Garner et al. (1982)	Canada	Western, North American	Non-clinical Late adolescents to young adults All women Normal weight	Females (normal controls): Mean (SD)=15.4 (11)	Females (normal controls): Not reported
Griffiths et al. (2000)	Australia	Western, Non-American Non-European	Non-clinical Late adolescents to late adults All women Normal weight	Females (with EAT-40 < 30): Mean (SD)=10.2 (7.2)	Females (with EAT-40 < 30): 9.5%
Neumarker et al. (1998)	Germany	Western, European	Non-clinical Early to mid adolescents Mixed gender Normal weight	Females (non-ballet controls): Mean (SD)=12.4 (11.1) Males (non-ballet controls): Mean (SD)=7.5 (4.2)	Females (non-ballet controls): 7.4% Males (non-ballet controls): Not reported

Table 5.8 (Continued).

Study	Country	Population	Sample Characteristics	EAT-40 Sum Score	EAT-40 > 30
Pereira et al. (2008)	Portugal	Western, European	Non-clinical Early adolescents to young adults All women Normal weight	Females: Mean (SD)=11.5 (8.1)	Females: Not reported
Vetrone et al. (2006)	Italy	Western, European	Non-clinical Late adolescents All women Normal weight	Females: Mean (SD)=16.6 (11.5)	Females: 13.4%
Williams et al. (1986)	United States	Western, North American	Non-clinical Early to mid adolescents All women Normal weight	Females (normal controls): Mean (SD)=17.6 (8.3)	Females (normal controls): Not reported

5.4.3.2. Have Disordered Eating Attitudes and Behaviors Changed in Bulgaria Since the Peak of Socio-Cultural Transition in the 1990s?

I know of only one, not very recent study—by Boyadjieva and Steinhausen (1996)—that used the EAT-40 to discuss eating attitudes and behaviors among young urban Bulgarians. This study had a small, predominantly female sample drawn from a limited number of elite high schools, and its participants were much younger than participants in the current study (see Table 5.8). Therefore it was hard to deduce whether disordered eating attitudes and behaviors have increased, decreased, or remained the same in Bulgaria since the peak of socio-economic transition in the early to mid 1990s. The mean EAT score in Boyadjieva and Steinhausen's (1996) study was 17.5 and the proportion of high scorers was 10.4%, whereas in the present study these numbers were 11.9 and 11.5%, respectively. Because the current sample was made of adults as opposed to young adolescents, disordered eating attitudes and behaviors may have actually increased over the past 15 or so years. It is also possible that individuals growing up at the time peak of transition may have retained their presumably more disordered eating attitudes and behaviors into their adulthood, leading to cohort effects as opposed to a true increase in disordered eating. Indeed, it is interesting

that the present research was conducted roughly 15 years later than Boyadjieva and Steinhausen's (1996) study, with participants who were approximately 31 years old, and rates of disordered eating were similar to those of 16-year-olds from about 15 years ago.

5.4.4. RELATIONSHIP BETWEEN AGE AND DISORDERED EATING ATTITUDES AND BEHAVIORS

5.4.4.1. Men

Given that eating disturbances generally are much less prevalent among men than women (Preti et al., 2009), it was not surprising that the men in this study scored lower than women on the EAT-40 and had much lower proportion of high scorers—1.3% for the entire male sample, 2% for men aged 18-29, and none in the other three age categories. Even though BMI increased notably as men aged, weight status did not seem to influence disordered eating attitudes and behaviors. For the male sample disordered eating attitudes and behaviors and age did not correlate either, but there was a small negative trend. Previous research, however, suggests that disordered eating increases, or at the very least does not decline, as men age, possibly due to age-related increases in BMI (Heatherton et al., 1997; Keel et al., 2007). The lack of correlation between the rates of disordered eating and age among men in the current study could be attributed to a number of methodological issues—most likely the small size of the male sample, but perhaps also the use of a gender inappropriate instrument for measuring disordered eating attitudes and behaviors. Indeed, though oftentimes used with males, the EAT-40 has not been validated for men, but only for women. Additionally, there could be culturally unique explanations for the current findings. While these exceed the scope of the current dissertation research, questions concerning the interrelationship between body image, disordered eating, weight status, and age among Bulgarian men in the context of socio-cultural transition demand further investigation.

5.4.4.2. Women

A much more intriguing picture emerged for the female portion of the sample, which is the main reason that this chapter (and dissertation) focuses on women. Contrary to prior reports in the literature, initial analyses revealed increasing disordered eating in women as they aged. In fact older women in the sample, especially the elderly—65 years of age and above—displayed somewhat unique characteristics compared to the rest of the female sample. These women scored very high on the EAT, which suggested surprisingly elevated degrees of disordered eating. Even when controlling for the effects of BMI, the positive correlation between age and disordered eating attitudes and behaviors persisted among the thinner women in the sample, though not among the overweight and obese, for whom no correlation was observed. This lack of correlation between age and disordered eating attitudes and behaviors in the heavier women was in itself unusual. Research on the prevalence of eating disorders suggests a different pattern—in which disordered eating decreases after adolescence and young adulthood irrespective of BMI (American Psychiatric Association, 2000; Preti et al., 2009). Consistent with these epidemiological data, longitudinal studies also found a decrease in disordered eating as women transitioned from late adolescence into midlife (Heatherton et al., 1997; Keel et al., 2007). There is a generally accepted notion that disordered eating symptoms, as well as clinically diagnosable eating disorders, are most common among adolescents and college-aged women (Bushnell et al., 1990; Fairburn & Beglin, 1990; Tiggemann & Lynch, 2001). In sum, the literature predicted a decline in disordered eating across the lifespan for women, whereas the current data showed no such decline.

When the EAT was analyzed for principal components, it became obvious that the effect of age varied by component, and that younger and older women scored high on the EAT-40 for intrinsically different reasons. Younger women were more likely to score high due to a genuinely disordered eating mentality characterized by dieting, perceived overweight, fear of fatness, and a

strong drive for thinness (i.e., high scores on the “Drive for Thinness” component), but only if they were in the “heavy weight” category. In other words, the finding that these overweight and obese women were struggling with their weight explained their disordered eating. This association between obese BMI status and elevated EAT-40 scores among these urban Bulgarian women is consistent with previous research (Babio et al., 2009; Garfinkel & Newman, 2001). Moreover, consistently with prior literature fat phobia, dieting, and the desire for thinness—as reflected by the current analysis’ “Drive for Thinness” component (i.e., Component 2)—declined as the heavier women in the sample got older (Webster & Tiggemann, 2003). Even though I found a significant positive correlation between age and thin women’s “Oral Control,” I had doubts about the meaningfulness of this correlation due to its very low adjusted R^2 . Nevertheless, the findings of Davies et al. (2000) corroborated high “Oral Control” scores among older women, which did not necessarily denote “an eating disordered attitude” as endorsement of such items reflected a realistic evaluation of the persons’ condition (e.g., reduced saliva levels, difficulties swallowing, early satiation, etc. making self-control around food easier). Thus, it seemed plausible that unlike younger women, the older women in this study tended to score high on the EAT, not because of “true” disordered eating (of the type found in younger women, i.e. related to body image and fat phobia), but due to conditions and behaviors typical of old age (Davies et al., 2000; Harris & Cumella, 2006). Indeed, as age increased, both thinner and heavier women scored higher on the “Food Exploration and Social Aspects of Eating” component that deals with the desire to seek novel foods or food environments, or socialize while eating. High scores on this component mean low novelty seeking and sociability, which could easily be explained by a normative decline in curiosity and/or an increase in depression symptoms as people transition into old age. Lack of novelty seeking has been proposed as one of three core areas of vulnerability to developing anorexia nervosa in the youth (Garfinkel & Newman, 2001). Depression has also been implicated in the development and

maintenance of eating problems (Garfinkel & Newman, 2001; Bulik, 2002). Thus, in young women one would expect more disordered eating and therefore higher EAT scores when novelty seeking is low and depression high. The present data clearly demonstrate that old age confounds these associations. This calls into question the utility of the EAT-40 for the measurement of eating disorder attitudes and behaviors in populations past adolescence and young womanhood (college age), and especially in the elderly (where high EAT scores may indicate age-related eating problems as opposed to body image related psychopathology). Indeed the original, as well as the Bulgarian versions of the EAT-40, have been validated only in young women—college-age and adolescents, respectively. And despite the fact that the EAT has been used with older populations, the focus of body image and disordered eating research—which most widely employs the EAT—have been high school and college students (Garfinkel & Newman, 2001; Grogan, 1999; Webster & Tiggemann, 2003). Therefore an important contribution of the present study is that it challenges the validity of the full EAT-40 in mature populations.

With respect to the other three components, “Food Preoccupation,” “Social Pressure to Eat,” and “Purging,” there were no age effects in either BMI category. Of these components, only “Food Preoccupation” seems to gauge explicit disordered eating symptom areas, such meal-related anxiety, and obsessive-compulsive thoughts and behavior towards food and eating. The degree to which the “Social Pressure to Eat” component reflects true disordered eating may be biased by the developmental stage of the person under pressure. For instance, underweight in a young girl is a concern to those who urge her to gain weight, because it is more likely to be a sign of a psychological disturbance such as an eating disorder, whereas in the elderly the common concern is malnutrition due to age-related diseases and/or normal physiological deterioration (Culross, 2008). Similarly, the “Purging” component may relate to an overt eating disorder, but could also be a sign of an illness, age-related or not. This component was made up of two rarely endorsed items,

“Vomit after I have eaten” and “Have the irresistible desire (impulse, need) to vomit after meals,” that may have cultural meanings not necessarily indicative of an eating disorder. Indeed, they were less commonly endorsed than in the West in a trans-cultural sample of women in Hong Kong (Garfinkel & Newman, 2001; Lee & Lee, 1996). In light of these confounders, it is hard to interpret the meaning of a lack of decline in “Social Pressure to Eat” and “Purging” with age—it could or could not be due to an actual eating disturbance. However, the fact that a truly eating disorder related component, such as “Food Preoccupation,” did not decline with age as one would predict based on the current literature, suggests that among urban Bulgarian women disordered eating ideation may really persist beyond the typical teens and 20s.

There are several possible explanations for this unorthodox observation. First of all, the relatively small number of participants within the older age categories may have resulted in limited power for analyses of changes in disordered eating with age. Second, I hypothesized that the observed age effects were due to cohort differences—that women who at the time of the study were in their 30s and 40s, were adolescents and young adults during the peak of socio-cultural transition, when the influx of Western media and thin-beauty imagery was at its fullest and most aggressive. As a consequence, these women may hold attitudes towards body weight and physical appearance that are more disturbed than women who formed their self-concept way before the transition—when there was virtually no exposure to Western ideology—or at least equivalent to women who grew up way after the transition—when Western lifestyle ceased to be as influential by virtue of being commonplace. Thus, with the exception of the elderly individuals, it is possible that the obtained age effects among women younger than 65 reflected historical changes in the beauty ideal associated with societal transformation, as opposed to naturally occurring age-related developmental processes. Indeed, cohort effects have been shown to be extremely important in understanding behavioral and personality change over the life course (Caspi, 1993; Elder & Caspi, 1992; Heatherton et al., 1997).

Nevertheless, only a longitudinal study could truly discern the cohort from developmental effects of age. From this perspective this study is limited by the cross-sectional nature of its design.

Some additional methodological limitations warrant discussion as they also impact the interpretation of the observed results. First, the reliance on self-reports may have introduced self-presentational bias in the data (Fairburn & Beglin, 1990). Due to recent increases in media attention on eating disorders in Bulgaria—observed firsthand by the researcher (myself) while in the field—accompanied by a growth in awareness about these conditions and a deepening of the social stigma associated with them, certain participants may have been reluctant to disclose eating problems, leading to an overall underestimation of the degree of disordered eating in the studied sample. Indeed, it has been shown that in non-clinical settings, measures of social desirability are negatively related to the self-reporting of eating disorder symptoms (Miotto et al., 2002; Preti et al., 2009). Moreover, willingness to participate in research about body image and eating habits may have been an issue for individuals with serious eating problems or overt eating disorders, who would have been less likely to fill out the survey. Even if these individuals proceeded to participate, their denial of illness may have resulted in lower scores on the EAT (Garfinkel & Newman, 2001). Additionally, participants may have been self-selected in that it was based on the extent to which the survey topics were of interest or relevance to the participants. In both cases, reports of disordered eating in the sample may have been biased due to participation bias. Nevertheless, the purpose of this study was not so much to determine the prevalence of disordered eating attitudes and behaviors in the Bulgarian population, as to serve as a starting point for the exploration of the antecedents of disordered eating in the present sample, so this limitation is not of serious consequence.

A number of study limitations also stem from the choice of a psychometric instrument for the assessment of disordered eating attitudes and behaviors in the sample. It should be noted that the EAT detects only current disordered eating attitudes and behaviors, and is neither able to

uncover past issues with eating, nor to predict the development of such issues in the future. Symptoms of eating disorders can wax and wane over time (Vetrone et al., 2006). And although the test has demonstrated good retest reliability up to 18 months (Garfinkel & Newman, 2001), any conclusions about the rates of disordered eating in this sample—extending beyond the point in time when data collection occurred—should be made with caution. Furthermore, the manifestation of eating disorder symptoms varies considerably and is sensitive to cultural influences: for instance at the close of the 20th century bulimic symptoms have become much more prevalent (Garfinkel & Newman, 2001). The EAT, on the other hand, was developed to measure symptoms of anorexia nervosa at a time when bulimia nervosa and binge eating disorder had not been yet classified. Thus, it is possible that the EAT may not be as sensitive an instrument for identifying participants with attitudes and behaviors typical of bulimics or binge eaters. Moreover, because the prevalence of a disorder must approach 20% for a test to be efficient in detecting it, the EAT is not very effective in screening for eating disorders that have very low prevalence (2-4% for young women) in the general population (Garfinkel & Newman, 2001). The relatively low positive predictive value of the test—its ability to predict how often a high score on a test will be an actual case—contributes to its inefficiency as a screening tool aimed at detection of partial or subclinical eating disorders so typical of community samples (Jacobi et al., 2004). Indeed the EAT works best for populations at “risk,” such as adolescents and young adults. Furthermore, in a two-stage screening study Vetrone et al. (2006) reported a high rate of false negatives on the EAT, which might also lead to underestimation of the degree of disordered eating in the target population.

A final set of limitations comes from the nature of the population from which the current sample was drawn. I did not conduct a full population-based study. In fact, the study sample consisted of mostly women, young (high school and college students), and highly educated participants. Ethnic, racial, urban, educational, and occupational statuses of participants were not

significant predictors of disordered eating attitudes and behaviors in either gender. Nevertheless, sampling was non-probabilistic, which may have constrained variability in socio-demographic characteristics of the sample. Therefore, the present findings may not generalize to other populations.

Despite these limitations, the current study also has many notable strengths. This is one of a few studies to assess the psychometric properties of the EAT across different age groups and especially with mature non-clinical populations. This represents a notable strength given that the EAT is one of the most frequently used instruments to assess disordered eating across a wide range of populations from diverse cultural backgrounds.

Although sampling was not random, it was nevertheless suitable, because it provided a sample of educated, urban Bulgarians who were most likely to have experienced the effects of socio-cultural transition. Moreover, Sofia was an excellent choice of location for this study, being the country's capital and therefore major point of influx for Western cultural influences and media. In addition, during recruitment, the researcher or a contact intermediary who was not a stranger established a personal contact with the participants, which may have fostered their trust and willingness to disclose sensitive information, including struggles with eating and body image.

With respect to the choice of a psychometric tool, regardless of its many shortcomings, the EAT is still a highly standardized and valid tool for the assessment of disordered eating attitudes and behaviors and its use allowed for meaningful trans-cultural comparisons of the current results. To minimize the risk of linguistic or semantic misinterpretation of the EAT, I used its Bulgarian incarnation, which had an established cross-cultural validity (Boyadjieva & Steinhousen, 1996) that Principal Components Analysis (PCA) confirmed empirically for the current sample.

5.5. CONCLUSION

In conclusion, this study revealed rates of disordered eating in a sample of urban Bulgarian women and men that were at least as high as those observed in the West, if not higher for women, given that the latter were on average older than their Western counterparts. Moreover, close to two-thirds of women displayed subclinical levels of disordered eating by scoring at least 10 points on the EAT-40, which was startling, considering that these female participants were also on average thinner than the typical Western woman. Contrary to what the literature predicts, levels of disordered eating did not decline with age in women younger than 65 (i.e., excluding the elderly participants). This lack of decline was likely due to cohort effects reflecting historical changes in the female beauty ideal associated with societal transformation, as opposed to naturally occurring age-related developmental processes. Due to scarcity of research in this area, it was hard to deduce whether disordered eating attitudes and behaviors had increased, decreased, or remained the same in Bulgaria since the peak of socio-economic transition in the early to mid 1990s. Nevertheless, it seemed plausible that disordered eating had remained relatively unchanged over the past 15 or so years, as women growing up at the time peak of transition had likely retained their presumably more disordered eating attitudes and behaviors into their adulthood, leading to cohort effects as opposed to true increases in disordered eating (no retrospective data was available on men to make any assumptions). Lastly, findings from this study clearly challenged the utility of the full EAT-40 to measure true disordered eating attitudes and behaviors in elderly populations. Unlike younger women, the elderly tended to score very high on the EAT, not because of true disordered eating, but likely due to conditions and behaviors typical of old age, such as dental problems (requiring cutting food into small pieces), lack of novelty seeking (low food exploration), and age-related depression, among others. Thus, there is an urgent need for the development of specially designed eating attitudes scales not only for mature populations, but also for men or other groups where the concept of body dissatisfaction may entail a

different experience from that of thinking of oneself as too big. The interrelationship between body image, disordered eating attitudes and behaviors, weight status, and age of Bulgarian men in the context of socio-cultural transition demand further investigation and should be addressed in a future write-up.

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CHAPTER 6

CULTURE-REACTIVE AND CULTURE-SPECIFIC IDIOMS OF BODY IMAGE AND EATING DISTRESS IN A SAMPLE OF URBAN BULGARIAN WOMEN

6.1. INTRODUCTION

Body image and eating disturbances have attracted substantial scientific scrutiny since they first entered the mainstream of Western cultural discourse in the seventies and eighties of the past century. At that time the incidence of eating disorders, such as anorexia nervosa and bulimia nervosa, appeared to increase in accelerating fashion in the United States, the United Kingdom, and Western Europe, especially for women (Gordon, 2001). Numerous authors have implicated socio-cultural factors in the epidemiology, development, and etiology of eating disturbances in the West (Gordon, 2001). In particular, since disordered eating often revolves around issues of body image dissatisfaction, fat phobia, and weight control in the West, a link between the growing cultural preoccupation with female thinness—reflected and transmitted by the mass media—and the rise of eating disorders has been noted. Until the 1990s reports on eating disorders coming from non-Western countries were virtually lacking (Gordon, 2001). Thus, it is not surprising that body image disturbance, disordered eating, and media's role in the promotion of thin beauty were seen as symptoms of a “culture-bound” syndrome typical of the modern, capitalist, affluent, and economically developed Western societies (Bruch, 1978; Keel and Klump, 2003; Lacey, 1982; Levine and Murnen, 2009). However, as research in the field expanded, body image and eating issues became “unbound” from their geographic affiliation with the West and gained recognition as a global phenomenon. Yet the emergence of eating disorders in non-Western cultures continues to be heavily blamed on media-transmitted Western values spreading internationally via the processes of Westernization and modernization (Groesz et al., 2002; Katzman & Lee, 1997; Rathner et al., 1995;

Willinge et al., 2006). This explanation represents a socio-cultural model for the spread of eating disorders in non-Western cultures (Fallon, 1990).

Despite the relative popularity of this view among social scientists, it would be imprudent to assume that disordered eating results merely from exposure to media selling Western thinness-obsessed culture. Only a small proportion of women develop clinically significant eating problems despite most being exposed to mass media (Stice et al., 1994; Tylka, 2004; Willinge et al., 2006). Moreover, not all women with disordered eating are motivated by a desire to be thin and even if they initially are, the thin-beauty ideal soon loses its capacity to motivate—the extreme drive for body manipulation and control continues long after this beauty ideal has been surpassed (Lintott, 2003). Female self-denial of sustenance in the form of “fasting girls” or “miraculous maids” is definitely not a novel phenomenon—it dates back at least to the 5th century AD—yet it had nothing to do with body image or the desire to lose weight (Bemporad, 1996; Brumberg, 2000). Similarly, most anorexic patients seen in London, Toronto, Rome, and Berlin between the two world wars did not display notable body image distortion or fat concern (Shorter, 1994). Even in modern times, in societies that are decidedly media saturated and smitten with thin beauty—both Western (the US, Canada, the UK, Europe) and Eastern (Hong Kong)—there have been numerous reports of non-eating in which the drive for thinness and fat phobia are absent. Such cases have at best been dismissed as “atypical” in the West and shoved into the EDNOS (eating disorders not otherwise specified) category, while non-Western practitioners have often stretched the strict clinical definition of anorexia nervosa to include them (Lee, 2001). Steinhausen (1985) argues that the further East one moves the less the belief concerning an “ideal (i.e., thin) body” serves as the anorexics’ explanation for their starvation behavior. Indeed, cases of non-fat phobic anorexia are increasingly seen in Asian societies (Lee, 2001; Miller & Pumariega, 2001). Thus, when examining susceptibility to body image disturbance and eating pathology, a close look at a country’s cultural biography is

warranted (Meehan & Katzman, 2001). Social, moral, and biological factors in the local environment remodel individual experience, as a result of which women's attributions for non-eating are often location-specific and more diverse than the globally accepted attributions of fat phobia and the drive for thinness (Lee, 2001).

To address this major limitation of the socio-cultural models, especially in the cross-cultural context, researchers have begun looking for culture-specific variables that moderate the impact of Western beauty norms on women's body image and eating pathology (Abrams et al., 1993; Cashel et al., 2003; Edwards-Hewitt & Gray, 1993; Heesacker & Neimeyer, 1990; Johnson & Petrie, 1996). Several authors have suggested that certain religious beliefs and practices may be instrumental in women's non-eating and dietary restraint behaviors. In an effort to trace back the origins of anorexia nervosa, historians like Brumberg (2000), Bynum (1988), and Bell (1985) have investigated a link between religious asceticism and women's voluntary self-starvation within the context of Western Judeo-Christian tradition. These authors contend that, due to complex social, economic, and political reasons, at least since the Middle Ages and until the early modern times, fasting was a major form of female expression that had decidedly ascetic underpinnings (Banks, 1996; Bell, 1985; Bemporad, 1996; Brumberg, 2000; Bynum, 1988). Asceticism is the practice of extreme self-discipline and abstention from all forms of earthly pleasure—including food, sex, sleep, and material comforts—for spiritual reasons. Rooted in the Gnostic teachings of Eastern religions like Jainism, Buddhism, and Hinduism, which eventually infiltrated early Christianity and flourished in medieval Western Europe, the steadfast ascetic control of the body reflects the conviction that true salvation comes from knowledge (“gnosis”) that all matter is essentially evil and that the soul is the only divine possession of mankind (Bemporad, 1996). This knowledge engenders a dualism between the sinful body and the pure soul, in which self-denial leads to holiness or spiritual superiority (Dell &

Josephson, 2007). Since food is the major source of livelihood for the evil body, the refusal of sustenance in the form of fasting is the centerpiece of ascetic experience (Rampling, 1985).

The role of Christian asceticism in voluntary self-starvation is, however, not limited to the religious past. In Rampling's (1985) words: "perhaps the special relevance of the Christian ascetic tradition for the modern problem of anorexia nervosa lies in the legacy it offers for the allegorization of feeding." Based on her report of two recent cases of non-fat phobic anorexia in the US, as well as the published accounts by contemporary women with anorexia, anthropologist Banks (1992 & 1996) maintains that for some modern anorexics—especially those from conservative fundamentalist traditions—religious asceticism continues to provide meaning for their non-eating. Many other researchers and clinicians have also commented on the asceticism that characterizes modern anorexic behavior (Banks, 1996; Bruch, 1978; Rampling, 1985). Even patients who do not identify as religious in the traditional sense may explain and/or justify their unhealthy eating in spiritual terms (Dell & Josephson, 2007). In other words, in the contemporary secular world, the asceticism of food denial may be rather spiritual than religious. Here I make a distinction between spirituality and religiousness as research suggests that these two concepts should not be used interchangeably. Unlike religiousness, spirituality is not confined to or by a specific denomination, affiliation, or a higher power, and thus it represents a broader, more universal construct (Carlson et al., 2004). Religiousness, on the other hand, implies an institution that is spirituality structured and organized. Overall, regardless of whether it is institutionalized or not, spirituality—as a vestige of the religious past—continues to be an important theme in modern women's body image and disordered eating experiences (Miles, 1995).

Although research acknowledges a spiritual component to body image and eating disturbances, the exact role of spirituality in the emergence, maintenance, or recovery from body image and eating issues remains unclear. Spirituality (beliefs and practices) has been viewed both as

a protective and a harmful influence on women's body image and eating attitudes, depending on which aspect of spirituality an individual emphasizes (Dell & Josephson, 2007; Dittman & Freedman, 2009; Homan & Boyatzis, 2010; Kim, 2006; Latzer et al., 2008; Smith et al, 2003). It is important, however, to mention that the majority of this research has been conducted in the West or through the lens of Western Christian tradition. To the best of my knowledge, no such studies have been done in cultures carrying the legacy of Eastern (i.e., Orthodox) Christianity. What makes Eastern Christianity interesting is not only that it features prominent ascetic principles (Meyendorff, 1962; Toti, 2008), but that these principles may also be more integral to the religion. Indeed, for cultural, political, and purely geographic reasons asceticism infiltrated early Christian cultures from the East (Bemporad, 1996). Thus, the exchange of ideas between Eastern ascetic philosophies and Orthodox values may have been longer and more intense than in the West.

Recognizing the need for further investigation of both culture-specific variables and the applicability of the socio-cultural models in a non-Western setting, in the current study I attempt to illuminate issues of spirituality, body dissatisfaction, and eating restraint behaviors in the context of present-day Bulgaria—a former Eastern Bloc country—that has been undergoing the processes of Westernization and modernization via the influx of Western media. Bulgaria presents a unique opportunity because prolonged fasting—a decidedly ascetic practice—is a standard component of Orthodox Christianity, Bulgaria's predominant religion. Despite decades of secularization (Serafimova, 2007), faith-based fasting remains widely popular in Bulgaria. Pilot data (from summer 2008) revealed that fasting was regarded as a socially accepted, traditional, health-promoting dietary behavior. With self-restraint behavior already a prevalent cultural norm, it is reasonable to expect a body image whose achievement is dependent on such behavior to be accepted more readily in Bulgaria than in a society where the behavior is discouraged or stigmatized. An openness to, and high level of acceptance of, fasting as a self-restraint behavior, may facilitate the adoption of an

anorexic attitude. Conversely, fasting may serve as socially acceptable façade to hide pre-existing disordered eating.

Based on a review of the available literature, there have been no studies in non-clinical settings dealing with issues of body image, body dissatisfaction, and disordered eating in Bulgaria. As a result, the effects of Western-type media—selling Western values including that of ultrathin beauty—on the beauty ideal, weight dissatisfaction and eating behavior of Bulgarians, whether young or old, remains largely unexplored. Similarly, relevant socio-cultural research is absent. Therefore it would be valuable to learn to what extent Bulgarians have internalized the ultrathin Western ideal and how this may have impacted their eating behavior, as well as how that impact is affected by local socio-cultural customs, such as faith and fasting.

Thus, the primary purpose of this study was to examine the interplay between Western and local culture in affecting body image and disordered eating attitudes and behaviors among urban Bulgarian women. Specifically, I asked the following primary questions: 1) Do Bulgarian women desire thinness and act on that desire? 2) Does a socio-cultural model for body dissatisfaction and disordered eating based on Western media's thin images apply to the Bulgarian context? 3) What are the roles of culture-specific factors, such as faith and fasting, in the schema of body dissatisfaction and disordered eating among Bulgarian women?

6.2. RESEARCH DESIGN AND METHODS

6.2.1. SETTING

Sofia, Bulgaria's capital and largest city (population of approximately 1.5 million), was selected as the site for this study. The sampling was that of convenience and was intended to provide a cross-section of ages. Participants were recruited through personal and professional contacts (intermediaries) established by the researcher (myself) at various institutions of higher

learning, secondary schools, and other places of employment (e.g. sports clubs, exercise studios, spa and cosmetic centers, hospitals, state-owned and private companies).

6.2.2. PROCEDURE

The survey was conducted over a period of approximately 3 months from May through August, 2009, with the majority of surveys collected in May and early June. Participants were given a questionnaire booklet to fill out either at home, or in the office or classroom, or another location providing an adequately disturbance-free environment. Brochures or business cards with my contact information were made available to all persons contacted. Additionally, a number of the surveyed participants offered to help with recruitment by distributing materials and talking to friends and acquaintances likely to become participants. Interested individuals who contacted the investigator either directly or indirectly (via an intermediary) were given a questionnaire booklet to fill out.

The survey was devised to take up to 30 minutes to complete, however secondary students were given a full school hour (with a 10-minute intermission) or a total of 50 minutes to work on the booklet. Similarly, university students had about an hour to complete the survey. The rest of the participants were not limited in terms of time (they could work on the questionnaire on their own time at a location of their convenience).

Of the 327 booklets distributed, 321 were returned with the consent form on top signed. Of these returned questionnaires, 2 were excluded due to being nearly blank. Thus, 319 questionnaires were used in the analyses, resulting in a final overall response rate of approximately 98%.

6.2.3. QUESTIONNAIRE BOOKLET

The questionnaire was designed as a 10-page booklet entitled “Food and Eating Habits of Modern Bulgarians.” It contained questions covering 5 topics: demographic information, disordered

eating attitudes and behaviors; degree of adoption of Western ideal body standards; body image and dissatisfaction; and Western media exposure and consumption. All survey data were self-reported. Detailed data on sociodemographics, anthropometric information, and eating attitudes and behaviors are presented elsewhere (see Chapter 5).

6.2.3.1. Socio-Demographic Information

The following information was asked of participants: gender; date and place of birth, and the location where they grew up; race; ethnicity; religious affiliation; language skills; legal marital status; employment status and professional category; current and highest achieved educational level; monthly household income and expenditure for food.

6.2.3.2. Anthropometric Information

Participants were asked to self-report their height (m) and current, lowest and highest weight (kg). Body Mass Index (BMI) was calculated as the ratio between each person's current weight (kg) to height squared (m^2) (Garrow & Webster, 1985). Participants were subsequently divided into four categories—underweight ($BMI < 18.5 \text{ kg}/m^2$), normal weight ($18.5\text{-}24.99 \text{ kg}/m^2$), overweight ($25\text{-}29.99 \text{ kg}/m^2$), and obese ($BMI \geq 30 \text{ kg}/m^2$)—based on the WHO International Classification of adult underweight, overweight and obesity according to BMI (World Health Organization, 1995, 2000, and 2004).

6.2.3.3. Faith

Aside from Religious Affiliation, which was recorded as part of Demographic Data collection, I assessed participants' "Faith." Participants were asked to select one among six of the following options: "Atheist (I think God does not exist)," "Agnostic (I neither believe nor disbelieve in God)," "Without Definite Beliefs (I have faith, but am NOT religious)," "Passive Believer (I believe in God, but am NOT observant)," "Active Believer (I believe in God AND am observant),"

and “Other (explain).” These response options were based on data from a previous pilot study (conducted in summer 2008). Consequent analyses deemed it feasible to collapse respondents into three main categories: “Non-Believers” (a combination of “Atheists” and “Agnostics”), “Passive Believers” (a combination of “Passive Believers” and individuals “Without Definite Beliefs) and “Active Believers” (made up of only the “Active Believers”). Subjects who chose “Other” as their answer were assigned to one of the three main categories on a case-by-case basis depending on relevant information that they provided to justify their response.

6.2.3.4. Western Media Exposure

Exposure to Western mass media was assessed by using a Media Consumption Frequency (MCF) measure derived from the dissertation work of Biloukha (2000) in the Ukraine. Analysis of pilot data (from summer 2008) revealed the appropriateness of this measure for the Bulgarian situation. MCF is composed of seven items. Participants were asked to report the frequency with which they watch Western movies, Western serials (e.g., soap operas, *Sex & the City*, etc.), Western music videos (like those shown on MTV, VH1, etc.), and other Western programming (e.g., fashion, beauty, reality on fTV, MTV, etc.). Additionally, frequencies of reading or perusing women’s (e.g., beauty and fashion) and men’s (e. g., *Playboy*, *Maxim*, *FHM*, etc.) magazines and fashion catalogues were also recorded. Participants were encouraged to consider any print media, TV/cable, DVD, VHS, cinema, and online sources. Consumption frequencies were assessed on a 7-level rating scale ranging from “Once per Year or Less (or Never)” to “Once a Day or More (or Constantly).” A composite measure was created as the sum of frequency scores of the seven items.

6.2.3.5. Body Image Perceptions and Attitudes

Participants were presented with the Contour Drawing Rating Scale (CDRS), a graphic rating scale developed by Thompson and Gray (1995), which consists of nine female and male contour silhouette drawings of graduated sizes ranging from 1 (smallest) to 9 (largest) with half-point

increments (e.g., 1.5 or 2.5, etc.) in between figures. Drawings 1 through 4 for women are considered to be anorexic, whereas male anorexic drawings range from 1 to 3; correspondingly, obese women and men are represented by drawings 7 through 9 (Thomson & Gray, 1995). Frederick et al. (2008) suggest that the body sizes displayed across the scale can be labeled as 2=very slender, 4=slender, 6=heavy, 8=very heavy. Based on observations and participant feedback from a pilot study, I permitted the use of half-point increments when making silhouette selections to increase precision; this approach has been supported by previous research using the CDRS (Wertheim et al., 2004). Participants identified their Present Figure by selecting a silhouette number that most closely matched their current figure (in terms of shape, size, or weight), as well as their Ideal Figure—the silhouette number that most closely corresponded to the figure they would like to have. The discrepancy between Present Figure and Ideal Figure is an often-used measure of body image dissatisfaction. A Figure Dissatisfaction Index was calculated as the difference between the Present Figure score and the Ideal Figure score. Thus, persons who desired thinner figures had positive scores and persons who desired fuller figures had negative scores. Thompson and Grey (1995) reported a one-week test-retest reliability of 0.78 for the CDRS and current figure ratings correlated with self-reported BMI ($r=0.59$) and self-reported weight ($r=0.71$), which implied good test-retest reliability and construct validity in a small young adult sample. Wertheim et al. (2004) also provided evidence of good 14-day test-retest reliability for the scale—ranging from 0.71 to 0.90—and satisfactory construct and discriminant validity in a sample of early adolescent girls.

Aside from reporting Present and Ideal Figure, participants also recorded the male and female figure they perceived as the healthiest, the figure that represented their perceived thinnest and heaviest appearance, and the figure that they “sometimes felt like,” as well as the one they imagined other people would ascribe to them, despite what they “knew their figure was like.”

6.2.3.6. Adoption of the Western Thin-Beauty Ideal

The original Socio-Cultural Attitudes Towards Appearance Questionnaire (SATAQ), developed by Heinberg et al. (1995) was used only with the female portion of the study sample. The SATAQ is a 14-item measure designed to assess women's recognition and adoption of Western societal standards of thin beauty. Participants responded to items using a 5-point Likert scale ranging from 1 (Disagree Completely) to 5 (Agree Completely). The questionnaire has two subscales—Awareness (6 items) and Internalization (8 items). The reported internal consistencies of these subscales in a young adult female sample were 0.71 and 0.88, respectively (Heinberg et al., 1995). Items from the Awareness subscale try to determine whether a woman regards thinness and attractiveness as highly valued in her own society. Of the 6 questions in this subscale, 3 mention thinness directly, 2 ask about importance of attractiveness without mentioning thinness, and one presumes a relationship between thinness and attractiveness, but does not state it directly (see Table 6.3). Items 6 (“In our society today fat people are **not** regarded as **un**attractive”), 10 (“Most people do **not** believe that the thinner you are, the better you look in clothes”), and 12 (“In today's society it is **not** important to always look attractive”) of the subscale were slightly modified to avoid double negatives, which are hard to comprehend in the Bulgarian language. Consequently, these items were no longer reversely scored as in the English version of the SATAQ. The Internalization subscale measures a woman's tendency to strive for the thin-beauty ideal portrayed in Western mass media. Questions of this subscale assess a woman's specific goals for her figure and refer to Western mass media sources like music videos, magazines, movies, etc (see Table 6.3). Item 4 (“I do **not** wish to look like the models in the magazines”) on this subscale was the only reversely scored item. Heinberg et al. (1995) reported that scores on both subscales converged well with multiple indices of body image and eating disturbance.

6.2.3.7. Dietary Restraint Behaviors

6.2.3.7.1. Dieting

Dieting behavior was assessed by analyzing responses on Item 37 (“Engage in dieting behavior”) of the EAT-40 (Garner & Garfinkel, 1979). Participants who responded to this item with “Never” were categorized as “Non-Dieters,” while all other participants, whose responses ranged from “Rarely” to “Always,” were collapsed into the “Dieter” category.

6.2.3.7.2. Fasting

Participants were asked to report the frequency with which they engaged in fasting behavior and were given the options of “Never,” “Occasionally,” “Regularly,” “NOT applicable” and “Other (accompanied with an explanation)” as possible responses. These responses were derived from pilot study data (from summer 2008). During later analyses, response options were collapsed into two main categories—“Non-Fasters” (who opted for “Never” or “NOT applicable”) and “Fasters” (who indicated that they engaged in the behavior “Occasionally” or “Regularly”). Participants who gave the response “Other” were assigned to either category on a case-by-case basis depending on the specific explanation that accompanied their response.

6.2.3.8. Disordered Eating Attitudes and Behaviors

Disordered eating attitudes and behaviors were measured using the Bulgarian version of the 40-question Eating Attitudes Test (EAT-40) originally developed by Garner and Garfinkel (1979). This version of the EAT-40 was used in clinical and non-clinical samples of Bulgarian adolescents (M = 15.2, SD = 1.3 years) by Boyadjieva and Steinhausen (1996). Translations of the 40 test items were performed by Dr. Svetlana Boyadjieva, a bilingual psychiatrist and seasoned expert in the screening, diagnosis, and treatment of eating disorders in Bulgaria.

Participants rated their agreement or disagreement for each of the forty items on a 6-point Likert scale ranging from “Never” to “Always.” The severity of their responses was scored from 0 to 3 with only the most symptomatic responses—“Often”, “Very Often”, and “Always”—given scores of 1, 2, and 3, respectively. Six out of the 40 questions—number 1 (“Like eating with other people”), 18 (“Like my clothes to fit tightly”), 19 (“Enjoy eating meat”), 23 (“Have regular menstrual periods”), 27 (“Enjoy eating at restaurants”), and 39 (“Enjoy trying new rich foods”) were scored reversely (1= “Sometimes,” 2= “Rarely,” 3= “Never”) as indicated by Garner and Garfinkel (1979). Question 23 (“Have regular menstrual periods”) was not scored for men and menopausal women (Eagles et al., 2000). All answers were then summed and respondents who scored above a cutoff of 30 were considered at risk for an eating disorder. The small scale and limited funding of this study did not, however, allow for clinical determination and referral of eating disorders in the sample under investigation.

6.2.4. TRANSLATION CONSIDERATIONS

The questionnaire booklet, recruitment brochure, and study consent form were developed in English by the researcher (myself). The questionnaire booklet was translated into Bulgarian by the researcher, and back-translated into English by a second bilingual individual living in the United States. The study brochure and consent form were translated and back translated by two separate bilingual individuals (one living in Bulgaria and the other in the United States) other than myself (Osman & Sobal, 2006; Harkness et al., 2004). All translators are fluent in Bulgarian and English and familiar with Bulgarian and Western cultures. Most questions from the questionnaire (except the EAT-40 items) were piloted during summer 2008 with a sample of 47 Bulgarians, whose translation suggestions and comments were taken into account during translations. I had available the Bulgarian version of the EAT-40, which I reviewed and modified only minimally to assure that items will be comprehensible and get at the desired information.

6.2.5. ETHICAL CONSIDERATIONS

All surveys were collected anonymously and participants were assured that their participation was voluntary and that their answers would be absolutely confidential. In each recruitment setting the study was briefly introduced as being about the food and eating habits of contemporary Bulgarians. Furthermore, all participants were required to read and sign a consent form, which was stapled on top of each questionnaire booklet. To avoid students' influencing each other's answers, all surveys were completed simultaneously in the classroom in the presence of the researcher (myself) and a professor or a teacher, and collected directly by the researcher. It was made clear to students that participation was voluntary and that they could refuse to fill out the survey and leave the classroom at any time. Participants reached through a contact person were provided with sealable envelopes and given an additional option to staple closed their questionnaire booklet to keep it confidential. This study was approved by the Cornell University Institutional Review Board.

6.2.6. DATA ENTRY AND ANALYSIS

All data were entered manually by the researcher (myself) and double-checked for accuracy. Data from questionnaires were analyzed quantitatively using a variety of statistical techniques and software packages. Descriptive statistics, paired t-tests, Analysis of Variance (ANOVA), Student's t test for pairwise comparison of means, univariate and multivariate linear regression, and Classification and Regression Trees (CART)/recursive partitioning analysis were performed using JMP (JMP, Versions 7 & 8, SAS Institute Inc., Cary, NC, 1989-2007). Partial correlations among variables were calculated using PASW Statistics 18, Release Version 18.0.0 (SPSS, Inc., 2009, Chicago, IL, www.SPSS.com). Fisher's exact test was computed with StatXact 9 (Cytel, Inc., Cambridge, MA).

When it comes to research problems requiring classification of cases into various risk categories, traditional statistical procedures often turn out to be inefficient or cumbersome to use

compared to the less conventional CART/recursive partitioning analysis. CART is a powerful, yet flexible non-parametric statistical platform, which offers several advantages over classical methods. It allows for a large number of possible predictors and can handle dimensional data that are highly skewed or multi-modal, as well as binary or polytomous (i. e., multi-level) categorical data with either ordinal or nominal structure (Feinstein, 1996; Lewis, 2000). CART is also excellent at detecting complex interactions (or patterns) among predictors that may be impossible to uncover using standard multivariate regression (Lewis, 2000). It is superb for data exploration or modeling, its output is easy to comprehend and interpret, and its accuracy is comparable or superior to other models (Lim et al., 1997). For all these reasons CART was an especially appealing technique, which enabled me to meet my main objective of uncovering factors influencing dietary restraint behaviors among urban Bulgarians.

Since CART is a rather unconventional technique, it is necessary to briefly describe its major elements. The analysis begins by growing a classification (for categorical responses) or a regression tree (for continuous responses) by recursively splitting data into partitions, called nodes (or leaves). To execute each split, the CART algorithm selects the best possible predictors at the best possible values to maximize the purity of the child nodes (Lewis, 2000). For categorical responses, such as dietary restraint strategy, the split criterion is either the candidate predictor with the largest G^2 (the likelihood-ratio chi-square) or the largest LogWorth (the log of p-values for the chi-square statistic adjusted for the number of ways that splits can occur) value. The latter is the default in JMP. Partitioning continues until a maximum size tree is grown that largely overfits the data, meaning that it fits noise and idiosyncrasies in the data that are unlikely to occur with the same pattern in a different data set (Lewis, 2000). To deal with this problem, the maximal tree is then “pruned” upwards until an optimal size tree—one that fits structure rather than noise—is selected. If the goal of analysis is data exploration, the optimal tree is selected interactively based on its ease of

interpretability and indicators such as minimal change in R^2 or Receiver Operating Characteristic (ROC) curves. If, however, the goal is predictive modeling, it is necessary to perform additional model validation (Gaudard et al., 2006). The latter is done by either obtaining a model development and a model evaluation data subset, or by using k -fold cross-validation when the original data set is too small to subdivide, or is large enough but has too few observations on key variables (Gaudard et al., 2006). In k -fold cross validations, which was the current study's case, the original data set is split into k sections with one section reserved for model evaluation and the remaining $k-1$ combined into a model development subset. Then the entire model-building procedure is repeated k times with a different subset as the evaluation subset. The average performance of these k models (reflected by the cross-validated R^2) is an excellent estimate of the performance of the overall model (produced using the entire dataset) on a future independent data set (Lewis, 2000). The cross-validated R^2 is oftentimes lower than the overall R^2 , however, the former is a more “honest” estimate of a model's Goodness-of-Fit—one that conventional regression does not report. To offer a fair comparison, I have reported both R^2 values in the results section of the current chapter.

6.3. RESULTS

In the current chapter, I report only on the female sample that was used for fasting and body image related analyses. Means, standard deviations, and ranges for all continuous variables are summarized in Table 6.1.

Table 6.1. Summary characteristics of the sample (females) for continuous variables, N=205.

	Mean (Median)	Standard Deviation (SD)	Range
Age	32.1 (26.0)	16.3	18-81
BMI	22.0 (20.8)	4.9	14.9-52.7
MCF	26.3 (27.0)	7.9	9-43
Awareness	22.7 (23.0)	4.3	6-30
Internalization	22.6 (23.0)	7.1	8-40
Present Figure	5.3 (5.0)	1.7	2-9
Ideal Figure	4.1 (4.0)	1.0	2-7
Healthiest Figure	4.2 (4.0)	0.9	2-7
Body Dissatisfaction	1.2 (1.0)	1.3	-2-6
EAT-40	16.4 (14)	10.0	1-56

6.3.1. SOCIO-DEMOGRAPHIC INFORMATION

A total of 235 women participated in this study. Of them, 30 were excluded from analyses due to missing data on faith, fasting, BMI, or the SATAQ subscales. The resulting sample was made of 205 women ranging in age from 18 to 81 years with a median and mean age of 26 and 32.1 (SD=16.3) years, respectively. Approximately 61% of the sample was made up of young women between 18 and 29, 17% were between 30 and 44, and 18% between 45 and 64 years of age. Only 4% of women were “seniors,” older than 65 years. All women were Caucasian and nearly all (96%) ethnically Bulgarian. Most women (80%) could read and understand spoken English, and a sizeable number (28%) were comfortable with at least one additional Western European language (e.g., French, German, Spanish, or Italian). Virtually all women (99%) were Christian and the majority of them (96%) were Orthodox. Only 2 women (1%) self-reported religious affiliation other than Christianity.

The majority of women were born, grew up, or (at the time of data collection) living in large urban areas. Most of them were never married (67%), some were in a first and only marriage (23%), and very few were either remarried (3%), or separated or divorced (5%), or widowed (2%). High-school seniors and university students (5% of whom were graduate students) accounted for about half of this sample (53%), and the rest came from diverse occupational groups (e.g., university

professors, researchers, school teachers, bank employees, accountants, lawyers, medical doctors, nurses, psychologists, salespersons, architects, engineers, artists, etc.). Unemployed and retired women were only a small fraction of the present sample. Almost everyone had earned (or was in the process of earning) the equivalent of at least a high-school diploma. Close to half of women (43%) had earned the equivalent of a college or university degree, with 33% of the study sample holding a graduate (master's and above) degree, and 4% having completed more than one higher education. In summary, the present sample consisted of mostly young, urban, single, highly educated women.

6.3.2. BODY MASS INDEX (BMI)

Women's BMI ranged from 14.9 (underweight) to 52.7 (obese) with a median of 20.8 and a mean of 22.0 (SD=4.9) kg/m². These latter values are within the normal weight range using criteria adapted from the World Health Organization (1995, 2000, & 2004). Across the entire sample of women, the majority (61.2%) were of normal weight. However, a sizable proportion of women (21.6%) were underweight, whereas only 12.3% were overweight and even fewer (4.9%) obese. There was a significant positive correlation ($r=0.49$, $p<0.0001$) between age and BMI.

6.3.3. FAITH

In terms of faith (i.e., spiritual belief), a large proportion of women (77%) considered themselves "Passive believers," followed by fewer "Non-Believers" (17%), and an even smaller group of "Active Believers" (7%). While "Non-Believers" and "Passive Believers" did not differ in age, both were significantly younger than "Active Believers" (both $p<0.05$; Student's *t* pairwise comparisons among means). Unlike faith and age, faith and BMI were not related.

6.3.4. WESTERN MEDIA EXPOSURE

The frequencies of exposure to various types of Western mass media are presented in Table 6.2. For each electronic media source, I defined 4 different levels of exposure intensity—very low

(once per year or less, including never, up to a few times per year), low (once per month to a few times per month), high (once per week to a few times per week), and very high (once a day or more, including “constantly”). With respect to print media sources, I considered exposure frequencies of once per month to a few times per month to be “Moderate.”

Table 6.2. Frequencies of exposure to Western media types and sources (number of participants and % of the overall sample).

		Very Low		Moderate		High		Very High	
		N	%	N	%	N	%	N	%
Print Media	MAGAZINES:								
	Women’s	73	35.6	70	34.2	55	26.8	7	3.4
	Men’s	177	86.3	23	11.2	5	2.4	0	0
	CATALOGUES	78	38.1	80	39.0	41	20	6	2.9

		Very Low		Low		High		Very High	
		N	%	N	%	N	%	N	%
Electronic Media	MOVIES	6	2.9	56	27.3	114	55.6	29	14.2
	SERIALS	47	22.9	47	22.9	86	42.0	25	12.2
	MUSIC VIDEOS	41	20	42	20.5	66	32.2	56	27.3
	SHOWS	79	38.5	61	29.8	49	23.9	16	7.8

Electronic media (e.g., movies, serials, music videos, shows) were consumed more frequently than print media (e.g., magazines and catalogues). Among electronic media, movies, serials, and music videos were consumed with the highest frequencies, while fashion, beauty, reality, or other entertainment shows were somewhat less popular. Of the print media sources, beauty and fashion catalogues were perused more frequently than womens’ beauty and fashion magazines. Not surprisingly, men’s magazines (such as Playboy, Maxim, FHM, etc.) were least popular among these women.

The composite measure of media consumption frequency, MCF, was independently related to participants' age ($p < 0.0001$)—as women grew older, their levels of exposure to Western media diminished significantly. Media use was not associated with BMI.

6.3.5. ADOPTION OF THE WESTERN THIN-BEAUTY IDEAL

Women's respective mean scores on the SATAQ Awareness and Internalization subscales were 22.7 ($SD=4.3$) and 22.6 ($SD=7.1$), and the median was 23 for both subscales (see Table 6.1). Results in Table 6.3 suggest that most women perceived beauty and thinness as very important factors in contemporary Bulgarian society. Women tended to experience some degree of pressure to look good in order to achieve personal or professional success. Moreover, a large proportion (71%) of them agreed that fatness was viewed as unattractive in Bulgaria, whereas thinness was beautiful. Conversely, women tended to disagree with the items from the Internalization subscale, especially if an item directly discussed emulation of media-featured beauty (Items 1, 3, 5, 7, and 14; see Table 6.3). Yet, roughly half of all women wanted to look like a model or thought that clothes look better on thin models.

Item 6 ("In our society today fat people are regarded as unattractive") from the Awareness subscale did not correlate well with the rest of the subscale items, resulting in a Cronbach's α of 0.69. Excluding item 6 boosted the internal consistency of the Awareness subscale to a Cronbach's α of 0.72. The Cronbach's α coefficients for the Internalization subscale was 0.82. Higher Awareness of the thin-beauty ideal was associated with higher BMI ($p < 0.05$), but not by women's age when holding BMI constant. Women's Internalization, on the other hand, was independent of both age and BMI. As expected, the scores on the subscales were significantly positively correlated ($r=0.32$, $p < 0.0001$; see Table 6.5).

Table 6.3. Percent of women (out the overall sample) agreeing with the items of the SATAQ Awareness and Internalization subscales (note that percent agreement combined individuals with “Agree Completely” and “More Agree than Disagree” answers).

AWARENESS SUBSCALE	#6. In our society today fat people are regarded as unattractive.	#6 71%
	#8. Attractiveness is very important if you want to get ahead in our society today.	#8 82%
	#9. It’s important for people to work hard on their figures/physiques, if they want to succeed in today’s society.	#9 59%
	#10. Most people believe that the thinner you are, the better you look.	#10 60%
	#11. People think that the thinner you are, the better you look in clothes.	#11 57%
	#12. In today’s society it is important to always look attractive.	#12 86%

INTERNALIZATION SUBSCALE	#1. Women who appear in TV shows and in movies project the type of appearance that I see as my goal.	#1 36%
	#2. I believe clothes look better on thin models.	#2 44%
	#3. Music videos that show thin women make me wish that I were thinner.	#3 35%
	#4. I do not wish to look like the models in the magazines.	#4 42%
	#5. I tend to compare my body to people in magazines and on TV.	#5 36%
	#7. Photographs of thin women make me wish that I were thinner.	#7 34%
	#13. I wish I looked like a swimsuit model.	#13 48%
	#14. I often read magazines like Cosmopolitan, Vogue, Glamour, other (specify) and compare my appearance to the models.	#14 15%

6.3.6. BODY IMAGE PERCEPTIONS AND ATTITUDES

A remarkable proportion of these urban Bulgarian women (72%) desired to be thinner by at least one silhouette size (median=1.5, mean=1.9, and SD=1.0)—here I am referring only to the women who desired to be smaller. Alternately, only 22% of women were bodily satisfied (they did not want to change their current figure) and very few (6%) desired a fuller figure (up to 2 silhouette sizes). Across the entire sample, median body dissatisfaction was 1 figure, the mean was 1.2 (SD=1.3)—refer to Table 6.1—and the difference between Current and Ideal Figure selections was significantly different from zero (t -Ratio=13.3, $p < 0.0001$). Among the aforementioned women who desired to be smaller, the majority ($N=99$, 67.4%) were of normal weight, followed by overweight

women (N=25, 17.0%). Interestingly, somewhat more underweight than obese women desired a thinner figure (N=13 vs. N=10, 8.8% vs. 6.8%, respectively). Bodily satisfied women were either underweight (N=24, 52.2%) or had normal weight (N=22, 47.8%). In contrast, none of the overweight or obese women were satisfied with their body or desired to be fuller. Among those who desired a fuller figure, most were underweight (N=7, 58.3%) and the rest were of normal weight (N=5, 16.7%). Looking at body image by BMI category, a notable number of underweight women (30%) desired to be yet thinner, even though these women's BMI was below 18.5 kg/m², whereas only 16% wanted to gain weight; in fact, most (55%) were happy to be ultrathin. Moreover, even normal weight women were predominantly bodily dissatisfied (79%), while way fewer (18%) were satisfied. Women's body image attitudes across the entire sample and by BMI category are presented in Table 6.4.

Table 6.4. Women's body image attitudes across the entire sample and by BMI category.

	Desiring Thinner Figure, N (%)	Satisfied with Present Figure, N (%)	Desiring Fuller Figure, N (%)
Whole sample (N=205)	147 (71.7)	46 (22.4)	12 (5.9)
Underweight (N=44)	13 (29.6)	24 (54.6)	7 (15.9)
Normal (N=126)	99 (78.6)	22 (17.5)	5 (4.0)
Overweight (N=25)	25 (100)	0 (0)	0 (0)
Obese (N=10)	10 (100)	0 (0)	0 (0)

Controlling for age, BMI was highly positively correlated with Present ($r=0.71$, $p<0.0001$) and somewhat less highly with Ideal Figure ($r=0.36$, $p<0.0001$), confirming a good concurrent validity for the CDRS. Controlling for BMI, age had no effect on either Present or Ideal figure selection. In other words, a heavier woman would select a larger figure to represent her current body, but would also idealize a larger body, regardless of age. Body dissatisfaction was once again positively correlated with women's BMI ($r=0.63$, $p<0.0001$), but not their age when holding BMI constant. Predictably, Present and Ideal Figure were highly intercorrelated ($r=0.57$, $p<0.0001$).

Medians, means, and ranges for Present and Ideal Figure selections are reported in Table 6.1. Women selected a Present Figure between silhouettes 2 and 9, and an Ideal Figure between 2 and 7—choices representing a range between anorexic and obese body shapes. Women’s modal choice for Present Figure was number 5 and that for an Ideal Figure was 4. The modal Healthiest Figure selection was also 4 (median=4, mean=4.2, SD=0.9). Even though women’s perceptions of an Ideal and Healthiest Figure appeared to be similar, when comparing the two means by a paired t test, the mean Ideal Figure was significantly thinner than the mean Healthiest Figure (t -Ratio=2.95, $p<0.05$). In other words, the women in this study idealized figures that they perceived as somewhat unhealthy. Interestingly, they also reported on occasion “feeling fatter” (mean difference=0.3, t -Ratio=-3.8, $p<0.05$) and thought that other people saw them as thinner than they actually were (mean difference=0.2, t -Ratio=3.1, $p<0.05$), which is suggestive of mild body image distortion. Regardless of age, as women got heavier, they thought others might see them as heavier than they actually were ($r=-0.15$, $p<0.05$), however, their feelings of being fat surprisingly diminished ($r=0.21$, $p<0.05$).

6.3.7. DIETARY RESTRAINT BEHAVIORS

About 74% of the women in the current sample controlled their food intake in one way or another. I looked at two different types of dietary restraint behavior—dieting and fasting.

Two-thirds of all women (66%) reported that they engaged in dieting to various degrees, which is remarkable, given that more than three fourths of women in this sample were of normal weight. Furthermore, for about 17% of women dieting was problematic—they dieted often, very often, or always—frequencies viewed as beyond normal by the authors of the EAT (Garner & Garfinkel, 1979). Fasting, on the other hand, was practiced by 40% of Bulgarian women regardless of their age or BMI. Fasting and dieting were correlated dietary restraint behaviors ($r=0.21$,

$p < 0.05$). Given that dieting was more popular than fasting, the majority of fasters (78%) were also dieters, while slightly fewer than half of dieters (47%) also fasted.

Since my interest was to understand the rationale behind these women's dietary restraint, I needed to disentangle fasting from dieting in order to see their individual effects with regard to other relevant variables. For this purpose, I split women into four dietary restraint categories. Women who reported never controlling their food intake fell into the "None" category, "Fasting" contained women who only fasted, "Dieting" contained women who only dieted, and women who engaged in both fasting and dieting were grouped into the "Both" category. The number and percent distribution of women among these categories was 52 (26%), 70 (35%), 18 (9%), and 62 (31%), respectively. The choice of dietary restraint behavior was independent of women's age, but related to BMI—women who practiced both fasting and dieting were significantly heavier ($p < 0.05$) than women who did not control their food intake in any way (see Table 6.6).

6.3.8. DISORDERED EATING ATTITUDES AND BEHAVIORS

The overall EAT-40 mean score for the current female sample was 16.4 (SD=10.0) and the median 14. Women's EAT-40 sum score did not depend on their age, however, a higher BMI was associated with a higher EAT-40 score ($r = .21$, $p < 0.05$). More specifically, obese women had significantly higher EAT-40 sum scores compared to underweight and normal weight women (both $p < 0.05$; Student's *t* pair-wise comparisons among means). Garner and Garfinkel (1979) proposed that a score of 30 and above should be used to separate individuals with possible clinical eating disorders from those who are not affected. A total of 21 women (10.2%) in this sample scored at or above 30. Of them 11 (52.4%) were between 18 and 29, 4 (19%) between 30 and 44, 4 (19%) between 44 and 65, and 2 (9.5%) over 65 years of age. Among high-scorers, middle-aged women (30-44 years) had significantly higher mean EAT scores ($p < 0.05$, Student's *t* pair-wise comparisons among means) than young women (18-29 years), but not significantly higher than older women (44-

65 and 65+ years age categories), though these relationships were borderline ($p=0.065$ and $p=0.084$, respectively). Because of the way EAT-40 items are scored, only the most symptomatic responses are given values of 1 to 3 points, whereas less symptomatic responses are weighed as 0. Therefore, even if an individual scores below 30 on the EAT-40, she may still endorse eating attitudes and behaviors that are disordered. The lower the score on the EAT-40, the less disturbed the eating behavior, until dropping below a threshold where there are hypothetically no eating disturbances whatsoever. I set this threshold for subclinical eating disturbances at $EAT-40 \geq 10$ as has been suggested before in the literature (Babio et al., 2009; Schneider et al., 2008). Interestingly, a substantial proportion of women (74%) in the current sample displayed disordered eating attitudes and behaviors by scoring 10 or more points on the EAT-40.

6.3.9. RELATIONSHIPS AMONG MEASURES OF MEDIA EXPOSURE, THIN-IDEAL AWARENESS, THIN-IDEAL INTERNALIZATION, BODY IMAGE AND DISSATISFACTION, AND DISORDERED EATING ATTITUDES AND BEHAVIORS

To explore the associations between measures of media consumption, thin-ideal awareness and internalization, figure scale measures, and disordered eating attitudes and behaviors, I employed a partial correlation analysis, which allows for the assessment of relationships among two variables while adjusting for the effect of other variables. In particular, I controlled for age and BMI to remove possible confounding, since age and BMI were intercorrelated and also related to many of the other measures. Partial correlations among MCF, Awareness, Internalization, Body Dissatisfaction, and EAT-40 are presented in Table 6.5.

Table 6.5. Pearson partial correlations among variables—media consumption frequency (MCF), thin-ideal adoption (SATAQ Awareness and Internalization), body dissatisfaction, and disordered eating attitudes and behaviors (EAT-40)—controlling for age and BMI.

	MCF			
Awareness	0.05	Awareness		
Internalization	0.21*	0.32***	Internalization	
Body Dissatisfaction	-0.06	0.12	0.23*	Body Dissatisfaction
EAT-40	0.21*	0.26***	0.37***	0.11

Note: Age and BMI were controlled. All significance tests were two-tailed:

* $P < 0.05$

*** $P < 0.0001$

Exposure to Western media (measured by MCF) was positively correlated with Internalization of the thin-beauty ideal ($r=0.21$, $p<0.05$), as well as disordered eating attitudes and behaviors ($r=0.21$, $p<0.05$) as measured by the EAT questionnaire. Disordered eating attitudes and behaviors were also positively correlated with Awareness ($r=0.26$, $p<0.0001$) and Internalization ($r=0.37$, $p<0.0001$) of the Western thin ideal, but—interestingly—not with body dissatisfaction ($r=0.11$, $p>0.05$, NS). As expected, Awareness and Internalization were highly positively correlated ($r=0.32$, $p<0.0001$). Higher levels of Internalization were associated with higher body dissatisfaction ($r=0.23$, $p<0.05$) and the choice of a thinner Ideal Figure ($r=-0.20$, $p<0.05$). Likewise, an increasingly thinner Ideal Figure was common among women whose disordered eating attitudes and behaviors intensified ($r=-0.22$, $p<0.05$).

Higher Awareness and Internalization of the thin ideal were conducive to a bigger difference between women’s choices of Current and Healthiest Figures ($r=0.21$, $p<0.05$ and $r=0.15$, $p<0.05$, respectively)—that is, women thought they were bigger than what they perceived as healthy. Last, but not least, their “feelings of being fat” intensified as exposure to Western media increased ($r=-0.15$, $p<0.05$). In other words, even though exposure to Western media was not related with more bodily dissatisfaction, it led to some mild body image distortion. Intriguingly, women who often felt

irrationally fatter were also the ones who thought others saw them as thinner than they believed themselves to be ($r=0.23$, $p<0.05$).

In a standard least squares regression (Whole Model: $R^2=0.29$, R^2 Adj.=0.26, $N=202$, $p<0.0001$), disordered eating attitudes and behaviors were significantly associated with SATAQ Awareness ($b=0.34$, $SE=0.16$, $p<0.05$) and Internalization ($b=0.35$, $SE=0.1$, $p<0.05$), as well as by the choice of dietary restraint behavior. In particular, the lack of dietary restraint was negatively associated with EAT-40 score ($b=-3.6$, $SE=1.1$, $p<0.05$).

Table 6.6 characterizes women in each of the four dietary restraint categories (None, Fasting, Dieting, and Both) in terms of age, BMI, MCF, Awareness, Internalization, body dissatisfaction, and EAT-40 scores. Results are shown as means and respective standard errors. There was a significant relationship between dietary restraint behavior and measures of media exposure, internalization of the thin ideal, body dissatisfaction, and disordered eating attitudes and behaviors (all $p<0.05$). Dieters had higher mean media exposure scores compared to fasters and women who did not control their food intake. Exclusive dieters, along with women who both dieted and fasted, had higher mean Internalization scores compared to women who did nothing. Exclusive dieters and women who both dieted and fasted also had higher body dissatisfaction and EAT-40 scores than did women who only fasted or did nothing. P-values are shown in Table 6.6.

Table 6.6. Comparisons among mean (SE) scores on all variables (age, BMI, MCF, SATAQ Awareness and Internalization, body dissatisfaction, and EAT-40) across the four dietary restraint categories (None, Fasting, Dieting, Both).

	None, N=52	Fasting, N=18	Dieting, N=70	Both, N=62
Age	30.6 (2.3)	32.5 (3.9)	30.0 (2.0)	35.6 (2.1)
BMI	20.8 (0.7)	20.6 (1.1)	22.3 (0.6)	22.9 (0.6) ^A
MCF	24.7 (1.1)	23.4 (1.8)	28.1 (0.9) ^B	26.5 (1.0)
Awareness	21.8 (0.6)	21.9 (1.0)	23.2 (0.5)	23.0 (0.5)
Internalization	19.9 (1.0)	20.8 (1.6)	24.2 (0.8) ^A	23.3 (0.9) ^A
Body Dissatisfaction	0.7 (0.2)	0.6 (0.3)	1.5 (0.2) ^B	1.4 (0.2) ^B
EAT-40	10.6 (1.3)	13.2 (2.2)	18.5 (1.1) ^C	20.1 (1.2) ^C

Note: Student's t pair-wise comparisons among means (SE):

^A {p<0.05 compared to None only}

^B {p<0.05 compared to None and p<0.05 compared to Fasting}

^C {p<0.0001 compared to None and p<0.05 compared to Fasting}

Aside from measures of media exposure, thin-ideal Awareness and Internalization, body dissatisfaction and disordered eating attitudes and behaviors, women's choice of dietary restraint strategy (or lack thereof) was significantly associated with their faith (p<0.05, Fisher's exact test), a relationship independent of age or BMI. Since fasting, as a food-related behavior, has its roots in religious tradition, it was not a surprise that exclusive fasting without dieting was practiced only by spiritual women (i.e., Passive and Active Believers) and not by Non-Believers. In this respect, exclusive fasting was different from exclusive dieting. Nevertheless, fasting did not seem to be a strictly religious or spiritual experience. In fact, about 18% of women who claimed to be atheist or agnostic (i.e., the Non-Believers) fasted in conjunction with dieting and 14% of Active Believers did not fast at all. Intriguingly, the most spiritual participants were also the most controlling of their eating—Active Believers dieted, or fasted, or did both, but there were no women among the Active Believers who did not in some way restrict their food intake.

To further investigate the factors associated with dietary restraint and understand their complex interactions, I employed CART analysis. Eight variables (age, BMI, Faith, MCF, SATAQ Awareness and Internalization, body dissatisfaction, and EAT-40) were selected as possible

predictors of dietary restraint behavior (i.e., None, Fasting, Dieting, Both). Using 5-fold cross-validation, the partitioning algorithm was permitted to continue until the largest possible tree was grown in 29 recursive splits. This maximal tree was then pruned upwards to an optimal tree that was complex enough to fit data accurately and have good predictive power, but not so complex to be overfit and cumbersome to interpret. The optimal tree was achieved in 10 splits, had 11 terminal nodes (leaves), and fitted data fairly well ($-2\text{LogLike}=397.04$; $R^2=0.24$). In comparison, the 5-fold cross-validation tree had a slightly lower, but still satisfactory, Goodness of Fit ($-2\text{LogLike}=436.08$; $R^2=0.17$). Note that the -2LogLike statistic corresponds to the residual SS in ordinary least squares regression. The split history and pruning steps are shown in Figure 6.1.

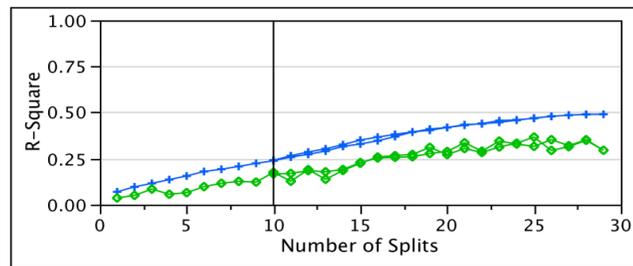


Figure 6.1. Split history for the overall (top/**blue**/+) vs. 5-fold cross-validation (bottom/**green**/◇) trees (the vertical line indicate optimal tree).

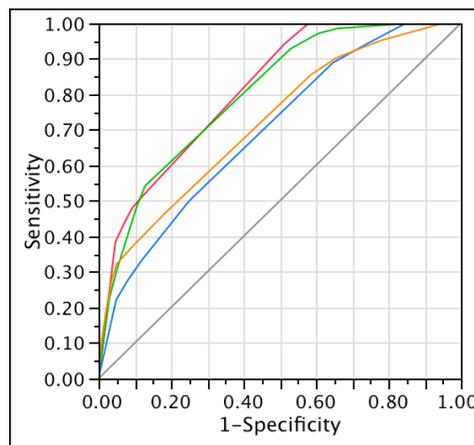


Figure 6.2. Optimal tree's Receiver Operating Characteristic (ROC) curves and areas under the curves for each dietary restraint category (response level): **Red**=None (81.3% area), **Green**=Dieting (80.1%), **Blue**=Fasting (69.7% area), and **Orange**=Both (72.1% area).

As can be seen from Figure 6.1, CART started to overfit data after about 18 splits—the graphs of the overall and cross-validation trees began to flatten meaning that further splitting added little discriminative ability to the model. The graph of the cross-validation tree even began to flatten, indicating a drop in the model’s predictive power (i.e., its ability to predict dietary restraint behaviors in samples other than the one on which it was initially fitted).

The optimal tree’s ROC (Goodness of Fit) curves and corresponding under-the-curve areas for each response level (i. e., dietary restraint category) are presented in Figure 6.2. Note that the closer a curve is to the left and upper boundaries of the graph (the larger the area under the curve), the better the sorting efficiency of the model. The model performed best for women who did not control their food intake (no restraint) and worst for the exclusive fasters.

Figure 6.3 shows the optimal classification tree, which was used to explain the conditions leading to different dietary restraint behavioral choices. The initial split resulted in a higher (EAT-40 ≥ 18) and a lower (EAT -40 < 18) score group with regards to disordered eating attitudes and behaviors. If women had higher EAT-40 scores, their level of faith was most likely to predict consequent dietary restraint behaviors. Active Believers with higher EAT-40 scores had the strictest dietary restraint (e.g., they fasted, dieted, or did both, but none did nothing). Conversely, the dietary restraint behaviors of less spiritual women (Passive Believers and Non-Believers) were influenced by their level of thin-ideal Awareness. The higher the Awareness score, the more controlling were women of their eating. In fact, all women whose Awareness scores exceeded 25 were food intake restrictors who chose a strategy depending on age and BMI. Fasting was the preferred strategy for very thin women (BMI <21.5) and women older than 22 years of age, whereas very young (age <22) and somewhat heavier women (BMI ≥ 21.5) put an emphasis on dieting. If Awareness was low, dietary restraint was lowest among ultrathin women (BMI <19.1) compared to slightly heavier

women ($BMI \geq 19.1$). Interestingly, media exposure ($MCF \geq 20$) led to more overall dietary restraint with an emphasis on dieting, but also some exclusive fasting.

When disordered eating attitudes and behaviors were less pronounced, dietary restraint was also less intense and body dissatisfaction was associated with the choice of dietary restriction strategy. Body dissatisfaction greater than half a figure size was associated with more dietary restraint (via fasting, dieting, or both) compared to bodily satisfied women (body dissatisfaction < 0.5). However, if the latter were atheist or agnostic (Non-Believers), they were likely to only diet, but never fast. In contrast, spiritual (Passive and Active Believers) bodily satisfied women were also the least likely to restrict food intake, especially when levels of thin-ideal Internalization were low (< 23).

In summary, total dietary restraint (e.g., number of restrictors, number of restriction strategies, combined restriction strategies) increased in parallel with disordered eating attitudes and behaviors, in that the strictest dietary restraint was practiced by the most spiritual women or by women who were highly aware of the societal thin-beauty ideal when they were less spiritual (i.e., in Non-Believers or Passive Believers). Among the latter, dieting was the preferred strategy when women were young or if BMI, Awareness, Internalization, or media exposure scores were higher. Exclusive fasting was mostly typical of spiritual women who displayed less disordered eating attitudes and behaviors and more body satisfaction. Nevertheless, exclusive fasting was also found among an older subgroup of women who had the strictest dietary restraint.

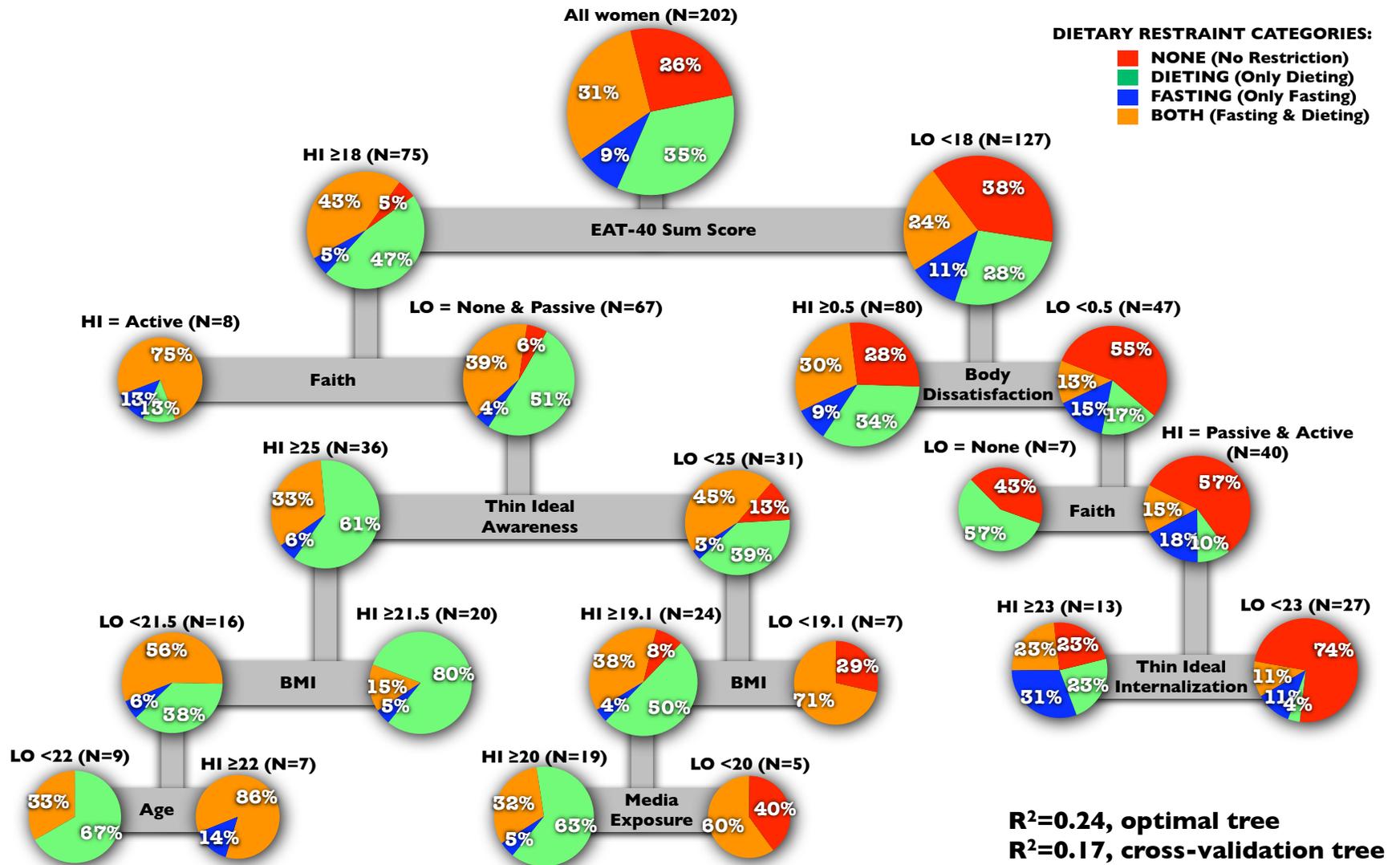


Figure 6.3. Optimal classification tree characterizing dietary restraint behaviors.

6.4. DISCUSSION

The primary purpose of this study was to examine the interplay between Western and local culture in affecting body image and disordered eating attitudes and behaviors among urban Bulgarian women. Specifically, the following primary questions were addressed: 1) Do Bulgarian women desire thinness and act on that desire? 2) Does a socio-cultural model for body dissatisfaction and disordered eating based on Western media's thin images apply to the Bulgarian context? 3) What are the roles of culture-specific factors, such as faith and fasting, in the schema of body dissatisfaction and disordered eating among Bulgarian women?

6.4.1. SITE AND PARTICIPANT SELECTION

A detailed discussion of the rationales behind site and participant selection is provided elsewhere (see Chapter 5). Briefly, Sofia's status as a metropolis—hence a major gateway for Western influences—and the city's modernity, large population, and multiple avenues for data collection, made it a particularly appropriate site for studying the impact of Westernization and modernization on body image and eating behavior. The recruitment procedure available to me was that of convenience and snowball sampling (i.e., via key intermediaries), rather than random sampling. This was because I did not have access to up-to-date census data and recruitment over the phone was not feasible due to an outdated and unreliable phone directory, and the unwillingness of Bulgarians to disclose personal information to strange callers. Similarly, mail-in surveys were deemed impractical, especially since there was an added risk of confusion and inaccuracy of responses due to lack of familiarity with the survey format. Despite my best effort to obtain a sample that was as diverse as possible, the study sample consisted of mostly young, urban, single, and highly educated women, who were virtually uniform in terms of race, ethnicity, and religious denomination. Because participation relied heavily on personal interest in the survey topics, there was also a potential for self-selection bias among the participants, even though I tried to minimize

this bias by advertising the study in rather broad terms, as an exploration of the “food and eating habits of modern Bulgarians” (please note that the word “modern” was translated as “contemporary” in the Bulgarian version of all study materials to avoid the connotation “trendy”). Put shortly, the female sample that I obtained was not representative of all Bulgarian women and any conclusions based upon it should not be automatically extended to the entire female population of Sofia or Bulgaria. Nevertheless, the sampling procedure was appropriate for the purposes of this study, because it provided a group of highly educated urban women who had the most opportunities for exposure to Western values and ideas, including media messages on nutrition, dieting, and the beauty ideal. Additionally, these women were skilled at Western-European languages, thus even more receptive to Westernization, since there was no language barrier to weaken its influence. Lastly, these women were highly literate, therefore able to follow written instructions and complete a questionnaire of unfamiliar format with minimal errors.

6.4.2. DO THESE BULGARIAN WOMEN DESIRE THINNESS AND ACT ON THAT DESIRE?

Body dissatisfaction is broadly defined as a person’s negative thoughts and feelings about his or her own body (Grogan, 1999). In this sense, to be bodily dissatisfied does not necessarily mean to desire a slender body. However, within the field of body image and eating disorders, it is generally accepted to equate body dissatisfaction with a drive for thinness, especially in the case of women (Dittmar et al., 2009; Myers & Crowther, 2009; Tiggemann, 2004). In the current study I have adopted this narrower definition. The current data revealed remarkable levels of body dissatisfaction among these urban Bulgarian women—72% of them desired to be thinner. Fewer than a quarter (22%) were truly bodily *satisfied*—desired no change—and the rest (6%) wanted a bigger figure. These levels of body dissatisfaction were startling given that most dissatisfied women in this sample had normal weight. Even underweight women—30% of them—wanted to be thinner while the majority (55%) were in fact happy to be ultrathin. On the other end of the spectrum, none

of the overweight or obese participants were happy with their current size. Even though women generally overestimate their body weight status (Fallon & Rozin, 1985; Haberman & Luffey, 1998; Mortenson et al, 1993; Sciacca et al., 1991), the disparity between the proportion of women desiring a thinner figure and the proportion of overweight and obese women in the current sample was too large for the disparity to be blamed solely on overestimation.

Not only did these Bulgarian women experience high body dissatisfaction, they actually took great measures to alleviate it. It was, in fact, astonishing to observe that these Bulgarian women engaged in dieting at rates similar to Western populations—66% in this study compared to 60-80% in the West (Amigo & Fernandez, 2007; Mintz & Betz 1988; Tylka, 2004)—in spite of being on average much lighter than the typical Western woman (International Association for the Study of Obesity, 2011). The prevalence of dieting in the present sample was alarming in that over half of the underweight women were dieting. If additional dietary restraint behaviors like fasting were considered, the statistics were even more surprising—about 74% of the sample engaged in some form of dietary restraint. Clearly, thinness was a highly desirable and enthusiastically pursued aesthetic ideal for these Bulgarian women.

Put into perspective, the observed levels of body dissatisfaction were in line with those typical of the West, and perhaps a bit higher, if only women desiring to be thinner in the sample were considered (and women desiring no change or a fuller figure were excluded). For instance, in a classic study of American college students using the Stunkard Figure Rating Scale (Stunkard et al., 1983), Fallon and Rozin (1985) reported a discrepancy between current and ideal body size of 0.86. In a follow up study of Australian college students using the same instrument, Tiggemann (1991) reported a similar discrepancy of less than one figure—ranging from 0.65 for young to 0.92 for mature women. Another study using the same instrument as the present study, the CDRS, revealed a discrepancy of 1.2 among British teenage girls (Furnham et al., 2002). Figure discrepancy was 1.4

for North American, 1 for Western European, and 0.8 for Eastern European women (Croatsians, Estonians, and Poles, but **not** Bulgarians) in a recent survey of body image using the CDRS instrument across 26 countries and 10 world regions (Swami et al., 2010). For comparison, the current study's discrepancy was 1.2 for the entire sample and 1.9 among women desiring thinness per se. Overall, it was fascinating to observe that these Bulgarian women had levels of body dissatisfaction that were similar to those of Western women who were on average younger and heavier.

That thinness was so desirable among these Bulgarian women was evident by their choice of an Ideal Figure deemed anorexic by Western standards (Thompson & Grey, 1995). Women idealized a slender figure even if they perceived it as somewhat unhealthy. In absolute terms, the mean perception of Present Figure (5.3) and the mean choice of Ideal Figure (4.1) in the present study were somewhat higher compared to other studies using the same figure rating scale, the CDRS. Swami et al. (2010) reported a Present and an Ideal Figure of 4.7 and 3.4 for North American; 4.6 and 3.6 for Western European, and 4.6 and 3.7 for Eastern European women (Croatsians, Estonians, and Poles), respectively. It was surprising that in the present study women who were in reality quite thin considered themselves too heavy and selected larger Present and Ideal Figures than heavier Western women. The finding that Bulgarian women favored a heavier ideal than women in the Swami et al. (2010) study could be due to belated effects of the thin ideal in Bulgaria following the fall of Communism and the emergence of a free market economy (Catina & Joja, 2001). Additionally, the current participants were relatively older, and hence may have acquired a more realistic and healthy body image with age (Peat et al., 2008; Webster & Tiggemann, 2003). Nevertheless, the women in this study selected also a heavier Present Figure and experienced somewhat higher levels of body dissatisfaction compared to the sample of women studies by Swami et al. (2010), despite being on average thinner, thereby negating the aforementioned possibilities.

Instead there may be a possible misconception of body image among Bulgarian women as an expression of their high body dissatisfaction (Kjærbye-Thygesen et al., 2004). In support of this line of thinking, as BMI dropped the present participants increasingly reported “feeling fat” and thought that others saw them as thinner than they actually were. It is noteworthy to mention that body image distortion, or seeing oneself as too heavy and thinking others wrongly perceive you as smaller, is a familiar feature of eating disorders (American Psychiatric Association, 2000; Crowther & Sherwood, 1997).

An alternative explanation would be that the CDRS was not culturally valid for Bulgarian women, though I have no reason to believe this to be the case. I opted for the CDRS after receiving extensive criticism of another popular scale, the Stunkard Figure Rating Scale (Stunkard et al., 1983), by participants in a pilot study of body image in Bulgaria (conducted in summer 2008). The CDRS was seen as an improvement, since it features a set of very realistic looking drawings that have been used successfully in a number of samples of varying ages and ethnicities, and cultures (Furnham et al., 2002; Swami et al., 2010; Thompson & Grey, 1995; Wertheim et al., 2004). Furthermore, I permitted the use of half-point increments when making silhouette selections to increase precision. This approach has been supported by previous research using the CDRS (Wertheim et al., 2004). As a result women chose a wide range of rating points under and halfway between figures suggesting that the figure rating scale was working well (Gardner, 2001). Lastly, the good concurrent validity of the drawings (their ability to accurately assess perceived body size) was corroborated in the current sample by a strong correlation between Present Figure ratings and self-reported BMI ($r=0.71$, $p<0.0001$). In summary, the CDRS was an appropriate tool for assessing ideal body image and body dissatisfaction among these urban Bulgarian women.

6.4.3. ARE THESE BULGARIAN WOMEN DISORDERED EATERS?

Given the observed high levels of body dissatisfaction in the current female sample, and the finding that these women idealized an unhealthy thin body size, it was not a surprise that they also experienced high levels of disordered eating attitudes and behaviors (Babio et al., 2009; Schneider et al., 2008). Indeed, a substantial proportion of these women (74%) displayed subclinical levels of eating disturbances. At a mean EAT score of 16.4 and 10.2% of women high scorers (i.e., EAT score over 30), the eating attitudes and behaviors of these Bulgarian women were at least of the same magnitude as the levels observed in Western cultures, if not higher (Alonso et al., 2005; Garner et al., 1982; Garner & Garfinkel, 1979; Griffiths et al., 2000; Neumarker et al., 1998; Pereira et al., 2008; Vetrone et al., 2006; Williams et al., 1986), especially since the present sample did not include individuals at the height of risk for eating disorders—those younger than 18 years (American Psychiatric Association, 2000; Preti et al., 2009).

The lack of correlation between age and disordered eating attitudes and behaviors (total EAT-40 scores) in this sample was quite unusual. The literature suggests a different pattern, in which disordered eating attitudes and behaviors decrease as women transition from late adolescence into midlife (American Psychiatric Association, 2000; Bushnell et al., 1990; Fairburn & Beglin, 1990; Heatherton et al., 1997; Keel et al., 2007; Preti et al., 2009; Tiggemann & Lynch, 2001). While the proportion of high scorers in the current sample appeared to decrease across the age categories, this was likely related to oversampling of younger individuals and not to a decrease in disordered eating attitudes and behaviors. In other words, contrary to what the literature predicts, the data showed no decline in disordered eating attitudes and behaviors across the lifespan for these Bulgarian women. A possible explanation would be cohort differences—that women who at the time of data collection were in their 30s and 40s, were adolescents and young adults during the peak of socio-cultural transition, when the influx of Western media and thin-beauty imagery was at its fullest and most

aggressive. As a consequence, these women may hold attitudes towards body weight and physical appearance that are more disturbed than women who formed their self-concept before the transition—when there was virtually no exposure to Western culture—or at least equivalent to women who grew up way after the transition—when Western lifestyle ceased to be as influential by virtue of being commonplace. In support of this hypothesis, I observed that among high scorers in the sample, 30 to 44 year-old women had significantly higher EAT-40 scores than 18 to 29 year-olds. Nevertheless, only a longitudinal study could truly discern cohort from developmental effects of age. From this perspective the present study is limited by its cross-sectional nature.

Unlike age, BMI was significantly associated with EAT sum score in this study. Specifically, obese women had higher EAT scores compared to underweight or normal weight women. The association between obese BMI status and elevated disordered eating attitudes and behaviors among these urban Bulgarian women is consistent with previous research (Babio et al., 2009; Garfinkel & Newman, 2001). It is generally believed that female obesity is linked with poor body image and thereby may play a role in the development of eating disorders (Schwartz & Brownell, 2004).

6.4.4. DOES A SOCIO-CULTURAL MODEL FOR BODY DISSATISFACTION AND DISORDERED EATING BASED ON WESTERN MEDIA'S THIN IMAGES APPLY TO THE BULGARIAN CONTEXT?

A socio-cultural model for the spread of body image and eating problems in non-Western cultures consists of several interrelated elements. Firstly, exposure to the ultrathin beauty ideal—along with other Western socio-cultural norms, for which Western media is the main vector—leads to a rise in awareness and consequent rise in internalization of the thin ideal among certain (vulnerable) members of the receptive non-Western society (Bilukha & Utermohlen, 2002). The increase in awareness and internalization of the thin ideal results in an increase in body dissatisfaction, which reflects how strongly a person believes that she deviates from the thin ideal, regardless of her actual body size or shape (Schwartz & Brownell, 2004). Body dissatisfaction in

turn drives vulnerable individuals to obsessively restrict their food intake and/or engage in a number of maladaptive weight-control behaviors (Field et al., 1999; Heinberg et al., 1995). Food restrictions (i.e., dietary restraint), especially dieting, are a known risk factor for the emergence of eating pathology (Cashel et al., 2003; Striegel-Moore & Cachelin, 2001).

To begin applying a socio-cultural model to the Bulgarian context, I needed to insure that these Bulgarian women were not only exposed to Western media, but that they repeatedly consumed the types of media that feature an abundance of thin-ideal images—print (fashion magazines and catalogues) or electronic (movies, serials, music videos, and fashion programming). Such media are deemed most influential for the emergence of negative body image and disordered eating among women (Cusumano & Thompson, 1997; Henberg et al., 1995; Levine & Murnen, 2009; Stice et al., 1994). The MCF questionnaire was used for this purpose, since it targets exactly these types of media—several of them—making for a more specific assessment of media exposure. The women in this sample were indeed exposed to a variety of potentially harmful media. At once to a few times per week for electronic and once to a few times a month for print sources, frequency of media consumption was high enough to be potentially deleterious to body image (Field et al., 1999). By virtue of being all-pervasive and easily accessible (e.g., lower cost, higher convenience, etc.), electronic media (especially movies, serials, and music videos) were consumed more frequently than print media (magazines and sales catalogues). In fact, the consumption frequency of all surveyed media sources more or less mirrored their overall availability to the public (e.g., sales catalogues are often free and more widespread than magazines; movies, serials, and music videos take up a larger proportion of TV programming time, etc.). Not surprisingly, women had very little interest in men's magazines like Playboy, Maxim, or FHM, though they might have underreported consumption due to embarrassment and the stigma associated with such magazines. In summary, the women in this sample were sufficiently exposed to a number of thin-image-laden Western media. Of them young

participants were the most avid consumers, which is consistent with recent trends in media use for the United States and Bulgaria (Rideout et al., 2010; National Statistical Institute of Bulgaria, 2010).

In agreement with a socio-cultural model, media exposure and thin-ideal Awareness were related to thin-ideal Internalization (see Table 6.5). However, similar to the findings of Bilukha and Utermohlen (2002) from another transitional Eastern-European state, the Ukraine, media exposure was unrelated to Awareness. This could be due to a number of reasons, including language issues and the actual content of the Awareness subscale items. In support of the language issue thesis, Item 6 (“In our society today fat people are regarded as unattractive”) did not correlate well with the rest of the subscale items, resulting in a less satisfactory internal consistency (which was Cronbach’s $\alpha=0.69$). Excluding item 6 boosted the internal consistency of the Awareness subscale to a Cronbach’s α of 0.72. As Bilukha and Utermohlen (2002) demonstrated for the Ukraine, and based on observations from pilot data on Bulgarians (from summer 2008), Slavic language speaking individuals perceive reverse keyed items differently from directly keyed items. To improve comprehension, I modified the reverse keyed items of the Awareness subscale—one of which was Item 6—to eliminate double negative statements, which markedly improved internal consistency of the subscale compared to the one observed in the Ukrainian study (Cronbach’s $\alpha=0.32$). Nevertheless, Item 6 may not have been modified enough for Bulgarians to easily comprehend its meaning. Replacing “unattractive” with “ugly” might have been more appropriate, since the Bulgarian word for “unattractive” is rather uncommon, thus less easy on the ear. Other than language issues, the lack of association between media exposure and Awareness could be attributed to the finding that the Awareness subscale contains no items that directly pair media sources with adulation of thin beauty. Unlike the Awareness subscale, the Internalization subscale measures agreement with media rather than societal attitudes towards appearance, hence its positive relationship with media exposure.

The women in this sample were as aware of the socio-cultural thin-beauty ideal as were their Western counterparts, but appeared to internalize it slightly less intensely (Cashel et al., 2003; Griffiths et al., 1999 & 2000). The internal consistencies for both SATAQ subscales were within the range of values reported in the West (Cashel et al., 2003; Heinberg et al., 1995), thus minimizing the likelihood that the SATAQ may have been inappropriate for the Bulgarian situation. That the mean Internalization scores were somewhat lower in the current sample seemed logical inasmuch as internalization of any societal norm would require time for that norm to “settle in” once an individual is made aware of its salience. In other words, it is possible that after the fall of the Iron Curtain, Bulgarian women may have just recently become aware of the Western thin beauty norms and not yet begun to really accept them. Over 20 years of transition, however, would seem a long enough period for internalization to be plausible. Westernization had a quite rapid effect on body image in other media-naïve cultures (Becker et al., 2002). Given that the women in this study were on average older (as opposed to Western studies which mostly target teenagers or young adults) it is also likely that they internalized the thin-ideal stereotype less intensely simply because they were too old to be easily influenced by media messages. For multiple developmental reasons media impact adolescent girls’ body image more severely than that of adults (Clay et al., 2005). Nevertheless, the present data revealed no association between age and Internalization scores for women, thereby challenging developmental stage interpretations. Interestingly, women agreed least with (i.e., scored lowest on) those items from the Internalization subscale that implied a direct personal pursuit of media-featured beauty. Therefore, it is possible that a “third person effect” was at stake here, because people have a proclivity to think that media impact the beliefs, attitudes, or actions of others more strongly than their own (Duck & Mullin, 1995). More general statements from the Internalization subscale were endorsed more readily (e.g., Items #2 and #13; see Table 6.3). Moreover, because of the subscale’s high face-validity, participants may have been less willing to

acknowledge the impact of media influences on their behaviors in an effort to provide more socially desirable responses (Cashel et al., 2003). Conversely, the Awareness subscale's items are less direct, ergo less face-valid, so they were more openly endorsed by these participants. It is noteworthy that one of the most highly endorsed items on the Awareness subscale (even at a rather conservative estimate of endorsement that counted neutral answers, e.g. "Neither Agree nor Disagree," as disagreement) was that physical attractiveness is key to personal and professional success in Bulgaria. Evidently, these Bulgarian women viewed thinness not only as beautiful, but also as economically advantageous. Equating beauty with success is not unheard of in many cultures (Striegel-Moore et al., 1986). However, in a society where transition brought forth limited economic opportunities and high unemployment, especially for women (Nesporova, 2002), the pressure to always look good (i.e., thin) may be stronger, therefore more detrimental to women's body image and eating habits (Nasser & Katzman, 1999). It may then be no wonder that the women in the present sample experienced high levels of disordered eating attitudes and behaviors that persisted way past their young adulthood.

In further support of a socio-cultural model for the Bulgarian situation, Internalization (but not Awareness) of the societal pressures about thinness and attractiveness was significantly associated with the choice of Ideal Figure and with body dissatisfaction among the women in this sample. Indeed, the literature is consistent about the presence of a direct relationship between thin ideal Internalization and women's body dissatisfaction, whereas Awareness seems to play a more indirect role (Cusumano & Thompson, 1997; Stice et al., 1994 & 1996). The lack of a direct link between Awareness and body dissatisfaction in the current study confirms previous suggestions that Internalization of the societal thin-beauty ideal is key for developing body dissatisfaction. In other words, it is not just the awareness of societal pressures, but—more importantly—the acceptance of them that leads to body dissatisfaction (Calogero et al, 2004). Past research also reveals that the

media's effects on body dissatisfaction are indirect, often by way of influencing thin-ideal Internalization (Stice et al., 1994; Stice et al., 1996). Moreover, media exposure has been directly linked to body image distortion (Field et al., 1999), which is another aspect of the body image construct. (Crowther & Sherwood, 1997). Both of these findings were replicated in the current study. Inasmuch as body dissatisfaction generally increases as a person's BMI increases (Stice et al., 2001), it was not a surprise to find a positive correlation between body dissatisfaction and self-reported BMI in this study. More intriguing was that in this sample body dissatisfaction did not correlate with women's age. While some studies show that body dissatisfaction is invariant with age (Webster & Tiggemann, 2003), in others body dissatisfaction actually intensifies (Franzoi & Koehler, 1998; Tiggemann, 1992). Overall, the literature seems to reach a consensus that body dissatisfaction remains remarkably stable as women age, but the importance of physical appearance tends to diminish over time (Peat et al., 2008). While the current data clearly support the former statement, the invariance of disordered eating attitudes and behaviors with age in this study disagreed with the latter. The rates of disordered eating attitudes and behaviors over age among these women imply that for Bulgarian women looking attractive may be an extraordinarily important task. This strong emphasis on physical beauty may thereby sustain the negative effects of body dissatisfaction on disordered eating attitudes and behaviors in spite of women's advancing age. Economic incentives in the face of an unforgiving job market, as mentioned previously, may be part of the explanation for the lasting importance of physical appearance for these Bulgarian women. Clearly, further research is needed to substantiate and expand on any of these claims.

Consistent with the socio-cultural models, body dissatisfaction in the present study was related to dietary restraint, which in turn was significantly associated with disordered eating attitudes and behaviors. The finding that no correlation was found between body dissatisfaction and disordered eating attitudes and behaviors was initially surprising, considering that such a correlation

has been repeatedly documented in the past (Cusumano & Thompson, 1997; Phelps et al., 1999; Polivy & Herman, 2002; Stice et al., 1994). Yet, past literature also acknowledges that women can display normative body dissatisfaction without ever developing serious eating problems (Mazzeo, 1999; Striegel-Moore & Cachelin, 1999). After all, while most women are exposed to the media-portrayed thin ideal and experience normative body dissatisfaction, very few develop clinically significant eating problems (Tylka, 2004; Willinge et al., 2006). Therefore, there must be intervening factors that trigger the progression of body dissatisfaction into diagnosable eating pathology (Cashel, et al., 2003; Stice et al., 2001; Tylka, 2004). Consistent with this research, among Bulgarian women thin-ideal awareness and internalization, as well as dietary restraint, acted as intermediaries in the intricate pathways from media influences through body dissatisfaction into eating disorder symptomatology (see Table 6.5). Although like other authors I found a direct correlation between media exposure and disordered eating attitudes and behaviors (Stice et al., 1994), this association disappeared in regression analyses, thereby confirming the greater role of Awareness, Internalization, and dietary restraint rather than direct exposure to media in the development of eating disturbance (Calogero et al., 2004; Cashel et al., 2003; Cusumano & Thompson, 1997; Stice et al., 1994, 1996, & 2001; Stormer & Thompson, 1996; Twamley & Davis, 1999).

Based on the present evidence, could it be concluded that a socio-cultural model applies to the Bulgarian context? The short answer is yes. The current data reveal that Western media were indeed implicated in these Bulgarian women's body image and eating problems. The more media women consumed, the more accepting they were of the societal thin-beauty norms. Subsequently, they experienced normative body dissatisfaction very much like their Western counterparts. They desired an ultrathin body even when they saw it as less healthy. They strived to achieve this body by engaging in alarming rates of dietary restraint and they experienced notable levels of disordered eating attitudes and behaviors. Nevertheless, there were several limitations to the utility of a socio-

cultural model for the Bulgarian situation. First, the correlational nature of this study precluded knowing with certainty the causal directions among the observed relationships. As several authors suggest, it may well be that women who experience the most eating disorder symptoms are also most vulnerable to media and societal pressures for thinness, and seek out Western media precisely because they feature the thin images and weigh-loss strategies they crave the most (Bilukha & Utermohlen, 2002; Griffiths et al 2000; Stice et al., 2001; Willinge et al., 2006). Second, the observed associations were relatively small in magnitude. Thin-ideal Internalization was low compared to what would be expected from the proposed model—despite high levels of body dissatisfaction and disordered eating attitudes and behaviors—and media exposure did not directly relate to thin-ideal awareness. Likewise body dissatisfaction did not predict disordered eating attitudes and behaviors. On that account, it was possible that these Bulgarian women did not rely so heavily on media messages for their body image and eating behavior (Madanat et al., 2006). Thus, the present study sought to determine whether two affiliated culture-specific factors—faith and fasting—were involved in the complex mechanisms that produce and perpetuate disordered eating attitudes and behaviors among these urban Bulgarian women.

6.4.5. CULTURE-SPECIFIC FACTORS IN THE SCHEMA OF BODY DISSATISFACTION AND DISORDERED EATING ATTITUDES AND BEHAVIORS AMONG THESE BULGARIAN WOMEN – WHAT ARE THE ROLES OF FAITH AND FASTING?

While the literature acknowledges a spiritual component to body image and eating disturbances, the exact role of spirituality in the emergence, maintenance, or recovery from body image and eating issues remains unclear. The evidence is complex and conflicting, showing that spirituality may have both negative and positive effects on how women view their bodies, food, and the act of eating (Dell & Josephson, 2007; Dittman & Freedman, 2009; Homan & Boyatzis, 2010; Kim, 2006; Latzer et al., 2008; Smith et al, 2003). Part of the reason for this may be the multifaceted

nature of the spirituality construct itself. As I mentioned in the introduction to this chapter, the terms spirituality and religiousness, although conceptually related, should not be used interchangeably. Spirituality implies the functional, more intrinsic aspects of devoutness, whereas religiousness represents the more substantive, extrinsic ones (Marler & Hadaway, 2002; Pargament, 1999). In this sense, spirituality appears to be a more basic expression of human faith, while religiousness can be viewed as an external facet of spirituality. The latter explains my use of the term spirituality (rather than religiousness) when referring to these people's devotional life. Understanding the construct of spirituality is further complicated by the need to grasp its multiple dimensions (e.g., spiritual affiliation, belief, practice, salience, consolation, etc.) and the varied ways in which modern individuals define and express it (e.g., the emergence of rather personalized, non-traditional forms of spirituality). Thus, to facilitate comprehension, in this study I approached spirituality from three different angles. I looked at the current participants' spiritual affiliation (religious or otherwise), the strength of their belief (or faith), and their adherence to faith-based practices (especially fasting).

In terms of spiritual affiliation, this sample was almost exclusively Christian (99%) with the majority of women (96%) belonging to the Orthodox denomination. Although this distribution was not representative of the Bulgarian population at large—where 82.6% are Orthodox Christians, 1.2% non-Orthodox Christians, and 12.2% non-Christians—it was typical of the population of Sofia which is predominantly Christian and 95.9% Orthodox (National Statistical Institute of Bulgaria, 2001). Thus, the current findings should be considered applicable only to the Christian (and specifically the Orthodox) portion of urban Bulgarian women. Because of this virtual uniformity of religion among the participants, religious affiliation did not correlate with age, BMI or any of the media exposure (MCF, SATAQ Awareness and Internalization), body image (Present and Ideal Figure, Body Dissatisfaction), or eating disturbance (dietary restriction, EAT-40) variables.

Although I found a small positive correlation between religious affiliation and faith ($r=0.16$, $p<0.05$), this correlation was suspect considering that there were just 7 non-Orthodox and 2 non-Christian women in the sample. A larger number of women in either of these categories would have been necessary to detect a true difference in the level of faith among women from different religious affiliations. In short, while a link between religious affiliation and body image and eating problems has been established in the past, especially for Judeo-Christian traditions (Smith et al., 2004), the current sample lacked the variation in religious affiliation that would enable one to ascertain such a connection. Thus, I directed my attention to the other two dimensions of spirituality that were measured—belief (faith) and practice (fasting).

Unlike religious affiliation, which only indicates attachment to a particular form of spirituality, spiritual belief reflects the actual depth of one's faith. This depth of spiritual belief—or the salience of spirituality in an individual's life—is most commonly implicated as a relevant factor in the body image and disordered eating literature, since actual intrinsic belief is more meaningful than external self-definition (Smith et al., 2004). Additionally, spiritual belief (as opposed to religious belief or affiliation) is not confined to a specific creed, practice, or higher power, thereby enabling the avoidance of biases that occur when simply considering religiousness as defined here. Focusing on spiritual belief and practice was especially appropriate for the Bulgarian situation, given that in polls and surveys Bulgarians would almost exclusively self-identify as Christian—creating an inaccurate impression of high spirituality—while in reality being weakly religious (Ghodsee, 2009; Kanev, 2002; Zuckerman, 2006). As Kanev (2002) contends, for Bulgarians religious affiliation symbolizes national and cultural identity rather than true religious or spiritual feeling. Thus, looking at strength of faith and involvement in spiritual practices rather than religious or spiritual attachment was a better way of assessing true spirituality and its role in the schema of body dissatisfaction and disordered eating among these Bulgarian women.

In accordance with past sociological research portraying Bulgarians as spiritual “in their own way” (Kanev, 2002), the present data revealed a rather non-traditional approach to spirituality among the women in this sample. For instance, the majority (77%) of these participants self-identified as Passive Believers, meaning that they believed either in God or a “higher power,” but strangely did not consider themselves observant or even religious. These were followed by a sizeable proportion of Non-Believers (17%) reporting lack of faith in (atheists) or uncertainty about (agnostics) the existence of God, and lastly, by Active Believers (7%) who claimed both belief in God and observance of religious practices and traditions. In striking similarity, Kanev (2002) reported that only 10% of Orthodox-identified Bulgarians actually saw themselves as religious and followed the prescriptions of the Church (these individuals roughly paralleled the current sample’s Active Believers), while 85.6% were religious “in their own way,” could not say whether they were religious, were not interested in religion, or were not religious and thought the prescriptions of the Church to be wrong (i.e., roughly the current sample’s Passive Believers); and 16.6% were atheist or agnostic (i.e., the present sample’s Non-Believers). The finding that there were so few Active Believers among the present women reinforced Kanev’s (2002) notions of weak “conventional” religiousness among Bulgarians at large. Indeed, in a pan-European study of religious beliefs and practices, Bulgaria was listed among the least religious nations (Halman & Draulans, 2004). According to another study, even religiously self-identified Bulgarians displayed high degrees of hesitation and uncertainty about their faith (Bogomilova, 2004). In sum, based on all these pieces of information along with my personal experiences growing up in Bulgaria, it was feasible to surmise that the spirituality of the women in this study was of type that Kanev (2002) spoke of—latent, traditional, everyday-life spirituality existing as a socio-cultural adaptation without a clear idea of the nature of the faith.

This peculiar form of spirituality that characterized this female sample crystallized in the way women engaged in the practice of faith-based fasting. The ascetic practice of fasting was of particular interest to me not only because it is a standard component of Bulgaria's dominant religion—Orthodox Christianity—but also because it remains widely popular among contemporary Bulgarians, despite their latent spirituality. As much as 40% of the women in the current study engaged in faith-based fasting, even though most (77%) did not consider themselves observant (i.e., these were the Passive Believers). At the same time 14% of Active Believers claimed to be observant while simultaneously failing to observe the very essential element of Christian (and especially Orthodox) practice that is fasting; at the same time, 18% of Non-Believers nevertheless engaged in faith-based fasting. These contradictory observations made sense only if seen as indications of what Bogomilova (2004) argues to be Bulgarians' "hesitant" faith—spiritual uncertainty and hesitation evident through the lack of knowledge of religious doctrine, acceptance of only part of religious fundamentals, lack of interest in or consistent observance of Church rituals, low church attendance, and lack of correspondence between religious convictions and daily behavior. Spirituality that is implicit and personalized, and the disentanglement of belief and practice in which belief exists without practice and practice happens without belief are consequences of secularization (Bogomilova, 2004; Serafimova, 2007). In other words, based on previous research backed by the present data, I contend that fasting for Bulgarians no longer equals a strictly religious rite, but has rather become a culturally unique tradition, a custom performed without thorough understanding of its spiritual fundament.

Unlike dieting, fasting, especially in its extreme forms (i.e., the complete cessation of sustenance) has been studied primarily as a manifestation of serious eating disturbance in the context of radical religious asceticism—recall the fasting of medieval female saints or Victorian era's "fasting girls" or the fasting of contemporary extremely devout women (Banks, 1996; Bell, 1985; Bemporad,

1996; Brumberg, 2000; Bynum, 1988). However, given the Bulgarian situation, how can one make sense of faith-based fasting among predominantly secular individuals? Would such “secular fasting” be a risk factor for the emergence of eating disturbances, a symptom of such disturbances, both, or something else? It is plausible that the mainstream acceptance of fasting in Bulgaria may be conducive to the development of disordered eating by virtue of exposing individuals to this self-restraint behavior that can subsequently turn extreme. Under certain circumstances, some individuals who might start out fasting for spiritual, moral, or health reasons may begin to fast fanatically to achieve a “perfect” body. Alternately, fasting may function as an additional dietary restraint strategy and/or a socially acceptable disguise for women with already existing disordered eating, given the traditional nature of the behavior. Along with spiritual belief, traditional fasting in Bulgaria represents a culture-specific phenomenon whose role in female body dissatisfaction and disordered eating demands attention. To the best of my knowledge, this study is the first to attempt addressing these issues.

Interestingly, despite these participants’ non-traditional, implicit spirituality, I was able to detect a significant positive association between women’s faith and their involvement in dietary restraint behaviors. In fact, the most spiritual participants also displayed the most dietary restraint. All Active Believers were dietary intake restrictors and the majority (72%) of them used combined strategies (fasting plus dieting) to achieve food control. In contrast, a notable proportion of Passive Believers and Non-Believers (about 30% in either category) did not restrict their food intake at all, while those who restricted it used combined food restriction strategies to a much lesser extent (e.g., 30% of Passive Believers and 18% of Non-Believers). The association between faith and dietary restraint remained significant even when controlling for women’s age and BMI. Adjustments for age and BMI were necessary as older individuals are usually more spiritual than younger individuals (Halman & Draulans, 2004; Kim et al., 2008) and heavier individuals more driven to restrict their

dietary intake (Viner et al., 2006). Indeed, in the current sample Active Believers were slightly older than either the Passive Believers or Non-Believers and heavier women were more likely to use combined dietary restraint strategies. Notwithstanding its direct link to increased dietary restraint, faith was not directly related to disordered eating attitudes and behaviors in this sample. Neither was it directly related to any of the media exposure, Awareness and Internalization, or body dissatisfaction variables. Although these findings could have been due to the small number (N=14) of Active Believers in this sample and therefore insufficient power to detect differences among faith groups, a more likely explanation was that for these Bulgarian women faith seemed to influence disordered eating indirectly and only to the extent that faith affected dietary restraint behaviors.

Since I distinguished two types of dietary restraint behaviors—dieting and fasting—I sought to determine their individual roles in the schema of body dissatisfaction and disordered eating attitudes and behaviors among the women that were studied.

6.4.6. WHAT ARE THE INDIVIDUAL ROLES OF DIETING AND FASTING—WHICH FACTORS DESCRIBE THESE BEHAVIORS?

Dietary restraint in general, and fasting and dieting specifically, have all been linked to eating disorder symptomatology in the past (Griffiths et al., 2000; Nejad et al., 2005; Stice et al., 2005; Viner et al., 2006). However, dieting has received much more attention, presumably due to the behavior's rather straightforward nature. Dieting implies a desire for weight loss in pursuit of the idealized thinner figure that Western society imposes, hence the connection of dieting to disordered eating attitudes and behaviors as part of a socio-cultural model. Dieting has been regarded both as a risk factor for the onset, as well as a sign of an already existing eating disorder (American Psychiatric Association, 2000; Keel et al., 2007). Consistent with this research, dieting among the women in the current sample seemed to be the dietary restraint behavior that intervenes in the complex pathway leading from media influences through body dissatisfaction to disordered eating. Indeed, women

who dieted (exclusively or in combination with fasting) were much more likely to consume more media, to have higher levels of thin-ideal Internalization, to experience more body dissatisfaction, and to engage in unhealthy eating behavior, compared to women who only fasted or never controlled their food intake (see Table 6.6). Moreover, according to the CART analysis (see Figure 6.3) dieting was the preferred food restriction strategy whenever EAT-40 scores were high and women were less spiritual, more aware of the socio-cultural ideal of thinness, heavier, more exposed to Western media, and younger (in that order). When EAT-40 scores were low, dieting was naturally less common; nevertheless, it occurred more often among women with higher body dissatisfaction, lack of spirituality, and higher levels of thin-ideal internalization (in that order). In short, dieting among the women that were studied was exclusively for body image.

In contrast, there seemed to be a different rationale behind fasting, depending on whether women experienced high or low levels of disordered eating attitudes and behaviors. Exclusive fasting was much more popular among women with lower EAT-40 scores, more body satisfaction, and higher levels of spiritual belief (see Figure 6.3). In fact, exclusive fasters—like women who never controlled their food intake—had some of the lowest levels of media exposure, thin-ideal awareness and internalization, body dissatisfaction, and disordered eating attitudes and behaviors (see Table 6.6). Therefore, such fasting had little to do with media influences, body image, or disordered eating attitudes and behaviors and more to do with actual faith. In the case of women with lower EAT-40 scores, faith and fasting seemed to be *protective* against negative body image and obsessive dieting. Indeed, research shows that body image and eating problems can be avoided or remedied by practices aimed at improving spiritual welfare (Dittman & Freedman, 2009; Smith et al., 2003). Positive aspects of spirituality—those emphasizing love, acceptance, and tolerance by God (or a higher power) and providing a sense of purpose, connectedness, or community, may foster self-esteem, self-acceptance, and feelings of self-worth that are not rooted in appearance (Boyatzis et

al., 2007; Carlson et al., 2004; Dell & Josephson, 2007; Homan & Boyatzis, 2009 & 2010; Jacobs-Pilipski et al., 2005; Kim, 2006). Nevertheless, exclusive fasting was practiced by only 9% of the entire female sample. All other fasters (78%) also dieted, especially if their EAT-40 scores were notably higher (see Figure 6.3). These non-exclusive fasters very much resembled exclusive dieters in terms of media, body image, and disordered eating attitudes and behaviors (see Table 6.6). Thus, for this particular group of women fasting was simply an additional strategy for weight management and the achievement of an idealized figure in line with the socio-cultural models.

Moreover, faith seemed to play a *harmful* role in these women's body image and disordered eating attitudes and behaviors because it motivated overall dietary restraint. It is possible that elevated dietary restraint among the most spiritual women in the sample was the result of an overemphasis on ascetic principles inherent in Orthodoxy. Consistent with this finding, the literature shows that the body-mind dualism of body image and eating problems may be instilled or exacerbated by spiritual beliefs and practices favoring ascetic ideals that are rigid, punitive, and perfectionist in nature (Banks, 1996; Chatters, 2000; Dell & Josephson, 2007; Homan & Boyatzis, 2010; Joughin et al., 1992; Kim, 2006; Miles, 1995; Pargament et al., 2001; Rampling, 1985; Richards et al., 2006). In summary, the higher the levels of disordered eating attitudes and behaviors that women in the current sample experienced, the more likely they were to employ all dietary restraint strategies available to them and the more they were inclined to use spirituality to justify and reinforce their restrictive dietary behaviors.

There were several limitations to this study that require consideration. To begin with, the cross-sectional design that was used did not allow for strong causal inferences and may not have adequately reflected the temporal associations among the variables (Stice et al., 1994). A well-controlled, longitudinal study would have been ideal for closely tracking the evolution of disordered eating and body image disturbances, alas, at a much higher cost that I could not afford. Moreover,

the reliance on measures that were exclusively self-reported and highly face-valid may have encouraged erroneous or socially desirable responses as part of self-presentation bias, thereby diminishing the reliability of the study's conclusions. Due to recent increases in media attention on body image disturbances and eating disorders—observed firsthand by me while in the field—accompanied by a growth in awareness about these conditions and a deepening of the social stigma associated with them, willingness to participate in research about body image and eating habits may have been an issue, especially for individuals uncomfortable with their bodies or those experiencing serious eating problems (or overt eating disorders), who would have been less likely to fill out the survey. Even if these individuals proceeded to participate, they may have been reluctant to disclose body image or eating problems and less willing to acknowledge the impact of societal influences on their behaviors, leading to an overall underestimation of the degree or salience of such issues in the studied sample. Admittedly, in non-clinical settings, measures of social desirability are negatively related to the self-reporting of body image and eating disturbances (Miotto et al., 2002; Preti et al., 2009). Furthermore, participation may have been self-selected in that it was based on the extent to which the survey topics were of interest or relevance to the study's participants. In either case, reports of body image and eating problems in this sample may have been skewed due to participation bias.

Some additional limitations also deserve attention as they may affect the interpretation of these findings. First, I excluded women with missing or incomplete data, which not only diminished the overall sample size available for analysis, but also the sample sizes available for within and between group comparisons. This reduction in sample size may have resulted in a loss of statistical power. Nevertheless, excluded women were not systematically different from the rest of the sample. Second, due to the exploratory nature of this study I used rather simple measures of dieting behavior, faith-based practice (fasting behavior), and spiritual belief (faith) to look for novel trends

and associations in the data. Indeed, fasting and dieting were each assessed using a single item, providing little information about the nature or intensity of each restrictive dietary behavior. Similarly, spiritual belief was measured by a single question focusing on the level of faith participants experienced, while other important features of spirituality—e.g., the importance of faith in one’s life, the consolation power placed in faith or the spiritual community, intrinsic vs. extrinsic reasons for engaging in spiritual practices, and the role of spirituality in coping with body image or eating issues—were not included. A more comprehensive assessment of dietary restraint and spirituality, possibly via the use of standardized measurement tools adapted to the Bulgarian situation, would have added to our understanding of the culture-specific (faith and fasting) idioms of body image and eating distress among the women in this sample. Lastly, no retrospective data were available concerning Bulgarian women’s body image and eating disturbances during the communist period, thus I was not able to ascertain the temporal historical trends in the prevalence of these disturbances and the factors involved in their progression. It is possible that body image issues and disordered eating were prevalent in Bulgarian society even before the massive influx of Western cultural influences and before individuals were free to openly express their spirituality, thus an entirely different set of cultural factors may be implicated in the development and maintenance of body dissatisfaction and disordered eating among Bulgarian women.

A final set of limitations stem from the nature of the population from which this sample was drawn. I did not conduct a population-based study. In fact, the study sample consists of mostly young, urban, single, and highly educated women who were virtually uniform in terms of race, ethnicity, and religious denomination. The non-probabilistic sampling that I used may have constrained variability in socio-demographic characteristics of the sample. Therefore, the current findings may not generalize to other populations.

With respect to these limitations, the cross-sectional nature of this investigation was a good choice keeping in mind its exploratory, hypothesis-generating nature. This cross-sectional design provided an inexpensive and quick way of determining the prevalence of body image and eating issues among the women in this sample, and was useful to highlight interesting associations that could be further explored using more rigorous measurement techniques. Given that participation was anonymous and confidential, and no personal identifying information was recorded on the survey booklets, the perceived pressure to provide socially desirable responses should have been kept at a minimum. Moreover, I tried to curtail erroneous reporting by being, whenever possible, physically present at the site and time of survey administration to address participants' questions or concerns. If the latter was not feasible, participant's inquiries were addressed by study liaisons—high-school teachers, university professors, or other contact individuals—who had previously filled out the survey, were familiar with its content, and were trained by me to answer survey-related questions. Even though self-selection was inevitable, I attempted to minimize it by entitling the study and promoting its topic in rather general (less face-valid) terms as a study of “the food and eating habits of modern Bulgarians.” By not formally measuring weight and height in this study, participation bias towards individuals comfortable with their bodies was restricted, as taking formal anthropometric measurements often makes individuals hesitant to partake in a study (Twamley & Davis, 1999). Certainly, the literature repeatedly shows that self-reported weight and height are significantly correlated with actual measurements and are considered adequately valid for epidemiological and survey studies (Cashel et al., 2003; Davis & Gergen, 1994). Furthermore, the group differences observed on media, body dissatisfaction, disordered eating attitudes and behaviors, and faith variables were robust, despite decreased or unequal sample sizes that would typically have reduced power. Since data were missing at random, excluding missing values should have resulted in unbiased parameter estimates. Indeed, imputing values and including them in the

analyses had negligible effects on the resulting estimates. Even though I used single items to assess faith, fasting, and dieting, these items were customized to the current sample and pre-tested in a pilot study among urban Bulgarians. All other variables were assessed using well-established and validated psychometric instruments that had also been previously studied in samples of urban Bulgarian (e.g., my pilot study in summer 2008, Boyadjieva & Steinhausen, 1996) and Ukrainian women (Biloukha, 2000; Bilukha & Utermohlen, 2002). In addition, although sampling was not random, it provided a sample of educated, urban women who were skilled at Western-European languages and thereby highly receptive to Western cultural influences. These women were also highly literate, therefore able to follow written instructions and complete a questionnaire of unfamiliar format with minimal errors. Moreover, the location for this study, Sofia—being the country’s capital—was a major point of influx for Western cultural influences and media. Finally, the present study greatly benefitted from the use of CART/recursive partitioning analysis—a powerful non-parametric statistical platform—which detects complex patterns among a large number of predictors that may be impossible to uncover using standard multivariate regression (Lewis, 2000). CART also provides for data exploration or modeling, its output is easy to comprehend and interpret, and its accuracy is comparable or superior to other models (Lim et al., 1997). Additionally, when using cross-validation, CART provides an “honest” estimate of a model’s Goodness-of-Fit. Therefore, CART was an especially appealing methodology, which boosted confidence in the conclusions that were drawn from these results.

6.5. CONCLUSION

The present data indicate that body dissatisfaction among these urban Bulgarian women was normative. Dietary restraint was an intermediary in the complex pathway starting with media-transmitted Western cultural influences, passing through body dissatisfaction, and culminating in disordered eating attitudes and behaviors. Over-concern with thinness was a reaction to Western

thin-ideal culture, however the media could not be solely blamed for these women's body image and eating problems. Faith—a culture specific factor—seemed to influence disordered eating attitudes and behaviors by affecting dietary restraint behaviors as part of a separate, culture-specific pathway. Thus, for these urban Bulgarian women the socio-cultural models of eating disorders converged with local cultural factors at the node of dietary restraint. In short, in addition to the culture-reactive idioms of distress (those related to Westernization) trans-cultural body image and eating disorder researchers should also consider the culture-specific (those typical of the local culture). Moreover, I could not exclude the possibility that vulnerable women sought out media's thin-imagery or used negative aspects of spirituality (e.g., ascetic attitudes and excessive fasting) to camouflage, reinforce, or justify pre-existing disordered eating. Therefore, understanding vulnerability is crucial for the development of targeted, culture-sensitive approaches to disordered eating prevention, screening, diagnosis, and management. Further investigations in this area seem vitally important, as they would help professionals uncover culturally unique combinations of factors that moderate the relationship between dietary restraint and disordered eating. By being cognizant of such factors, professionals would be able to distinguish women who are more likely to have high levels of eating disorder symptoms from the many women who restrain their diet. Likewise, professionals could aim to foster protective factors and curb factors that intensify the relationship between negative body image and eating pathology.

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CHAPTER 7

TOWARDS AN UNDERSTANDING OF FASTING BEHAVIOR IN A SAMPLE OF URBAN BULGARIAN WOMEN

7.1. INTRODUCTION

7.1.1. A BRIEF HISTORY OF FASTING

Fasting, or the practice of voluntary non-eating—from the elimination of certain types or amounts of food to the complete cessation of food intake—was developed as a spiritual discipline independently by many religions and cultures around the globe (Kerndt et al., 1982). The ancient Greeks thought that demonic forces could enter the human body via food consumption, which contributed to the popularity of fasting (Kerndt et al., 1982). In both ancient Greece and Egypt brief periods of fasting were required in preparation for a number of spiritual rituals in which the practitioner sought encounters with supernatural forces, as well as the invocation of ecstatic, trance-like states, which were a medium for sacred visions or dreams (Bemporad, 1996; Kerndt et al., 1982; Miller & Pumariega, 2001). By denying oneself the pleasures of food (and sex), fasting also served as a form of penance and purification from sins in search of forgiveness from the deity, or as a means of supplication to influence superior powers (Bemporad, 1996). In biblical times the religious significance and value of fasting was recognized by Moses, Elijah, and John the Baptist as a form of powerful prayer that could help a prophet achieve divine revelations (Bemporad, 1996; Daniel 10: 2-14; Kerndt et al., 1982). Jesus Christ also fasted for similar purposes, but left no definitive rules about fasting other than to practice it privately and humbly (Alexiev et al., 2008; Kerndt et al., 1982; Luke 4: 1-2; Mathew 4: 2-3 & 6: 16-18). It is noteworthy that none of these early accounts of fasting in the West seemed to revolve around complete corporeal deprivation and punishment, as moderation in fasting was of utmost importance (Alexiev et al., 2008; Bemporad, 1996). The latter,

however, was not the case in Eastern religions like Buddhism, Jainism, or Hinduism, where spiritually motivated fasting was often prolonged and sometimes practiced until one's death (Bemporad, 1996). Such extreme forms of fasting (i.e., the complete cessation of sustenance) were rooted in dualistic worldviews, which regard the soul as the only divine possession of a human. In this sense the purpose of fasting was to release the immortal soul from the transient body as part of complete withdrawal from a material world seen as essentially evil (Bemporad, 1996).

It is generally believed that these dualistic Eastern philosophies infiltrated early Christianity by way of Gnostic cults that were introduced in the Balkans when Byzantium forcibly resettled populations from the Middle East (Bemporad, 1996; Lacey, 1982; Miller & Pumariega, 2001; Obolensky, 1948). Christian asceticism with its Gnostic elements gradually spread from the Balkans proper to the Mediterranean region of Western Europe—e.g., Northern Italy, Southern France (Lavrin, 1929), but it was not until the late Middle Ages that the practice of severe forms of fasting developed in Western Europe, especially among women (Bell, 1985). Extreme asceticism (including severe fasting) in women often became an object of reverence, with many women receiving sainthood in the Catholic Church, a phenomenon known as *anorexia mirabilis* (Bell, 1985). Over the course of the next few centuries these fasting women gradually lost their holy status to be considered demonically possessed, frauds, or even a source of entertainment (Miller & Pumariega, 2001; Bergh & Sodersten, 1998; Brumberg, 2000). With time *extreme* self-starvation became a clinical diagnosis (e.g. *anorexia nervosa*), which is how it is viewed currently (Bemporad, 1996; Miller & Pumariega, 2001). However, there is a striking contrast between the fasting of female saints or “miraculous maids” of earlier times and that of modern day anorexics, in that the former had overtly spiritual motivations for fasting, whereas the latter are driven by an overwhelming desire for thinness, at least in Western cultures.

It is these extreme forms of fasting that have drawn scientific attention primarily as manifestations of serious eating disturbance in the context of radical religious asceticism (e.g., anorexia mirabilis) or clinical eating disorders (e.g. anorexia nervosa). However, fasting in its less severe forms and especially fasting that does not fit neatly into either the spiritual or the body image and eating disorder category remains largely understudied. In the current article I focus on precisely this form of fasting by studying the case of modern urban Bulgarian women.

7.1.2. FASTING IN BULGARIA

The practice of fasting in Bulgaria has a long history, which dates back to the adoption of Orthodox Christianity in 865. Earlier accounts of fasting were likely related to pagan rituals and customs, which (as in the case of many local Christian Churches) were replaced by an elaborate system of fasting rules and regulations (Kerndt et al., 1982).

7.1.2.1. Traditional Fasting According to Orthodox Church Canon

Since traditional fasting in Bulgaria is the focus of discussion by participants in the current study, it is necessary to briefly explain its rules and regulations according to Orthodox doctrine. Fasting takes up a large proportion of the year, with between 180 and 200 days dedicated to some form of dietary restriction connected to major Church holidays, events, or celebrations (Sarri et al., 2004; Voronina, 2006). While Church regulations for such dietary restriction are complex, a description of the most common among them will facilitate later analyses. In general, the Bulgarian Orthodox Church declares two types of fasting—a mandatory *public* and a voluntary *private* fast—and five degrees of strictness in fasting (in descending order): 1) *complete* fast—the total abstinence from food and water, 2) *strict* fast (i.e., *xerophagy* in Greek or *subhoeljina* in Bulgarian, which literally means ‘dry eating’)—eating cold Lenten food (sometimes cooked, but mostly raw; often consisting of only bread) without added vegetable oil and no hot drinks, 3) *common* fast—eating hot Lenten food with added vegetable oil, 4) *relaxed* fast—eating some fish or other non-Lenten foods on

certain days or by permission from a priest (this fast varies individually), and 5) *uncommon* fast—eating food (usually appropriate for a strict fast) once a day after sunset (Alexiev et al., 2008). For the purposes of this article, I will refer to fast-appropriate food as Lenten (*postna* in Bulgarian) food, i.e. containing no meat, fish, or animal products (eggs, dairy, animal fats, etc.).

The devout are expected to fast *strictly* every Wednesday and Friday except during the week after Christmas, Easter, and the Pentecost, as well on the eve of Epiphany (January 5), on the day of Exaltation of the Holy Cross (September 14), and on the day of the Beheading of St. John the Baptist (August 29) (Alexiev et al., 2008; Sarri et al., 2004); Voronina, 2006). In addition to these daily fasts, there are four major multi-day fasting periods of varied duration and strictness throughout the year. The first fasting period is the 40-day Nativity (*Rojdenstvenski*) fast before Christmas during which meat, dairy, and eggs are not allowed, but fish and oil can be consumed except on Wednesdays and Fridays. The second period is the 49-day Great (*Veliki*) fast, or Lent, before Easter, which is the strictest. Meat, dairy, and eggs are not allowed throughout, while fish is permitted only on the second day, and vegetable oil can be consumed only on weekends (except on Saturday of Holy week) during Lent. Restrictions are particularly strict in the first week of Lent when on certain days (e.g. Clean Monday) all food or drink is suspended. The third fasting period, the Apostles' (*Petrovi*) fast, varies in length (8-42 days) and is set prior to the feast of St. Peter and St. Paul the Holy Apostles on June 29. This fast is not as strict as Lent—vegetable oil is permitted in all days of the fast, while fish is allowed on Saturdays, Sundays, and special feast dates. Lastly, there is a 15-day Dormition (*Bogorodichen*) fast prior to celebrating the Assumption (i.e., “Dormition” in Orthodoxy) of the Virgin Mary on August 15, during which in addition to avoiding meat, dairy, and eggs, it is necessary to abstain from fish except on the day of Transfiguration or Metamorphosis (August 6th), though vegetable oil is allowed on weekends. Seafood (e.g. crabs, shrimp, shellfish, etc.), snails, and bee products are allowed on all fasting days throughout the year, while wine is

allowed on a few occasions though its consumption is generally discouraged (Sarri et al., 2004; Alexiev et al., 2008).

In addition to abstinence from the physical pleasures of food, religious scripture requires moral purity—the exercise of humility and forgiveness for transgressions, the practice of prayer, the elimination of entertainment (including TV watching), and abstinence from passions (including sexual acts), vices (greed, pride, etc.), and impure thoughts or acts. Without these spiritual elements, fasting according to Orthodoxy becomes simply a diet (Alexiev et al., 2008).

7.1.2.2. Modern Fasting Among Urban Bulgarian Women—Possible Influencing Factors

Originally a part of religious doctrine, fasting has become deeply ingrained into the cultural traditions, customs, and way of life of Bulgarians. This is perhaps one of the reasons why so many contemporary Bulgarians continue to fast, despite being mostly secular in their orientation. During the communist period in Bulgaria (1944-1989) religious expression was largely suppressed (Serafimova, 2007). Like in other communist states (and especially the USSR) Church rituals and customs, including fasting, were strongly discouraged or even persecuted (Serafimova, 2007; Voronina, 2006). With the fall of communism, the Bulgarian Orthodox Church experienced a revival, however, the impact of communist secularization on Bulgarians' religious sentiment could not be undone (Kalkandjieva, 2008). Thus, Bogomilova (2004) argues that modern Bulgarians' faith is in fact "hesitant," i.e. marked by spiritual uncertainty evident through the lack of knowledge of religious doctrine, acceptance of only part of religious fundamentals, lack of interest in or consistent observance of Church rituals, low church attendance, and lack of correspondence between religious convictions and daily behavior. In my own survey of 205 urban Bulgarians 40% of women engaged in fasting with some degree of frequency, even though only 7% considered themselves active believers (i.e., believed in God and were actually observant) (see Chapter 6). This apparent disconnect between religious belief and practice reinforces Kanev's (2002) notions of weak

“conventional” religiousness among Bulgarians at large. As Kanev (2002) contends, for Bulgarians religious belonging symbolizes national, ethnic, and cultural identity rather than true religious or spiritual feeling. Indeed, census data reveal that up to 84% of Bulgarians would self-identify as belonging (at least nominally) to the Bulgarian Orthodox Church—the official Church of the state—all the while ranking among the least religious peoples in Europe and the world (Ghodsee, 2009; Halman & Draulans, 2004; Kanev, 2002; National Institutes of Statistics of Bulgaria, 2001). Based on the above observations I surmised that fasting for Bulgarians no longer meant a strictly religious rite, but had rather become a culturally unique tradition, a custom performed without thorough understanding of its spiritual foundation.

Given these circumstances how can one make sense of faith-based fasting among predominantly secular individuals? Since body image and eating disturbances seem to be on the rise in the Bulgaria of the post-communist period (at least according to oral reports by local clinicians), when the country embarked on a turbulent journey of socio-cultural transformation and Westernization, I wondered whether some Bulgarian women might fast to achieve the thin body idealized in the West. Indeed, my quantitative studies (see Chapters 5 and 6) suggested high levels of body dissatisfaction and disordered eating attitudes and behaviors among Bulgarian women living in the city of Sofia (the sample from which I purposively selected individuals for the current qualitative investigation). Keeping in mind that Bulgarian women were no less dissatisfied with their bodies than their Western counterparts, it was plausible that the mainstream acceptance of fasting in Bulgaria could be conducive to the development of disordered eating by virtue of exposing individuals to self-restraint behavior that can subsequently turn extreme. Alternatively, fasting may function as an additional dietary restraint strategy and/or a socially acceptable disguise for women with already existing disordered eating.

The purpose of the present study is to describe and understand the factors influencing fasting beliefs and behaviors in a sample of Bulgarian women living in Sofia, the capital of Bulgaria. Particularly, I was interested in exploring the relationships between: fasting and religiousness (spirituality), and fasting and body image (weight loss and the achievement of a thin-ideal figure), all the while searching for additional factors that might explain fasting behavior among urban Bulgarian women.

7.2. RESEARCH DESIGN AND METHODS

7.2.1. SETTING

Sofia, Bulgaria's capital and largest city, was selected as the site for this study due to the city's modernity, large population (approximately 1.5 million), and multiple opportunities for data collection. As a native of Sofia I had familiarity with the city and no serious cultural or language problems. I had also amassed a number of personal and professional contacts with members of the local community. Furthermore, Sofia's status as a metropolis, and hence a major gate for Western influences, make it particularly appropriate for studying the processes of Westernization and modernization, as they interact with the local culture to affect women's body image perceptions and eating behaviors.

7.2.2. RECRUITMENT PROCEDURE

This project used non-probability sampling techniques, such as convenience and snowball sampling, to recruit a cross-section of ages from the population of interest (i.e., urban Bulgarian women). A convenience sample of participants was recruited through personal and professional contacts (i.e., intermediaries) established by the researcher (myself) at various institutions of higher learning, secondary schools, and other places of employment (e.g., sports clubs, exercise studios, spa and cosmetic centers, hospitals, state-owned and private companies) where it was likely to find

individuals with desirable characteristics (e.g., varied age, spiritual beliefs and practices, and media consumption). Brochures describing the study and giving my contact information were given to key individuals (professors, teachers, instructors, beauticians, etc.) from the aforementioned locations, to distribute to potential participants. The recruitment process was greatly advanced by the efforts of these key persons who provided invaluable assistance in contacting and arranging appointments with interested individuals. Brochures were also given in lieu of business cards.

In the first stage of the overall dissertation study, participants were asked to fill out a survey either at home, work, school, or another location providing an adequately disturbance-free environment. The goal of the questionnaire was to collect quantitative data on a larger sample of Bulgarians (results from quantitative data analyses are presented elsewhere, see Chapters 5 and 6), as well as to screen for individuals with desirable characteristics for the purposes of maximum variation qualitative sampling via interviews (Lincoln & Guba, 1985). Individuals who had completed the survey were invited to volunteer their contact information directly on the survey booklet if they wanted to be interviewed in-depth. After reviewing volunteers' survey responses, I selected information-rich cases to contact for interviewing—candidates were purposively sampled for differing religious beliefs, fasting habits, age, and levels of media exposure. Individuals who still desired to be interviewed were invited to participate in up to two consecutive, in-depth, face-to-face interviews at a time and place of their choosing. The majority of interviewees chose to be interviewed at a public location (e.g., a café or restaurant) near their home, workplace, or school. Interviewee recruitment continued until reaching the point theoretical saturation when no new or relevant data seemed to emerge and information from interviews became somewhat redundant (Douglas, 2003; Glaser & Strauss, 1967; Goulding, 2002; Locke, 2001; Corbin & Strauss, 2008). Theoretical saturation was reached at 13 female interviewees. This number falls within the wider recommended range of 6 to 60 informants (Safman & Sobal, 2004).

7.2.3. INTERVIEWING PROCEDURE

All interviews were conducted approximately a month after surveys were administered by the researcher (myself)—a 28-year-old female nutrition doctoral candidate at the time of data collection. The goal of the first interview was to gather rich qualitative data on the phenomena under investigation. At the end of this initial interview participants were asked permission to be contacted for a second interview within a few weeks of the first one. The goal of the second interview was to follow up on issues, as well as confirm and clarify concepts, categories, and themes that emerge during the first interview. A semi-structured interview schedule was used for the first interview. This interview schedule was developed based on pilot study data (from summer 2008), as well as advice from experienced qualitative researchers who reviewed the script to assure quality and comprehensiveness. Their suggestions and corrections were incorporated into the script. In the course of the first interview, questions covering several topics were asked: friendships; physical activity; media, social, and cultural environment; attractiveness; religion, faith, and fasting beliefs; food rules and eating habits; healthy eating; weight history; body image; pursuit of pleasure and impulsivity. These questions varied slightly between interviews depending on the responses of each interviewee and also to reflect preliminary data analysis of earlier interviews. The second interview's questions and probes were unique depending on each particular interviewee, but all questions were based on those in the initial interview. The purpose of the second interview was to clarify issues raised in the first interview. In the current chapter, I focus on the qualitative portion of the collected data that only deals with urban Bulgarian women's religion, faith, and fasting (see Appendix 4 for this part of the original interview schedule).

Individual interviews lasted from about 50 to 180 min for the initial interview and about 30 to 60 min for the follow-up interview, with an average duration of 1h and 30 min, which falls within the recommended duration range of 60 to 90 minutes (Safman & Sobal, 2004). In a few cases, more

than one follow-up interview was conducted per interviewee's request, thus the entire interview process extended over the course of several meetings with a total duration of over 5 hours. Those cases, however, were an exception. All interviews were digitally recorded and transcribed with personally identifying details removed. The transcription protocol is included in Appendix 6.

7.2.4. DATA ANALYSIS

In the course of a study data are continually “selected, focused, simplified, abstracted, and transformed” as part of a process known as data reduction (Miles & Huberman, 1994). Data reduction is in fact “analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that final conclusions can be drawn and verified” (Miles & Huberman, 1994). In this particular study, the results from quantitative data analysis contributed to data reduction by narrowing down the scope of qualitative data analysis. Consequently, not all collected data, but only data relevant to the research questions, were processed in the analyses.

7.2.4.1. Grounded Theory

Qualitative data were analyzed using the grounded theory approach. As Bernard and Ryan (1998) and Strauss (1987) describe it, grounded theory provides the researcher with insight into participants' experiences; a sound methodology for identifying categories and concepts emerging from text; and the tools to link these concepts into substantive and formal theories. Using grounded theory for this project was essential, because of the lack of previous research regarding issues of body image and eating behavior in the context of modern day Bulgaria. This method allows for theory to arise directly from the data of how the phenomena under study may actually work (Bernard & Ryan, 1998).

Sections of text from transcripts were read several times and viable themes and concepts were identified. Codes, concepts, and categories were generated, reviewed, and modified by using the constant comparison method (Charmaz, 2000; Glaser, 1992). In this method events such as

participant's views, experiences, behaviors, actions, etc. were constantly compared within individual cases, as well as across the entire sample; events were compared to emergent categories; and categories were compared to each other. The relationships between categories were then used to build theoretical models, constantly checking those models against the data (Bernard & Ryan, 1998). The initial steps of data analysis were open (usually line-by-line) coding followed by axial coding. Open coding was used to generate provisional concepts or codes that seem to fit the data (Strauss, 1987). Axial coding involved a more intense analysis of data around single concepts in order to determine several core categories. This enabled selective coding, which involved coding systematically and concertedly for core categories (Strauss, 1987), and was used to saturate, integrate, and refine categories. As the analysis proceeded, there was a shift from descriptive to more abstract, higher-level categories, allowing for theory to lift off from the data.

Several techniques were used to further integrate and refine the coding process. First, field notes from interviews and participant observations were reviewed. Similarly, records of research-related thoughts, decisions, questions, and insights, collected throughout the study as part of a reflexive journal were read. Furthermore, during data analysis short notes (i.e., memos) were taken about the codes, as well as about potential hypotheses and new directions for the research (Bernard & Ryan, 1998). Last but not least, additional data, e.g. portions of transcript, written materials and/or photographs, were used to refine theory and fill in conceptual gaps. The emerging grounded theory informed decisions whether to use such data. This decision-making process is called theoretical sampling, in which the analyst decides on analytic grounds what data to collect next and where to find them (Strauss, 1987).

7.2.4.2. Use of Qualitative Analysis Software

I used a software package ATLAS.ti (ATLAS.ti Version 6.2.12, Scientific Software Development, Berlin, DE, 2002-2011) to assist me in managing the large numbers of documents for

this project. ATLAS.ti is a powerful yet easy-to-use software package for the qualitative analysis of large bodies of textual, graphical, audio, and video data. Access to all basic project components such as primary documents, quotations, codes and memos is fast and comfortable. Findings and interpretations can be visualized in a digital mind map throughout analysis. Some researchers have qualms about qualitative data analysis software programs on the grounds that they are difficult and time consuming to learn, on top of promoting a superficial view of grounded theory. They suggest that computer-assisted analysis may dehumanize data analysis (Charmaz, 2000). On the other hand, many other authors argue that learning to use software analytical tools is recommended, because these tools facilitate creative, systematic, and thorough research (Rubin & Rubin, 2005). I believe I was able to effectively use the selected software tool to gain a more holistic feel of the emerging grounded theory, as well as to assemble its parts.

7.2.5. CULTURAL AND LINGUISTIC COMPETENCE

One has to know enough of a language to comprehend its peculiar or significant linguistic nuances (Levy & Hollan, 1998). The variations of standard speech that interviewees use in discourse usually convey meaningful personal information. Hence, cross-cultural interviewing depends on the adequate linguistic competence of the interviewer. Similarly, a researcher should have considerable knowledge about a place and its people in order to understand the presence and significance of private variants and transformations of local cultural and social norms (Levy & Hollan, 1998).

As a native of Bulgaria and Sofia (the city where all interviews took place) I did not have serious cultural or language problems. In fact, I was able to easily “blend in” and gain participants’ trust before, during, and after interviewing, which encouraged their frankness. At the same time, as a doctoral student and someone who had lived in a Western country for a relatively long time, I was perceived as “interesting” by interviewees and was treated by them with more than the usual respect,

which boosted their willingness to partake and commit to the study. Participants who were recruited through intermediaries who knew them, they also felt a personal obligation to complete the interview process once it had been initiated. Thus, participant compliance was optimal and participation rates were high for the fairly short (3-month) duration of the study.

7.2.6. TRANSLATION CONSIDERATIONS

The cross-national nature of this project called for translation of study materials between the English and Bulgarian languages. All materials distributed to or used with participants—study brochure, consent forms, interview schedule—were translated from the source (English) into the target (Bulgarian) language. These materials were originally developed in English for, among other reasons, the convenience of my graduate advisors. The interview schedule was developed in English, translated into Bulgarian by me, and back-translated into English by a second bilingual individual living in the United States, whereas the study brochure and consent forms were translated and back translated by two separate bilingual individuals (one living in Bulgaria and one in the United States) different than myself (Osman & Sobal, 2006; Harkness et al., 2004). Some of the questions from the interview schedule had been piloted during summer 2008 with a sample of 47 Bulgarians, while newly developed questions were piloted with one Bulgarian woman living in the United States. Ambiguities were identified and cleared via on-going respondent debriefing (Harkness et al., 2004)—alternative wordings, if any, suggested by the aforementioned individuals were recorded in field notes. These translation suggestions and other comments were taken into account to assure that items were comprehensible and would get at the desired information. Moreover, a third independent bilingual individual reviewed all translated materials and reconciled any translation differences to guarantee translation quality. All translators were fluent in Bulgarian and English, and had adequate knowledge of Bulgarian and Western cultures, which ensured cultural validity of the translations.

Translation quality assurance was carried on until the end of the study. Comprehension of items or formulations was probed in each interview in debriefing sessions and necessary adjustments were made before the next interview. Probes addressed how well the respondents understood the questions asked, whether they felt the questions were relevant to their life, whether they were interesting, whether there were other questions pertaining to the subject that they would have liked to see added, whether they thought any of the questions to be too personal, etc. Judging by their feedback, as well as my observations of their behavior during and after the interviews, participants seemed to respond to questions without strain. Questions were easily comprehensible and getting at the desired information. Interviewees showed interest and excitement, and were engaged in the interview process.

During data analysis, raw textual data were handled in Bulgarian (with the exception of one interview transcript, which was handled in English). I only translated into English codes, themes, categories, and concepts that emerged from the data, as well as excerpts of text or quotations used to illustrate research findings. Quality of translation was assured by means of debriefing sessions with another bilingual individual who assisted me in selecting the most semantically appropriate English equivalents of Bulgarian words, phrases, and expressions. This person did not have access to the actual text or the identity of the interviewees involved.

7.2.7. ETHICAL CONSIDERATIONS

Each interview appointment began with a brief introduction session followed by a recorded session. During the introduction the overall topic and purpose of the interview was explained, and the interviewees were prompted to read and sign an Informed Consent Form, which explained the purpose of the interview, as well as the way interview information would be used. Interviewees were also assured of confidentiality, asked permission to digitally record the interview, and their questions

were answered as necessary. Names were not recorded on any document that connects participant's name to her interview record. Signatures were obtained on the consent form only. Since Bulgarians seldom spell out their names when signing, but rather use an illegible, yet creative composition of their names' initials as a signature, identification of the interviewee by his or her signature is practically impossible. Digital voice recordings were downloaded to a computer immediately after obtaining the recording, and the recordings on the device were erased in preparation for the next interview. The computer folder where participants' files are kept is locked and only I have access to the password. Participants selected for interviewing (out of the pool of survey participants) were given a code to hide their identity, which was used to indentify their survey and interview, as well as their contact information. The code sheet with contact information was kept separately from the interviews and survey, and was destroyed once the interviews were complete. Interview transcriptions were carried by the researcher (myself), as well as by paid transcribers who had no way of personally knowing or identifying the interviewees. Before and during interview transcriptions specific identifiers were removed to ensure individuals' anonymity.

There were no direct and immediate benefits to study participants. Participants were monetarily compensated for partaking in the interview process. While this compensation was sufficient enough, it was not so high as to create a financial participation bias. The only risks to participants may have been the potential sensitivity of some of the questions in the interview. Interviewees, however, were assured at appropriate intervals that they do not need to answer any question they do not wish to answer and that they can stop the interview whenever they wish. By using questions from standardized measurement tools, by amending interview questions based on respondent comments, and by paying careful attention to question wording, the interview was kept as inoffensive and considerate of respondents' feelings as possible. This project was approved by Cornell University's Institutional Review Board (IRB).

7.2.8. TRUSTWORTHINESS

Several practical standards and evaluative tactics were followed to assure the quality of this research. To minimize bias stemming from my presence on-site and to assure credibility, I sustained “prolonged engagement” (Lincoln & Guba, 1985) with the research participants to the point of data saturation. Indeed, the I was involved with participants in all phases of research—during the initial survey, the lengthy (50 to 180 min) first interview, and the relatively long (30 to 60 min) follow-up interview, which encouraged rapport with interviewees and promoted more honest responses. Similarly, many of the interviews took place in congenial social environments such as cafes, restaurants, or the informant’s home, which reduced both the researcher’s threat and her exoticism (Miles & Huberman, 1994). My familiarity with the studied community, with its people, language and culture—being a native of Sofia—allowed me to fit into the landscape and keep a low profile. Having frequented the city over the last five years—three of which were research-focused visits—allowed me to also engage in multiple participant observations, thereby building trust with the members of the studied culture, and facilitating social and cultural insight, which resulted in stronger rapport with interviewees despite the relatively short duration of the study.

To address possible bias arising from my involvement with the research participants and ensure credibility, I used a reflexive journal where I recorded matters of importance to the project.

To further boost research credibility, I used the technique of member checking (Lincoln & Guba, 1985). Member checking in the sense of the interviewer paraphrasing, summarizing, and restating information received during a conversation to make sure that it is heard or understood correctly, was done throughout both interviews. Additionally, the second interview was used to formally follow up on questions and topics from the first interview, as well as ask interviewees to confirm, clarify, and comment on emerging concepts and themes, and the links between them.

Nevertheless, special effort was made to refrain from the dangers of “romanticizing respondents’ accounts” (Atkinson, 1997; Barbour, 2001)

To minimize bias stemming from use of data collection techniques, I sought data from multiple sources and recorded these data carefully. By scrutinizing and constantly comparing data from multiple sources (e.g., interview recordings, observations, written documents, field notes, etc.) and by integrating results obtained with different analytical methods (qualitative and quantitative) I triangulated data in order to validate and confirm the findings from my research, thereby ensuring its quality.

To minimize bias related to abusive generalizing, I used my reflexive journal to record thick descriptions of my field experiences as a means of achieving research transferability (Lincoln & Guba, 1985; Miles & Huberman, 1994). Similarly, in the write-up of my research I continued to provide a sufficiently detailed account of research participants, settings, and processes, so that readers can assess the extent to which my research conclusions are transferable to other times, settings, situations, and people. Additionally, to minimize elite bias and to increase transferability, I looked for diverse (to the extent possible) participants within the population of interest—from both genders, various age groups, and different socio-economic backgrounds. This technique is known as purposive sampling.

To minimize distortions stemming from researcher bias and the use of data analysis methods (Miles & Huberman, 1994), I have kept clear records of methodological changes and decisions since the beginning of this project. I continued to do so until the development and reporting of findings. Furthermore, to ensure the credibility and confirmability of my findings, I will allow public access to research related documents that are not subject to ethical concerns. These may include parts of my reflexive journal, as well as the interview schedule, field notes, and other documents. All these documents are part of the audit trail for this study (Erlandson et al., 1993).

7.3. RESULTS

7.3.1. SAMPLE

The sample was made of 13 participants who ranged in age from 18 to 81 years, and included women of various relationship, occupational, and educational backgrounds. Special attention was given to participants' faith and fasting behaviors—interviewees were selected purposively to reflect a range of spiritual beliefs and fasting frequencies observed across the larger survey sample from which participants were drawn. Key socio-demographic characteristics of the interviewees, organized by increasing age, are summarized in Table 7.1. These data were collected as part of a survey (see Chapters 5 and 6) and used for screening participants with desirable characteristics. It should be noted that data in Table 7.1 reflect the *current* status, faith, or *traditional* fasting behavior as they were recorded on the questionnaire booklet. The current “Fasting” and “Faith” categories are detailed elsewhere (see Chapter 6, “Research Design and Methods”). Participants' names have been changed to preserve anonymity.

Table 7.1. Key socio-demographic characteristics of female interviewees (N=13).

Participant Name	Age	Relationship Status	Employment Status	Education Status	Current Fasting	Current Faith
Svetla	18	Never married (boyfriend)	Working student (school/ Marketing)	Secondary (8 th grade)	Sometimes	Passive Believer
Kama	18	Never married (boyfriend)	Working student (school/ Restaurant aid)	Secondary (8 th grade)	Never	Passive Believer (without definite beliefs)
Silva	19	Never married (boyfriend)	Student (university candidate)	Upper Secondary (9 th grade and above)	Sometimes	Passive Believer (without definite beliefs)
Yoana	19	Never married (boyfriend)	Student (accepted into university)	Upper Secondary (9 th grade and above)	Never	Non-Believer (agnostic)
Eva	28	Divorced (single)	Working student (university/ Paralegal)	Upper Secondary (9 th grade and above)	Never	Passive Believer
Daniela	28	Married, first and only marriage	Employed (Pharmaceutical sales)	Higher (University or equivalent)	Sometimes	Passive Believer
Gergana	28	Never married (single)	Employed (Researcher at university)	Higher (University or equivalent)	Regularly	Active Believer
Polina	29	Married, first and only marriage	Employed (Program manager, health research)	Higher (University or equivalent)	Sometimes	Non-Believer (agnostic)
Lina	31	Never married (single)	Employed (Communications manager)	Higher (University or equivalent)	Never	Passive Believer (without definite beliefs)
Nelly	44	Married, first and only marriage	Employed (Nail salon owner, manicure and pedicure specialist)	Upper Secondary (9 th grade and above)	Never	Non-Believer (agnostic)
Monika	52	Remarried	Employed (Sports club owner, manager, and instructor)	Higher (University or equivalent)	Sometimes	Passive Believer
Milena	77	Widowed	Retired (former engineer)	Semi-Higher (College or equivalent)	Never	Passive Believer
Sofiya	81	Married, first and only marriage	Retired (Retired surgical aid)	Upper Secondary (9 th grade and above)	Sometimes	Active Believer

A conceptual model—consisting of several key categories and sub-categories, and the links among them—was constructed to identify the components of fasting behavior and their relationship to spiritual beliefs (i.e., faith) and body image (i.e., weight control issues) as described by women in this sample (see Figure 7.1). There were 4 major components of fasting behavior: 1) Prerequisites: Meaning, Motives, and Attitudes, 2) Conditions: Learning; and Barriers, and Aids, 3) Practice: Rules and Exemptions, 4) Outcomes: Weight Issues; and Benefits and Detriments. These components were conditional upon an individual’s Personal Beliefs (about Faith, and Nutrition and Health), and all elements of the model were subject to continuous lifetime changes. Each element of the model (category or sub-category) enlists a number of themes with distinct dimensions of contrast. Model elements—components, themes, and their dimensions of contrast are described below.

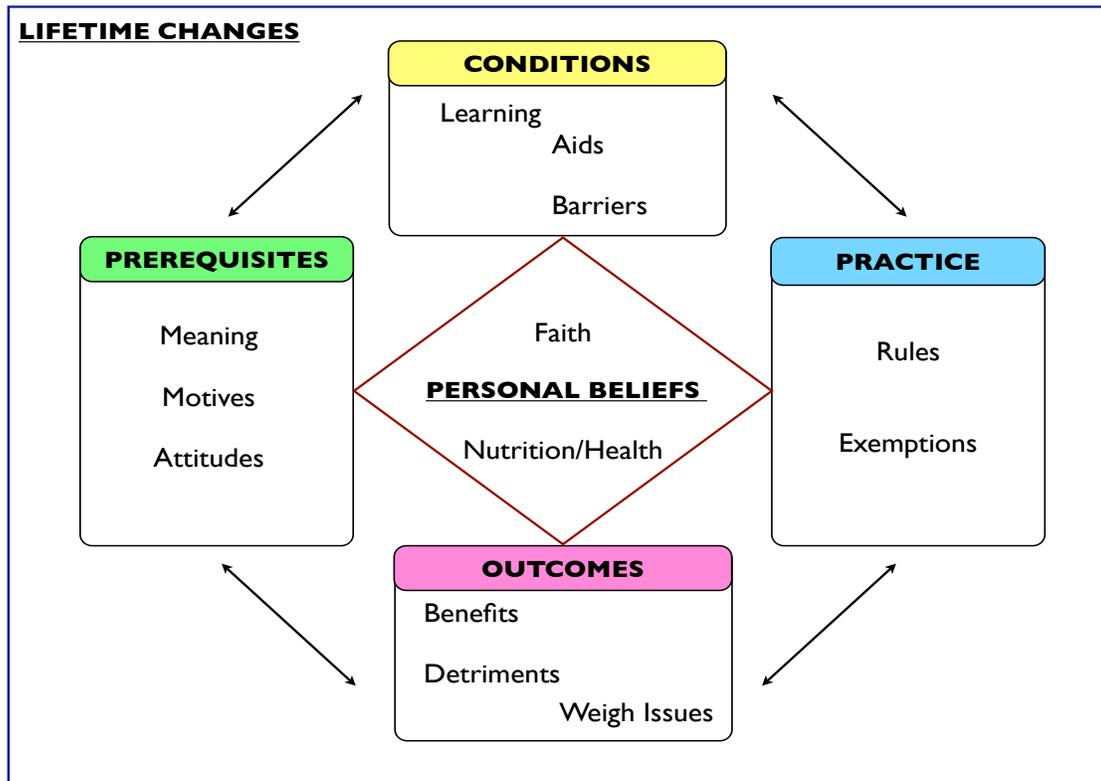


Figure 7.1. Conceptual model of fasting behavior among urban Bulgarian women (N=13).

It should be noted that there were two different kinds of narratives that were included in the analyses. Women who had never fasted (i.e., non-fasters) shared only their observations of others' fasting behavior, whereas women who had previously fasted (i.e., fasters) elaborated on their personal experiences with fasting in addition to discussing any observations of others' fasting they may have had to share. While direct experiences enable women to devise informed, presumably richer opinions about fasting behavior, women's observations and commentary about others' fasting habits are valuable in that they reflect the observer's beliefs, perceptions, and attitudes about fasting, in addition to revealing societal attitudes at large.

7.3.2. PREREQUISITES: MEANING OF FASTING

7.3.2.1. Traditional Meanings

Like any other behavior—dietary or non-dietary—fasting had a particular meaning for each interviewed woman, even if she had never fasted before. This meaning was distilled from a multitude of direct and/or indirect experiences involving fasting that a woman encountered throughout her life. The meaning of fasting was indeed a core component—in that it permeated all other themes and concepts—of the model explaining fasting behavior among these urban Bulgarian women. The ways in which women defined and understood fasting influenced their motivation for this behavior, the strategies and information sources they used to learn about it, and the rules they followed if they decided to practice. Moreover, the meaning vested in fasting affected how women valued this behavior—its possible outcomes—and thereby colored their overall attitudes towards it.

According to Orthodox Christianity, fasting is a spiritual discipline tied to the theological concept of synergy between body—a physical principle—and soul—a spiritual principle (Alexiev et al., 2008). Nearly all interviewees—regardless of age, faith, or fasting experience—were able to recognize this *holistic nature* of fasting. Physical principles underlying fasting included interrelated

concepts like *cleansing and purification of the body, giving the body a break, and bodily challenge*. Conversely, spiritual principles covered concepts like *spiritual cleansing and purification, building a moral character, abstinence from pleasure, spiritual challenge, and exercise in humility*.

What differentiated women was the significance they bestowed on one fasting principle over the other. Some women (despite being aware of the religious origins of fasting) thought of fasting in predominantly physical terms and defined it as a bodily experience. Interestingly, these were the youngest participants. Namely, Svetla (18), Kama (18) Silva (19), and Yoana (19) made up the teenage cohort of this study—women who came of age after the peak in socio-cultural transformation in the mid 1990s. Of them, only one interviewee, Kama (18), a non-believer, ascribed spiritual aspects to fasting by defining it “as a way of cleansing the soul, the body...” The rest of the teenagers focused on the physical. The remaining non-teenage women in the sample attributed a spiritual along with a physical meaning to fasting.

Non-teenage participants were grouped into three additional cohorts—young adults: Eva (28), Daniela (28), Gergana (28), Polina (29), and Lina (31), who came of age at the peak of socioeconomic transition; middle-aged adults: Nelly (44) and Monika (52), who came of age during communism; and two elderly women: Milena (77) and Sofiya (81), who came of age before the rise of communism in Bulgaria. Women in both cohorts had varied spiritual beliefs and fasting experiences. Nevertheless young adults tended to emphasize physical aspects of fasting, while older adults (middle-aged, but especially elderly women) defined fasting in increasingly spiritual terms. As women grew older, their interest in and motivation for fasting also gradually shifted from mostly physical towards spiritual (also see “Prerequisites: Motives for fasting”). For instance, although Eva (28) and Polina (29) acknowledged a link between religion (or spirituality) and traditional fasting, both women did not place too much importance on spirituality as an element of fasting. Polina (29) who had fasted only once before despite being an agnostic explained that she was driven to fast by a

desire for physical purification and weight loss (see “Prerequisites: Motives for fasting”). As she put it, she had an intellectual respect for the religious tenets of fasting, but did not feel that religion was important in her life or in her fasting practice:

POLINA (29): “*I: How do you define fasting?* P: Fasting...that is related to challenging the body. It’s considered to be abstinence from some kind of pleasure—spiritual and physical—for the purpose of cleansing and purification—spiritual and physical. I accept this idea, but I’m not fanatical about it.”

Likewise, Eva (28) who had never fasted in her life admitted that if she were to fast, she would do it for physical (e.g., *cleansing and purification of the body*), rather than spiritual reasons (see “Prerequisites: Motives for fasting”). Even though she self-identified as a passive believer, she appeared embarrassed about her lack of knowledge of fasting and of religious rituals in general. Her definition of fasting was overwhelmingly physical:

EVA (28): “*I: What do you think it means for a person to fast? How do you understand this term, personally?* E: This...hmm...I mean, I think it may be...I’m not very good with religion, but I think fasting...this was to cleanse the soul and the body, so when Christ is resurrected...and Lent ends, perhaps I’m embarrassing myself right now... *I: Oh no, don’t worry about it...I don’t want you to feel like you’re being tested. I just want to know your personal opinion, how you explain fasting to yourself.* E: Well, I think that this is good for purifying the body, I mean, from some toxic substances that get accumulated...now, I don’t know if that’s how it happens.”

Daniela (28) and Gergana (28) had a similarly physical take on fasting (especially at the beginning of their practice). However, because these women were more experienced (i.e., they had practiced longer), they were able to observe transformations in their practice and in the way they understood fasting (see “Lifetime changes: Transitions and transformation in the tradition of fasting”). For instance, Daniela (28), a passive believer, described fasting in her teens as immature—“childishly unaware”—and physical in nature (see “Prerequisites: Motives for fasting”), whereas she defined her current practice as “holistic in nature”—an even combination of physical (e.g. *cleansing and purification of the body*) and spiritual (e.g., *an exercise in humility*) principles:

DANIELA (28): “*I: Was there a spiritual aspect to it at the time [fasting in your teens]?* D: Back then there wasn’t, firmly no. Now there is. *I: At present, what is your definition for fasting, how do you*

understand this term, personally? D: This is a time for humility. *I: Meaning there is a spiritual aspect to fasting.* D: Definitely. *I: But you haven't turned your back on this...physical cleansing from intoxication.* D: No. *I: But it's somehow...* D: More complete...more holistic in nature.”

Even though Gergana (28) self-identified as an active believer, she admitted to not considering religious reasons when she first began fasting (also see “Prerequisites: Motives for fasting”). Like Daniela (28), Gergana (28)’s definition of fasting took on an increasingly spiritual spin as her practice progressed—for her fasting was an exercise in *abstinence from pleasure* for the purpose of *building a moral character*.

GERGANA (28): “*I: What does fasting mean to you, personally? What is your definition for fasting?* G: Fasting...this is... religion. *I: So, your definition involves religion?* G: Religion...this is such a question...I don’t know, perhaps I’m repeating myself...But during a fast it’s much easier to give up the things you feel attached to. I’ve made attempts, I’ve experimented with my favorite chocolate...during a fast you almost don’t feel like eating—the first 1-2 days—then you feel liberated from this chocolate. I’ve made attempts also after the [traditional periods of the] fasts, but it happens with much more difficulty. You need willpower, an effort for about a week to a week and a half, so your organism gets adapted...So, to what extent religion plays a role...I am a believer... *I: For you fasting isn’t only the physical aspect, but also the spiritual?* G: Yes, both aspects. That’s the conclusion I arrived to. It came to me gradually, with time.”

Like the other women in her cohort, Lina (31)—whose spiritual beliefs were undefined (meaning she reported having faith, but not considering herself religious)—saw fasting as a synergy of equally meaningful physical and spiritual principles. Nevertheless, she admitted to lacking a clear spiritual understanding of or interest in fasting before beginning to fast a couple of years earlier. As she put it, before then she “wouldn’t have had any reaction” to information about fasting, and fasting itself “wouldn’t have concerned” her at all.

The oldest group of interviewees—Nelly (44), Monika (52), Milena (77), and Sofiya (81)—appeared somewhat more preoccupied with the spiritual nature of fasting than younger women. Although elderly women—Milena (77) and Sofiya (81)—also saw fasting as a *holistic* experience, for them the physical effects of fasting were secondary (i.e., as side effects) as compared to the spiritual. Arguably, for these two interviewees fasting was a genuinely spiritual discipline. It should be noted

that Milena (77) and Sofiya (81) had come of age at a time (mid 1940s) and place (in villages) when communist secularization had not yet taken place. Curiously, these elderly women seemed to possess a nearly organic bond with Bulgarian cultural traditions, including intricate knowledge of religious rituals and mores. Even though they were no longer as strict about fasting as they used to be in their youth—Milena (77), a passive believer, no longer fasted, while Sofiya (81), an active believer, fasted only sporadically (see “Practice: Fasting rules and exemptions”)—both women attached a heavily religious meaning to their practice:

MILENA (77): “I: *What does it mean for a person to fast?* M: Giving the body a break. I: *Giving the body a break...what kind of a break?* M: Physical...I: *Physical...meaning a cleanse from toxins?* M: Yes. I: *And at the same time you mentioned the religious aspect. How much...So if you had to imagine the reasons for fasting as a pie, how much of this pie is made of the religious aspect and how much of it is made of the cleansing aspect? Which one is more important for the act of fasting?* M: About fasting I strongly support the recommendations coming from religion. []⁵ I: *Uhmm. Alright. But the main reasons you see as being religion...fundamentally?* M: Yes, religion is the foundation.”

SOFIYA (81): “I: *OK, but what is your personal opinion about fasting? What kind of practice is it? What should or shouldn't be avoided?* S: It's just that your body is cleansed and your soul is cleansed. I: *Uhmm, so it's spiritual and physical cleansing.* S: Yes. I: *And which one is more important—the spiritual or the physical purification?* S: The spiritual. I: *And the physical comes as a consequence...S: Yes, yes.”*

Importantly, for Milena (77) and Sofiya (81) the meaning of fasting never changed—in contrast to younger participants like Gergana (28) and Daniela (28)—even though their practice began earlier in life and, in the case of Sofiya (81), extended over a longer period of time. The definition of fasting for these elderly women remained rooted in religious dogma, even as they became somewhat less devout. Here is how Sofiya (81) recalled fasting in her youth. Notice that she seemed somewhat astonished at her religiosity at the time:

SOFIYA (81): “S: If I've fasted at 17-18 years of age, being young, and having the willpower for fasting, then I guess... I: *What do you mean?* S: I don't know... my faith must have been very strong. I: *So it's a question of faith, a test of faith.* S: Yes. And I have relied on my willpower.”

⁵ The notation [] indicates that some transcript is omitted. Refer to Appendix 6 for the full interview transcription protocol.

The two middle-aged women, Nelly (44) and Monika (52), also saw fasting as a spiritual act. Even if she herself did not engage in fasting, Nelly (44), who was an agnostic, considered it inappropriate to fast for non-spiritual reasons. Perhaps this explained in part why she had never fasted and was not interested in trying. Besides, she seemed appalled at what she labeled a “fashion craze” for fasting (see “Prerequisites: Motives for fasting”) among young women and believed fasting to be just a diet, *compartmentalized eating*, if stripped of its spirituality. In the same way, Monika (52) disapprovingly talked about “a fashion for fasting” among young girls. In contrast to such trends, Monika (52) defined fasting as cleansing of the body and spirit, but with an emphasis on spiritual elements, such as *spiritual challenge*, *abstinence from pleasure*, and strengthening one’s willpower en route to *building a moral character*. The same concepts came forth when she described her husband’s spiritually inclined practice:

MONIKA (52): “I: *What does fasting mean to you?* M: People who are deeply religious think that this is cleansing and purification of the body, and on the other hand, a test for the soul...When you deny yourself pleasure, like gluttony... this way you harden your willpower. [] He [her husband] considers it [fasting] from a religious standpoint...he’d even eliminate coffee, because he wants to see whether he can overpower it, and in about 3-4 days he doesn’t feel like drinking it any more...”

7.3.2.2. Alternative Meanings

It is important to mention that in addition to the above-described traditional (i.e., religion-based) meaning of fasting, narratives contained alternative definitions for fasting that could be found in Bulgarian society. These alternative definitions included *vegetarianism* (non-ethical), *dieting for weight loss* (standard *diets*, including regimens like *compartmentalized eating*), and dietary regimens or aids for *bodily cleansing* (*periodic cleansing fasts* and *fasting pills*).

One of the interviewees, Kama (18), seemed to equate fasting with *vegetarianism*. She explained she did not fast, because she was a vegetarian, which suggested that for her fasting meant simply following dietary rules (i.e. avoiding meat) that resembled vegetarianism. Interestingly, like

her overwhelmingly physical take on fasting, Kama (18) admitted to a rather *physical form of vegetarianism*—one that did not involve ethical principles:

KAMA (18): “I: *You just don’t find meat tasty, it’s not because...for instance...some people are vegetarians, because they want to protect animals and...?* K: Well, simply because....It would be very hypocritical if I say I want to save the animals. Because if it were true, I wouldn’t be wearing leather purses, leather shoes, leather belts...etc. ...if I wanted to save the animals. I: *So these are reasons you wouldn’t consider.* K: That’s correct.”

Based on my participant observations in the field, as well as the analysis of survey materials, Kama (18) was not alone in equating fasting and vegetarianism. A number of Bulgarians found fasting pointless in the context of a vegetarian diet—fasting had lost its identity to vegetarianism—which was inadvertently captured by the survey study (presented in Chapters 5 and 6). Nevertheless, not all vegetarians confused the two dietary practices. There was another vegetarian in the sample, Lina (31), who had attempted fasting once before. For this woman, fasting had an identity that was clearly distinguished from vegetarianism.

A number of interviewees expressed a belief that for certain Bulgarians (especially young women) fasting meant *dieting for weight loss*. As one interviewee, Polina (29), put it: “fasting without spirituality is just a diet.” Although the majority of these interviewees were familiar with this societal perception about fasting, they believed it was either a misconception or that fasting was ineffective as a weight control strategy (see “Weight control issues and fasting”). One diet in particular that participants mentioned as being often equated with fasting was the so-called *compartmentalized eating*—a widely popular dietary regimen that favors certain food combinations over others for the purposes of health, but most importantly weight loss. For example:

NELLY (44): “N: If you’re not a believer, but you fast, you should say that you’re instead practicing compartmentalized eating, that you avoid meat and such things...”

MONIKA (52): “I: *Do you think there are people in Bulgaria who use fasting as a weight loss strategy?* M: Based on my observation many young girls hear about this and decide to fast for this reason. They think fasting is a type of compartmentalized eating, you don’t mix different types of foods...But I disagree...”

In addition to dieting for weight loss, fasting could also be interpreted (by some) as a bodily cleanse—a diet aimed at physical purification from toxic accumulations in the body. Such *periodic cleansing* fasts included *lite regimens*, *weekly cleanses*, *wheat regimen*, and *moon cycle fasts*. For example, although Kama (18) claimed lack of interest in traditional (i.e., religious) forms of fasting, she admitted to fasting non-traditionally by engaging in short dietary regimens (i.e., *lite regimens*) aimed at physical cleansing and purification:

KAMA (18): “I: *And you mentioned the soul—you think that purifying the soul is the purpose of fasting, not the opposite—the purely physical aspect, of the body? You see fasting as a religious...spiritual, or rather, a physical...experience?* K: Oh, yeah...here, in this sense fasting can be seen from this perspective—like, you know, cleansing of the organism. Everybody does this, every organism needs cleansing...for instance I do it for 2-3 days. I mean, you know, simple things such as salads, and similar...like, teas, for as long as the organism takes a break from the seasons.”

Lina (31) described a few similar cleansing regimens that she observed were widely popular among her friends and acquaintances. One of them was the *weekly cleanse*:

LINA (31): “L: Wait, I just thought of something else. There’s another form of fasting... so there was the new moon-full moon, wheat... Part of the people I know—I have in mind an older couple around 50-60 years old—they’ve adopted this—once a week they do a cleansing regimen. My cousin, also acquaintances of mine, friends who have adopted a ‘healthy lifestyle’—they have decided to eat whatever the heck they want and the whole week it’s ‘yoo hoo’, ‘life is life’, alcohol, cigarettes, everything, but one day during the week, for instance, they fast only on fruit, veggies, and tea. Once a week, once every 7 days. I’d say that’s quite widespread as well. I: *You put this under the common denominator of fasting?* L: Well, yeah. Various print media have written about this and I also know many people who do this. That’s all I wanted to add.”

Another cleansing fast was the *moon cycle fast* that a number of her coworkers practiced to detoxify their bodies:

LINA (31): “L: Another kind of fasting that people practice is during full and new moon. The number of female coworkers who tell me ‘it’s full moon, I’m going to fast’ or ‘it’s new moon, I’m going to fast’ has been increasing. I: *But these are not Orthodox fasts.* L: No, they aren’t, but in recent years that’s become the other popular way of cleansing—at the time of full and new moon. I: *Again, you mean cleansing the body from accumulations?* L: Cleansing from toxins, this is the modern way of putting it. I: *So the physical...the body is being cleansed, but the spirit is somewhat overlooked?* Well, they don’t mention any spiritual aspects, they only mention that cleansing of the body.”

Yet another cleansing regimen was the *wheat fast*, which Lina (31) believed to be famous also for its purported healing properties. Curiously, this wheat fast—developed in the early 1900s by a locally famed natural healer, Peter Deunov⁶ (Deunov, 2008)—was in fact “prescribed” at “health centers” as a cure-all to people suffering from certain illnesses:

LINA (31): “L: Also, Peter Deunov’s wheat regimen has become very popular. They began prescribing his wheat fast a lot at a number of centers for healthy living. *I: I’ve heard about it, yes. They prescribe it?* L: Well, yeah. It’s prescribed for certain diseases. *I: And people go there [to the centers] and pay money to do this regimen?* L: Hmm, I don’t know. They go there for some illness and are prescribed some herbs, but part of this prescription would be to also do the wheat regimen. Recently I even found a site, “Earth for lease,” and what did I see there? The wheat regimen. Afterwards I saw a book, then a newspaper...and then everywhere ... I’d run into the wheat regimen. I had no idea this regimen was so popular. So when a [female] coworker of mine—who has nothing to do with any sort of spirituality—told me the other day “I did the wheat regimen and it had an incredible effect on me”, I just stared at her. I myself have never done it, even though I have such a nice attitude... about this, you know, and I haven’t made up my mind to do it yet.”

The above quote provides an insight into the media’s role in the growing popularity of cleansing fasts among Bulgarians—such fasts have become so prominent that they are picked up by mass media and popularized even further.

Lastly, one interviewee (Monika) described the use of *fasting pills* in lieu of fasting for the purposes of physical cleansing and purification. Although she herself disagreed with this practice and implied it was wrong, this interviewee observed that for the individuals using them fasting pills were as effective as fasting:

MONIKA (52): “M: I have acquaintances that eat and drink everything during the fasts, they like eating, but take some cleansing pills and call this fasting—cleansing their bodies in that way.”

It is important to mention that some of the above-described “alternative fasts” had spiritual roots (e.g., the wheat regimen by Peter Deunov) very much like traditional fasting. Nevertheless, it was clear that some people did not fast for overtly spiritual reasons. Instead, they seemed driven to

⁶ Peter Konstantinov Deunov (11 July 1864 - 27 December 1944) was a spiritual master called Master Beinsa Douno by his followers. Founder of a spiritual movement called the Universal White Brotherhood.

fast by the perceived health benefits of physical cleansing and purification. What is more, it seemed weight loss was not the primary focus of any of these dietary endeavors.

7.3.3. PREREQUISITES: MOTIVES FOR FASTING

Naturally, what motivated fasting was related to the ways in which women defined and understood this dietary practice. Even so, such definitions did not directly transform into fasting motives or actual fasting behavior. An important role was played by other intermediary (e.g., predisposing, intervening, or reinforcing) factors. Regardless of whether women's experiences with fasting were direct or indirect, fasting behavior was driven by two major sets of motives—internal and external. Internal motives were related to perceived personal benefits from fasting, i.e. women were inspired to engage in fasting because they believed that the behavior would be beneficial for them. External motives, in turn, involved a catalyst—a precipitating event or an individual, group of individuals, or society at large, that provided an immediate stimulus for women to partake in fasting.

7.3.3.1. Internal Motives

Depending on the type of benefit achievable by fasting that women believed would be greatest, internal motives ranged on a continuum from physical to spiritual in nature. Motives that were predominantly physical in nature included *cleansing and purification of the body*, *weight loss or control*, *giving the body a break*, putting one's body to the test (i.e., a *bodily challenge*), and achieving or maintaining good health (i.e., *health promotion*). *Cleansing and purifying the body* was the prevailing motif throughout all narratives and it was directly linked to the meaning vested by women in fasting, as well as to women's nutritional and health beliefs (see "Personal beliefs: Nutrition and health"). *Cleansing and purification of the body* was also a commonly cited benefit from fasting (see "Outcomes: Benefits and detriments of fasting"). Women were motivated to fast, because they believed fasting would cleanse and purify their bodies from the toxic buildup inherent to normal, day-to-day life (see

“Personal beliefs: Nutrition and health”). Participants thought that *giving the body a break*—allowing it to rest physically, so that it’s able to “restart” anew—was a prerequisite for bodily purification, cleansing, recovery, and rejuvenation. As Kama (18) explained, “the body itself is strained by having to digest all these foods and drinks, etc. It should be given a break!” *Cleansing and purification of the body* was cited as an incentive, for instance:

SVETLA (18): “S: ...I know that fasting is being used to cleanse the body....[] I: ...*You mentioned cleansing of the body, that’s how you understand fasting. What kind of cleansing do you have in mind?* S: Well, I think, for instance, about cleansing the body from toxins, from accumulated food. Something like that... [] I: *And what was your motivation, personally, when you did this [fasting]?* S: Well, mainly this cleansing of the body...[]...because you look refreshed afterwards...”

Similarly, Daniela recalled fasting in her teens that was driven by an overwhelming desire for physical purification:

DANIELA (28): “*I: To fast, do you remember what motivated you, what compelled you to fast?* D: It [fasting] must have been rather childishly unaware, but overall for some sort of cleansing of the body. *I: [Cleansing] in terms of what?* D: Intoxication of the body. *I: Was there a spiritual aspect to it at the time [fasting in your teens]?* D: Back then there wasn’t, firmly no.”

When asked to imagine the possible motives of other fasters—friends, relatives, coworkers, etc. whose fasting was witnessed by interviewees— *cleansing and purification of the body*, as well as the closely related *giving the body a break*, were once again mentioned quite frequently (in fact, more frequently than when it came to personal fasting experiences):

SILVA (19): “*I: Uhm, ‘cause you mentioned that he [your father] fasted for health reasons and I was thinking that....* S: It was for cleansing of the body”.

GERGANA (28): “G: ...I’ve had girlfriends who do it [fasting] to feel more cleansed...”

NELLY (44): “*I: How about their [Bulgarians’] personal motivation [to fast]—is it religious or?* N: They rather want to cleanse their body. There’s a lot of logic and wisdom in this....[] *I: So it’s meant for cleansing of the body...for health.* N: Well, yes. Heck yeah! That’s just logical.”

MILENA (77): “*I: What do you think...is fasting popular in Bulgaria at the moment?* M: Recently, there is...I know people who are...now...modern...who are working...there are some who do fast. *I: There are...* M: But their goal is to give the body a break...*I: To give the body a break...not religiously...* M: Not for religious purposes...to give the body a break. *I: I see. And these are people at what age...30, 40...?* M: An acquaintance [male] of mine...he’s 50 years old, however, he follows the fasts from the beginning to the end. *I: Despite not being particularly*

religious? M: He's not religious. *I: I see...to give the body a break.* M: He's an attorney, I'm saying he's a civilized person...he wants to give his body a break."

Clearly, *cleansing and purification of the body* was both a personal motive for fasting, as well as a widespread societal perception about fasting that most interviewees espoused. In addition to cleansing and purification of the body, the desire for *weight loss and control* was also seen as an incentive for fasting behavior. For instance, Polina (29), a one time, newly fledged faster, admitted being motivated to fast by her expectation for *weight loss*, especially after witnessing a few of her female friends fast for weight loss and shedding pounds:

POLINA (29): "I: *So you were motivated by weight loss?* P: Yes, I was." [] *I: Do you think that people in Bulgaria could be fasting for weight loss purposes?* P: Yes, I have witnessed this in women and with results. *I: You think their motivation was weight loss?* P: Yes, it was mainly for this [purpose]. Well, of course, also for cleansing and purification of the body. There's this moment with traditionally long winter and Bulgarian holidays that involve meat consumption."

Like Polina (29), a few other participants expressed a belief in fasting for *weight loss* based on their observations of others' behavior:

YOANA (19): "I: *What do you think motivated her [your mom] [to fast]—religion, a spiritual meaning, weight loss?* Y: Weight loss."

GERGANA (28): "G: I had a friend who fasted with the goal of losing weight, but she didn't make it [the fast]"

However, unlike Polina (29), most fasters did not acknowledge *weight loss* as a personal motive for fasting. In fact, fasting for weight loss, despite being recognized as an existing phenomenon among Bulgarians, was seen in a somewhat negative light by most interviewees—it was labeled a "fashion craze" thereby judged trivial and superficial, and generally viewed as a misconception:

DANIELA (28): "D: Yes, I do assume this [that others may be fasting to melt pounds], it is possible, but this is an erroneous idea."

NELLY (44): "N: Yes...yes. That's precisely why they start doing this [fasting], so that they lose weight..."

MONIKA (52): "I: *Do you think there are people in Bulgaria who use fasting as a weight loss strategy?* M: Based on my observation many young girls hear about this [that fasting leads to weight loss] and decide to fast for this reason. They think fasting is a type of compartmentalized eating [a popular diet in Bulgaria], you don't mix different types of foods...But I disagree..."

As an alternative to *weight loss*, a few women talked about putting one's body to the test (i.e., *bodily challenge*) and *health promotion* as personal reasons for their fasting. For example, one interviewee explained that what initially prompted her to fast was a kind of curiosity to challenge and experiment with her body:

GERGANA (28): “G: I just wanted to try it [fasting], something prompted me on the inside...I wanted to see how my organism would react to this [fasting], what would change....]...at the beginning it was purely experimental.”

Two women cited *health promotion* as a reason for fasting—one of them commented on her father's decidedly secular fasting experiences, while the other attached spiritual meaning to her own fasting.

Indeed, spiritual motives were the second most frequently cited set of internal reasons for fasting that narratives revealed. Spiritual motives consisted of perceived emotional or spiritual well-being benefits that women anticipated in accordance with their degree of religiousness or spirituality. As with physical motives, the theme of cleansing and purification emerged again, this time in its spiritual incarnation—women engaged in fasting for *spiritual cleansing and purification*. Additionally, fasting was used as an *emotional coping mechanism*, having an *inner calling*, the need for *spiritual sacrifice*, ensuring *good luck*, and *spiritual challenge* in *overcoming one's consumerism*. *Spiritual cleansing and purification* was cited as a motive for fasting by women with different degrees of spirituality—an active believer, a passive believer, and a woman with no definite beliefs. Gergana (28) who was a regular faster and identified as an active believer explained that her motivation for fasting evolved from the mostly physical (i.e., experimentation with her body) to the spiritual realm as her practice deepened (see also “Lifetime changes: Transitions and transformations in the tradition of fasting”):

GERGANA (28): “G: ...However, after a while there were cleansing aspects [to my fasting]. Cleansing in terms of physical and spiritual purification. I: *This spiritual cleansing and purification, is it humility or ...how would you describe it?* G: Even in the last year and a half...a person feels more liberated, more humble, yes.”

Kama (18), a woman with no definite beliefs, who did not participate in traditional fasting, but nevertheless conducted short *periodic cleansing fasts* to cleanse her body (see “Prerequisites: Meaning of fasting; Alternative meanings”) referred to others’ fasting behavior as faith-based:

KAMA (18): “K: Yes, I mean if you’re like religious, with the goal of cleansing your soul, obviously people really do it... there’s nothing wrong in them doing this.”

Likewise, Eva (28) who is a passive believer who has never fasted, recognized a religious basis to fasting behavior, but was mostly interested in its physical aspects and thus expressed a disbelief that contemporary Bulgarians may fast for spiritual reasons unless they were extremely religious:

EVA (28): “I:...so, for other people you would say that in addition to this physical aspect, there is sort of a spiritual aspect, meaning spiritual cleansing and such.... E: [Nods] But I don’t know such [people]...I: You don’t personally know such people or you simply don’t think such people exist? E: Well, I suppose there are, but they would be extremely religious or something like that....here... I don’t know...”

Aside from spiritual cleansing and purification, Polina (29), a passive believer and a one-time faster, defined her interest in fasting as a *spiritual challenge in overcoming her consumerism*. She described her failed initial attempt at fasting, which she later followed with a successful fast, as:

POLINA (29): “P: I’ve always thought that I’m not a carnivore, but I discovered [by trying to fast] that I cannot go a long time without eating meat. So I wanted to see whether I could overcome the consumerist in myself.”

Unlike younger participants’ narratives, the narratives of the two elderly interviewees—Milena (77) and Sofiya (81)—conveyed distinctly religious motivation when it came to fasting behavior. Milena (77), a passive believer who does not currently fast, recalled a fasting episode in her youth that served as an *emotional coping* mechanism following severe personal trauma:

MILENA (77): “I: I see. And what motivated you to fast...what was the reason? M: A religious [reason]. I: Religious...for spiritual purification or? M: Well, spiritual...because I lost a son when I was 21...I: Uhmm...uhmm. M:...and next year I had to go take care of my parents out of town [in the countryside] I: Uhmm...uhmm. M: And I was basically being a servant at church...I: Uhmm. M:...because I couldn’t be in contact with other people. I: Uhmm. M:...they were talking about children, grandchildren...and I...I: Uhmm. That must have been a difficult period for you. M: ...but the mourning [people] were coming there [to church]...I: Aha.

M: ...and that's why. I: *Aha...so it was for religious reasons...to somehow handle the difficulties you were facing in your life at the time...* M: Yes. I: ...*at an emotional level.* M: Yes."

Like Milena (77), Sofiya (81), an active believer and occasional faster, described her fasting in *spiritual* terms. Sofiya (81) was driven to fast by an *inner calling*—a need to make a *spiritual sacrifice* to God in exchange for *good luck*:

SOFIYA (81): "I: *When you personally fast, is this your motivation to fast? Why do you try to, or...?* S: Because I have an inner calling. I: *An inner calling like a need? Or...* S: Yes, a need. I: *What kind of a need? Why do you feel you need this [fasting]?* S: I don't know, Rosa, simply to show someone... I: *Who?* S: God. To show God that I'm making a sacrifice when I fast...something of this sort. I: *But why do you need to make such a sacrifice?* S: For health... for good luck. I: *As a kind of gesture to God, for him to give you health and good fortune.* S: Yes, yes, yes..."

7.3.3.2. External Motives

In addition to being internally motivated to fast, interviewees often required an additional external boost, i.e. a catalyst in order to initiate fasting. Such a catalyst (or trigger) was either personal—an individual (or group of individuals) in the interviewee's immediate surroundings, or *societal*—a precipitating event, such as the beginning of a *traditional fasting period* (the longest two occurring before Christmas and Easter), that creates a favorable environment for proper fasting. Personal motivators that interviewees mentioned were *spouses, mothers, grandmothers, fathers, or friends (peers)*. In addition to inspiration, these individuals usually provided the necessary information about fasting that was needed to carry out a successful practice (see "Conditions: Learning to fast"). For example, Monika (52) explained that she first began fasting under the influence of her *husband* and Silva (19) pointed at her *father*:

SILVA (19): "S: ...perhaps because my father was fasting and so did I."

MONIKA (52): "I: *When did you first begin fasting?* M: Me...under the influence of my husband, because he is a strict follower for spiritual reasons and I started as well...[] I: *When you fast do you use your husband as a source of information?* M: Yes."

Mothers and *grandmothers* were prominent figures in women's narratives when it came to shaping fasting interests and habits. In fact, mothers and especially grandmothers were the most

important “keepers” and “carriers” of culture among the women I interviewed. For the most part, interviewees were driven to fast on their own and were thereby receptive to the advice and example of their mothers and grandmothers. However, for a few of the participants fasting was indeed passive—enforced by headstrong grandmothers at a time (usually childhood) when women lacked a clear understanding of or motivation to fast. Here is how a few women described their *mothers’* and *grandmothers’* influence:

KAMA (18): “S: Oh, when I was very little, we were on vacation, we went to my grandma’s with my sister and she made us—for a week before Christmas...something like that—fast.”

GERGANA (28): “G: I began fasting about 4-5 years ago. My mom had started [fasting] earlier and she said she felt great and I decided to try it.”

SOFIYA (81): “S: I remember...I was in the second grade, wasn’t I? We were little and were fasting, and grandma was very strict. We were literally starving! And in the morning at church, wow...a lot of people, it was *so very* beautiful! *I: How old were you then?* S: I was in the second grade, so 8-9 years old. *I: And was your grandma the more religious of...?* S: My grandpa as well, but he had a nasty character and this [fasting] simply didn’t suit him [his personality], but grandma was a saint! And we went—grandma took us...all the kids—to church...and in front of the church, at the entrance of the church—a rambler [uses “*asma*” an archaic, dialect Bulgarian word for vine] *I: What is a rambler?* S: A vine. *I: Ummm.* S: And all those plump grapes that the vine bore, you know, how they all get huge in August. And I went and took just one grape and put it in my mouth. And oh how I cried so much, because grandma said ‘now you won’t get Communion [uses “*konkam*” an archaic dialect word for Communion, not directly translatable in English], we won’t get you Communion now, because that’s a sin’...to nibble on something else [other than the Eucharist] prior to Communion. But the other grandmas were like ‘Oh, come on now, she’s just a kid’. Oh my, such an experience!”

Outside of the family context, women discussed being influenced by and (in some cases) learning about fasting from their *friends* and *peers*:

GERGANA (28): “*I: So what was your motivation at the beginning, to start fasting—what made you do it?* G: My mother was very pleased and my girlfriends too, and I decided to try it too.”

POLINA (29): “P: No, I have a friend, a priest, we were talking about it [fasting] and he made me excited about it.”

SOFIYA (81): “*I: And among your friends, I mean did people around you fast?* S: They did and we all received Communion together.”

Unlike personal motivators (i.e., other people), societal catalysts were rather abstract in nature—for instance, passively following the *cultural tradition* of fasting or actively engaging in the

purported “fashion craze” for fasting in Bulgaria that some of the interviewees cited. One woman talked about being motivated to fast simply by the fact that a traditional fasting period had begun (see also “Conditions: Aids and barriers for fasting; Fasting aids”):

DANIELA (28): “*I: What was your motivation back then [when you first began fasting]? D: It happened to be time for the Easter fast.*”

Another woman would link her early fasting experiences to traditional holidays as follows:

SOFIYA (81): “*S: We would go...especially when Dormition time came around...I: Yes, tell me more about the way you used to fast. S: When Dormition time came around we went to our village. We went there during the summer vacation and spent the whole summer. And prior to Dormition you fast strictly.*”

The idea that modern-day fasting may appeal to certain individuals by virtue of being a *fashion craze* also emerged from the narratives (see “Prerequisites: Meaning of fasting” and “Prerequisites: Motives for fasting”). As I mentioned previously, this fasting fashion was linked to a popular perception that fasting can be used for weight loss. Although most women denied personally engaging in such a fashion, they spoke at length about its potentially deleterious hold over others and especially over younger girls:

NELLY (44): “*I: What do you think is their motivation for fasting, other than a trend of a sort, because they all do it...N: I think there’s simply a fashion craze...[]...nowadays there happen to be many girls that say ‘I’m going to fast’, just because it’s like...perhaps...fashionable to say that, but at the same time they don’t do it [fasting] properly. And this [fasting] is related to faith, in my opinion, and should not be abused.*”

MONIKA (52): “*M: There’s some kind of a fashion for fasting in the last 5-6 years, but generally they [people] don’t follow this [fasting]—neither in its thorough, nor its correct form. They say they’re fasting... I have acquaintances that eat and drink everything during the fasts, they like eating, but take some cleansing pills and call this fasting—cleansing their bodies in that way. [] I: You feel that when Bulgarians fast, they do it for the purpose of physical purification of their system...why did you call this a fashion? M: Because that’s exactly how they see it, they influence each other, young people in particular...*”

7.3.4. CONDITIONS: LEARNING TO FAST

These participants learned about fasting by using several interrelated approaches, which I tentatively grouped into learning processes, learning contexts, and sources of information about

fasting. First and foremost, gaining knowledge about fasting was conditional upon motivation and interest in fasting. Not surprisingly, women who had fasted at least once before in their lives were much more knowledgeable about the practice compared to women who had never fasted. Nevertheless, even non-fasters were fairly familiar with the practice by virtue of witnessing their family, peers, or friends' experiences and, of course, simply by being immersed in and a part of Bulgarian culture. Contexts of learning varied from the familial—e.g., in the *family*, in the *village*—to the social—*at church* and (in modern times) on *the Internet*. Correspondingly, sources of information within the familial context were participants' spouses, *mothers*, *grandmothers*, or *sisters* who, as previously explained, often also inspired fasting behavior. For instance, Monika (52), an occasional faster, pointed to her *husband* as a source of knowledge about fasting. Similarly, even though she herself had never fasted, Eva (28) was familiarized with fasting after observing her *husband's* practice:

EVA (28): “E: I’ve no capacity when it comes to fasting...[]...I don’t know if this is correct, but I kind of remember my husband stuffing himself with potatoes and rice [while fasting]. []...Hmm, there’s I think a difference between the various types of fasting... []...Generally I...my husband had tried complete fasting, you know...*I: Restricting all animal...[products]? E: Yes, yes...*”

Additionally, Daniela (28) recalled learning about proper fasting from her *sister* years after her first experiments with fasting as a teenager:

DANIELA (28): “*I: Where did you seek advice, how did you learn to fast, in what ways?* D: As funny as it sounds, from my sister, because she was very much excited about it and had researched everything.” *I: Was this in the 11th grade, or...?* D: No, then it was somewhat...I can’t tell you how I learned back then, whether she fasted or not. But when I consequently decided to do it [fast], she [my sister] had the concrete information.”

Along with acting (in some cases) as motivators for fasting, *mothers* and *grandmothers* were consulted for specific information and instructions about the practice. Oftentimes, grandmothers were key instructors, because they were most intimately acquainted with cultural and religious traditions. In this sense, grandmothers were the most significant keepers and carriers of cultural knowledge and

memory. As an illustration, Svetla (28) explained that she sought advice from her *mother* and *grandmother*, both non-fasters currently, who were nevertheless knowledgeable about the practice:

SVETLA (18): “*I: When you did fast...there...for certain periods of time, where do you seek advice? How did you learn to fast?* S: Well, my mother is familiar with these things, although they don’t fast at home. I’ve also repeatedly asked my grandmother. *I: So, your family.* S: Yes, especially my grandma, she follows [the traditions for] the holidays, the Church ones. *I: Does your grandma fast?* S: No, but... *I: She does everything else...* S: Yes! And she’s familiarized [with the tradition].”

Similarly, Gergana (28) initially looked for advice from her *mother*, but later on customized her practice as she gained knowledge and experience:

GERGANA (28): “*I: When you were developing your fasting practice where did you seek advice about... what to do, how to fast, how did you build your routine?* G: I developed it myself. Every fast I’ve been selecting for myself what to do and how to do it. From my mother...I’ve somewhat considered what I’ve been told about fasting, but overall... it’s to a great extent a feeling.”

Sofiya (81) talked about her childhood experiences of fasting “in the village” where her grandmother lived. The *village* was a context in which tradition was learned close to the source:

SOFIYA (81): “*I: Where did you learn these rules [about fasting]?* S: From my grandmother. *I: She taught them to you.* S: Yes, my mom wasn’t religious. *I: She didn’t fast, is that right?* S: Only when she got older she fasted. Perhaps on Fridays.”

Alternately, within the social context interviewees reported using *peers* and *friends* as information sources, as well as consulting *priests* and *reading books* or other *spiritual materials* to gain knowledge about fasting. While most interviewees recognized the religious origins of fasting, there were different degrees to which they considered faith or religious sources for their fasting experiences. Milena (77) learned about fasting in *church*, by *observing the devout*, as well as by following the *priest’s* instructions and *reading books*:

MILENA (77): “*I: How did you learn how to fast?* M: Well, from people... *I: Acquaintances?* M: The devout, in church... *I: Ummm.* M: And the priest... whatever he’d tell me. *I: I see.* M: Whatever I’ve read... in books.”

Fasting and religion were similarly interconnected in the mind of Nelly (44), a non-faster, who attributed her generation's overall lack of knowledge about fasting to secularization during the communist period:

NELLY (44): "N: This thing [fasting] has never been explained to us, we're such a generation, you understand... Back in the day [during communism], it was more or less forbidden [to people] to go to church. But fasting is explained at church, I think..."

In contrast, Yoana (19), another non-faster, believed her secular mother (who was approximately the age of Nelly) learned about fasting by reading *spiritual materials*, but not by direct instruction from a priest or at church:

YOANA (19): "Y: My mother is an incredibly well-read person, she reads a huge number of books and I suppose that's how she got the gist of this [fasting]."

Likewise, when asked if she consulted her priest friend about fasting, one of the young adult participants said she turned instead to *the Internet* for advice. Polina (29) received specific instructions (such as fast-friendly recipes and menus) and support from a group of women on a fasting-themed web forum:

POLINA (29): "I: *Did you seek support and advice about fasting from your friend, the priest?* P: No... A group of us gathered to fast on the Internet...to whip up [incite] each other. The hardest part was choosing a menu for 40 days."

In summary, regardless of the type of context, women learned about fasting by the processes of *direct instruction* from a family member, a friend, a priest, or relevant written materials (e.g., books or websites/web groups) and/or by *modeling* the fasting behavior of family, peers, friends, or other religious or non-religious fasters. As Silva (19) explained, learning how to fast happened simply by being part of Bulgarian culture:

SILVA (19): "I: *Where did you look for advice...how did you learn how to fast?* S: Well, the way everyone knows, the way it's customary...I: *Uhhh, so you didn't seek specific advice, you simply...*S: The way it's routine in society."

7.3.5. CONDITIONS: AIDS AND BARRIERS FOR FASTING

In addition to learning how to fast, a number of intervening conditions hindered or, conversely, aided women in their fasting practice.

7.3.5.1. Fasting Aids

Fasting aids were internal or external factors or circumstances that helped women succeed at fasting. Individuals' *nutritional preferences* or their degree of *health consciousness* were examples of *internal* factors, whereas support for fasting from one or a group of individuals were external aids. For instance, fasting came easily to Silva (19), because her *nutritional preferences* happened to be in line with the dietary demands of fasting (an internal aid). At the same time, by making Lenten meals readily available, the participant's mother facilitated her daughter's practice, as the effort needed to carry it out was notably reduced (an external aid):

SILVA (19): "S: ...but I don't eat a lot of meat in general, I don't eat lots of cheese or yellow cheese either, I don't eat butter...only olive oil...so... []... I: *So you were curious because of him [her father]...you'd say you tried fasting, because you were curious about what your father was doing?* S: No, I fasted, because I don't like eating meat, I mean I don't like eating large amounts of it, and that's exactly when... that's the only period in which my mom was cooking for dad a lot, you know, rice, vegetables, which I really love, so I started [fasting] along with him [her father]."

Additionally, fasting may have been much easier for *health conscious* women with a pre-existing penchant for dietary restraint (an internal aid). As one interviewee put it:

YOANA (19): "Y: ...the sheer fact that you've decided to fast, I think, means that you're generally interested in what you eat..."

Lastly, along with providing needed information about fasting, *the Internet* (more specifically, a fasting-oriented female forum) served as a source of moral support and inspiration for one of the participants (an external aid):

POLINA (29): “I: *Did you seek support and advice about fasting from your friend, the priest* P: No... A group of us gathered to fast on the Internet⁷...to whip up [incite] each other...”

7.3.5.2. Barriers to Fasting

Women had to overcome a number of obstacles in order to initiate, maintain, or complete fasting. Like aids, fasting barriers could be internal and external in nature. Internal barriers were factors such as the woman’s low *oral control* (i.e., low dietary restraint)—her inability or lack of interest in restricting her dietary intake (in terms food amount or type), or her poor health condition—feeling physically *weak*, that compromised her fasting:

SVETLA (18): “S: ...I like to eat, I don’t like restraining myself...[]...Only plant-based foods as a whole. But I can’t eat this way.”

POLINA (29): “I: *Why was your pervious [first] attempt [at fasting] unsuccessful?* P: I’ve always thought that I’m not a carnivore, but I discovered [by trying to fast] that I cannot go a long time without eating meat...[]...personally, it’s hard for me to handle fasting...”

SOFIYA (81): “S: Now I don’t fast [as I used to, strictly]. Now I’m just trying to fast. I try, but there were days in which I was very weak. And fasting exhausts the body. So I started eating whatever I should and shouldn’t have...”

Conversely, external barriers for fasting were financial or family *commitment* issues—i.e., *higher cost* of food while having to create *separate menus* for other family members, as well as *low availability of fast-friendly foods*, which made it difficult for a woman to fast, because “they put stuff coming from animals in everything.” Additionally, as one woman explained, *religious expression was forbidden* during communism when she grew up, thereby making it even more difficult for her generation to learn about or engage in fasting:

EVA (28): “I: *Have you ever fasted?* E: No, I can’t make it through. When I feel like eating something [implying it’s hard to resist cravings]...[]... I: *Do you think fasting is hard to do, generally speaking? Because for you...if you feel like eating something, you wouldn’t be able to resist the urge; you think it [fasting] would require more willpower or just that...?* E: Well, for doing this [fasting] you’d have to completely change your eating habits. If you’re single, that’s OK...You’d be buying things that are, like, only for yourself... you can do it [fasting] by yourself. However, if you’re, for instance, like me—with a son, this means I’d have to do two different... things...things, you know, two separate bills... Yeah, I mean if I decided to fast, like I’d have to think for myself—what I can eat—then I have to think for him [her son], you understand I can’t tell him ‘you won’t eat this and that, ’cause we have to fast,’ you

⁷ The website this participant is talking about is www.bg-mamma.com.

know, and I'll have to think about buying things separately. *I: Yes.* E: That's it, fasting is a commitment. It's not as easy as saying 'I won't eat meat' and that's that. *I: I understand, it's more complicated. Especially for you since you have to think about somebody else in addition to planning for yourself.* E: That's correct."

NELLY (44): "Back in the day [during communism], it was more or less forbidden [to people] to go to church. But fasting is explained at church, I think..."

7.3.6. PRACTICE: FASTING RULES AND EXEMPTIONS

Interviewees described several different types of fasting rules, which ranged from relaxed to very strict depending on the intensity and degree of rigidity of the practice. Moreover, women talked about fasting exemptions—the conditions under which an individual was to be excused from practicing.

7.3.6.1. Practice Rules

A number of fasting rules dealt with dietary intake control—*food (and drink) types* that an individual could or could not consume while fasting. The strictest form of fasting was avoiding all *animal products* for the duration of the entire fast, including the restriction of *vegetable oils* in the last 3-7 days of fasting. Two elderly women—both of whom were religious—and a woman in her late 50s reported fasting this way—the former two in their youth and the latter currently:

MONIKA (52): "M: On certain occasions... I don't eat any meat, whenever I've decided that I can do a strict fast, I've done that as well. *I: What do you mean by a strict fast?* M: Vegan food—no proteins, only nuts, no animal products like milk, eggs...*I: Plant-based oils?* M: In general we [in the family] don't eat too much [vegetable oils]. When it's the last week of the fast...for the most part during the entire fast we eat beans, lentils, peas, rice, cabbage—things like that; but in the last week all these dishes are cooked without even a drop of oil... plenty of herbs and spices, and they're all very delicious, and everybody eats them [those dishes]."

MILENA (77): "M: Well, it was 40 days or so...fasting...it was the first week...and the last week I wasn't supposed to eat even [vegetable] oil...*I: Even [vegetable] oil. What are you supposed to eat during the first and last week?* M: Only...exclusively plant foods. *I: So, fruit and vegetables, what else?* M: Well, green beans for instance...legumes."

SOFIYA (81): "*I: What does it mean to fast strictly? Tell me more about this.* S: You don't eat butter, you don't eat eggs, you don't eat milk or yogurt. Anything that has these [animal] fats. *I: How about plant-derived oils?* S: Plant-derived oils—vegetable oil. You can eat [vegetable] oil."

You eat [vegetable] oil, but three days before taking Communion you don't consume [vegetable] oils as well."

The rest of the participants—all of whom were relatively younger—did not mention a *vegetable oil* restriction when asked to explain the meaning of strict fasting. Strict fasting for them meant only the exclusion of animal foods and products:

SILVA (19): "S: Well, I didn't eat meat, cheese, yellow cheese...*I: I see.* S: The way... the usual way a fasting goes..."

DANIELA (28): "D: So this means to exclude meat and dairy altogether, proteins in general... *I: I see. Meat and dairy, how about animal products...as a whole?* D: Also animal [products], completely...absolutely. [] You switch to potatoes, cucumbers, whole wheat bread, olives, and water."

The same rules were repeated when interviewees described their observations of others' fasting. Even non-fasters had a good idea of what dietary rules were to be followed during a fast:

YOANA (19): "Y: I've heard many things, but my personal opinion is that you shouldn't eat animal products. Many people simply don't eat meat, but eat fish, milk, eggs, cheese, however, my thinking is that if you do fast, you should fast the proper way—you shouldn't eat any animal products. *I: Have you ever fasted?* Y: No."

EVA (28): "E: ...there's complete fasting, that's when you don't eat anything that originates in an animal. Generally I...my husband had tried complete fasting, you know...*I: Restricting all animal...[products]?* E: Yes, yes..."

Only one young woman, Svetla (18), commented that: "there are people that fast by only consuming water." This was by far the strictest described fasting practice in all narratives. When it came to actual, personal behavior, none of the fasters that I interviewed partook in such a radical form of fasting. In fact, very few interviewees fasted even as strictly as avoiding all animal products.

In most cases, women willingly modified the traditional (religion-based) fasting rules to fit their knowledge and understanding of fasting, as well as their capabilities, preferences, needs, and goals. Even if women were well aware of the traditional dietary rules, they chose to not abide by them—non-conformist, customized fasting practices following flexible rules were the norm. This relaxed form of fasting, in its dietary intake variant, included dietary restriction behaviors from avoiding only meat, but consuming fish or other animal products, to substituting *fasting pills* (that

presumably had the same cleansing effects for the body) for all dietary restrictions (see “Prerequisites: Meaning of fasting; Alternative meanings”). On one occasion fasting simply equaled a brief bodily *cleanse*, similar to a cleansing diet (see “Prerequisites: Meaning of fasting; Alternative meanings”). Here is how some of the fasters described the dietary rules they followed:

SVETLA (18): “S: As far as I’m aware, I think that when you fast you’re forbidden animal products. Thus—no meat, no eggs, no milk. Only plant-based foods as a whole. But I can’t eat this way. I: *You said you had fasted before...* S: For instance, I emphasize the intake of fluids, lighter foods and the like. I: *Lighter in what sense?* S: Well, lighter [foods] such as soups, bouillons, fruit, salads and such things.”

GERGANA (28): “G: I started years ago with my way of eating, I said ‘no meat for 40 days!’ Next fasting period I began avoiding dairy products as well. I’ve had fasts in which I would start without meat and chocolate—what I’m addicted to—the first 20 days I would eat milk, yellow cheese, it just depends on how I feel.”

Non-fasters witnessed fasting rules that were quite similar:

YOANA (19): “I: *Do you know any fasters?* Y: I’ve heard about some [fasters] and also my mom has fasted a bit, but she simply didn’t eat meat. Otherwise, she ate fish, eggs, cheese.”

EVA (28): “E: Hmm, there’s I think a difference between the various types of fasting...there’s, you know, a fast, in which you don’t eat meat or something else there...[] Most people I know fast this way...for instance they try to limit meat consumption and eat more vegetables, cheese.”

However, there was a tendency for non-fasters to disapprove of fasting practices that were unduly modified and simplified. Such fasting behavior was considered superficial, thereby inappropriate:

NELLY (44): “I: *What do they do in terms of dietary habits...in terms of foods?* N: Basically... there’s a contradiction. So, she eats cheese, but wouldn’t eat meat. But isn’t cheese also an animal product, milk too?! You drink coffee with milk... But that’s powdered milk [they argue]... Oh, come on! Let’s make things clear, shall we [interviewee is laughing ironically]?”

In contrast to the type of food (and drink) consumed, the overall *amount of food* during a fast was usually not restricted by the fasters I interviewed. Interestingly, most interviewees thought of regular Lenten (i.e. vegan) food as non-satiating and reported having experienced or observed increased appetite during a fast (see “Personal beliefs: Nutrition and health”). However, fasters who grew up in a time (e.g., between the two World Wars) when food was scarce did not seem to overindulge in food while fasting (or in general), perhaps because they had learned to revere food

and therefore control their intake to preserve it. *Moderation* seemed natural for these women. As Milena (77) explained, she was always “satisfied by little” and her body didn’t crave food excessively during a fast, despite the lack of restriction on the amount of food she could consume:

MILENA (77): “I: *How about the amount of food eaten—was that restricted during this fast...a stricter fast such as this one?* M: No, it wasn’t restricted, but the body doesn’t ask for more than it needs. I: *It doesn’t ask for more. Uhmm, I see. So one shouldn’t eat in excess...like some who overindulge in...* M: No, no, you shouldn’t.”

Likewise, Sofiya (81) recalled near starvation while fasting as a child and attributed it to the vegan nature of Lenten food, but also hinted at the general scarcity of food at the time. For example, prompted by a question whether fasting could have been used for weight loss purposes in the past, she asserted that weight loss wasn’t a real issue in her childhood, whereas food insecurity was:

SOFIYA (81): “I: *What did you eat, you said you used to starve, almost? What do you mean by almost?* S: Well, almost, because all food was Lenten [the type of food, i.e. vegan food]. We were wolfing down beans and Lenten soups—from nettles, beets, from the leaves... I: *Uhmm.* S: ...only with a little bit of flour. The flour baked and water, and that’s what we munched. [] Back then, Rosa, overindulgence didn’t exist the way it does now. God! Cheese, what cheese... where do you get it from?! Yellow cheese... I: *So people back then weren’t as interested in losing weight, because they weren’t heavy and there was less food. In fact, they [people] needed to eat more.* S: Exactly I: *How about nowadays?* S: Nowadays things are different. There are plenty of foods now, tempting and such. There are people who love fatty foods, love cheese a lot.”

On the other hand, younger fasters (all of whom were born and grew up in a relatively richer and more secure food environment) struggled to manage their appetite during and after the completion of fasting. For these reasons, for many participants fasting was ineffective as a weight loss strategy (see “Weight control issues and fasting”). As an example, Silva (19) and Daniela (28)—both fasters—discussed having an *increased hunger* and thereby eating larger than usual amounts of food while fasting. Daniela (28) went on to attribute these increases in hunger to “the psychological moment... that you haven’t been fed if you didn’t have meat...” In similar fashion, non-fasters like Nelly (44) noted that most fasters treated fasting as a diet and consequently got trapped into a vicious cycle of restraint followed by bingeing:

SILVA (19): “S: Well, because you are actually eating, again a lot, for instance...you eat rice, you eat peas in greater amounts, so you fill in the emptiness left by not eating meat and similar products, and you compensate with something else.”

DANIELA (28): “D: Yeah, because then I kind of have to eat more frequently, because you get hungry faster when you eat potatoes without meat, without cheese or something else with them...Like the next time I get hungry is inevitably in 3 hours.”

NELLY (44): “N: So this [fasting] is...you simply make up a diet for yourself—20 days you diet, 5 days you eat like you’re insane [laughing], ‘cause you’re just so very hungry [laughing].”

In addition to dietary intake rules, a set of fasting rules dealt with the *duration* of fasting—i.e., the number of days a practice lasted. As was the case with dietary rules, duration rules were imposed with different levels of intensity—strict fasting lasted between 40 (usual duration) and 45 days, while *relaxed* forms of fasting spanned a shorter period of time. The duration of fasting differed among women, as well as across each woman’s lifespan, depending on factors such as age, *health* condition, and *oral control* (dietary restraint) capabilities. One example is Svetla (18) who fasted only for a few days, because she found it very difficult to restrain her dietary intake:

SVETLA (18): “S: ...just for a few days...well, it happened for instance...I haven’t been able to make it for the entire fast, but for example for a few days before that...[] I: *So at the times of the regular fasting periods...you didn’t fast for their entire duration, but for just a few days.* S: Yes.”

Another participant, Monika (52), fasted *partially*, while her husband practiced *strictly* for 45 days (i.e., this is among the longest traditional, religion-based fasting periods). In fact, she believed her husband was being excessive in his fasting habits. Because she considered this excess potentially unhealthy, along with her conviction that the duration of fasting should be abbreviated if an individual engages in sports or strenuous activities (see “Practice: Fasting rules and exemptions; Practice exemptions”), Monika (52), a group exercise instructor, had decided to fast for only 10 days:

MONIKA (52): “M: When he [my husband] strictly fasts for 45 days, I fast for 10 days. Not the entire fasts and I even feel that what he does is a bit too much.”

Monika (52) also expressed the belief that fasting should be done based on “a personal assessment, as long as you think you are capable of...” This same idea was reiterated in other narratives,

including that of Gergana (28), who fasted regularly, but varied each of her practices (from strict to more relaxed) depending on how physically prepared she felt:

GERGANA (28): “G: I decide how many days [to fast], but in some cases I’ve fasted for 40 days... []...The two fasts are usually very close to each other and when you complete an entire fast during the winter, in the spring you’re already exhausted, and then I typically do it only for 20 days.”

Strict fasting used to be practiced by Milena (77) and Sofiya (81), however, both women modified their practice as they aged—Milena (77) discontinued fasting altogether, while Sofiya (81) practiced for shorter periods of time:

SOFIYA (81): “S: For Easter, the entire fast, no...*I: Forty days, is that right?* S: No, can’t make it [this long]. But the first week I fast strictly and then take Communion.”

A third kind of rules had to do with *fasting episodes*—the different instances over the course of a year in which fasting was to be practiced. All participants, even those who had never fasted, like Nelly (44), were familiar with the two longest *traditional fasting episodes*—those prior to the major Christian holiday feasts—Christmas and Easter:

DANIELA (28): “*I: And what do you do when you fast, can you please describe exactly what you did?* D: Well...I follow...I follow the calendar, really... *I: You mean the Easter and...* D: And also the Christmas fast. Only these two [fasts]. I know there’s another fast. But I’m not sure when and what kind it is.”

NELLY (44): “N: Well, in summertime I don’t exactly know whether there’s any fasting...Mainly Easter—there’s fasting before Easter, there’s fasting before Christmas...”

In case of period rules, the stricter the fast, the more it overlapped with traditional fasting episodes. However, for one person, fasting was *non-traditional*—relaxed in a sense that it happened outside of the traditional period boundaries. It is important to mention that this individual identified as having no definite beliefs—she had faith, but was not religious:

KAMA (18): “K: ...But I don’t think this should be only for Christmas, Easter, etc. If a person wants to cleanse him- or herself, s/he could do this without [traditional] fasting; it’s not a matter of what you eat... []...Oh, yeah...here, in this sense fasting can be seen from this perspective—like, you know, cleansing of the organism. Everybody does this, every organism needs cleansing...for instance I do it for 2-3 days.”

Although religiousness generally guaranteed more thorough knowledge and stricter adherence to traditional fasting, it was only the elderly participants who mentioned and/or adhered to less *popular* fasting episodes, such as the two-week period before Dormition, as well as the fasting occurring on Wednesdays and Fridays:

MILENA (77): “M: They also say you should fast two days per week in addition to the regular fasts...all of this I consider normal...beneficial.”

SOFIYA (81): “I: *Alright. How do your religious beliefs influence your way of eating?* S: For instance, the days put aside for fasting; for example Wednesdays and Fridays. I: *Do you fast on these days?* S: Not strictly, but I try to. Especially Fridays...[] When Dormition time came around we went to our village. [] And prior to Dormition you fast strictly. I: *Ummm. When was that?* S: It [Dormition] used to be on the 28th of August.”

Another set of rules revolved around fasting *frequency*—the number of times per year interviewees actually engaged in fasting behavior. In terms of fasting frequency (excluding non-fasters) the fervency of a practice ranged from relaxed—fasting only “once successfully” to “two or three times” over the lifespan—to strict—a few times per year to every *traditional fasting period*. Below are a few examples of *stricter frequency rules*:

GERGANA (28): “I: *I saw you’ve written [in your survey] that you fast regularly...* [] G I began fasting about 4-5 years ago[]...I follow two fasts—before Christmas and before Easter. Same as usually...”

MONIKA (52): “I: *Otherwise, do you fast frequently?* M: I fast almost every year, but a little bit at a time [for a short duration of time]...[] I: *And you usually engage in fasting once [per year]...?* M: Not all of them [the regular fast periods].”

SOFIYA (81): “S: When I was a young girl, I used to follow every fast. [] I: *So in your youth you fasted regularly, is this correct?* S: Yes, correct.”

In addition to all practice rules described above, one last realm of fasting rules pertained to the restriction of other—*non-dietary*—kinds of earthly pleasures, such as alcohol and sex. While a fair number of interviewees recognized the dual (spiritual in addition to physical) nature of fasting, only two women (an agnostic and a woman with no definite beliefs) detailed non-dietary, rather spiritually inclined rules. Here is Nelly (44), an agnostic, discussing the fasting habits of others:

NELLY (44): “*I: What do they [fasters] do...more or less?* N: What do they do, hmm?...For instance, what fasting includes...well, fasting involves—other than not eating certain foods—it involves not having sex and such things...not having alcohol....[]...They, first of all, drink alcohol; secondly, have sex, etc. But afterwards run to church, cross themselves, and confess to the priest, which I don’t know if it exists in our religion....the confession part....whatever [laughing].”

7.3.6.2. Practice Exemptions

Exemptions from fasting were less frequently mentioned among participants compared to fasting rules. Fasting exemptions were conditions that rendered fasting inappropriate and served as an excuse from practicing for certain individuals at certain times. The fewer excuses were made, the stricter a practice was. The strictest form of fasting described by the interviewees allowed only for *severely sick people* to be excused from fasting. This is consistent with the traditional, religious views on fasting (Alexiev, 2008). For instance, Sofiya (82) who used to practice strictly even as *a child*, shared the following story from her past:

SOFIYA (81): “S: Sick people did not fast. *I: So you should be healthy in order to fast.* S: Yes. *I: And if you’re healthy and do fast, is fasting healthy?* S: It’s healthy, but if you’re sick—it isn’t. Especially...well, this exists now as well, but back then there was a lot of tuberculosis. *I: People with tuberculosis did not fast.* S: No. There was a very gentle woman. With a very fragile organism and gentle looks, and she got sick from tuberculosis. It started with clouding of her lungs, etc. Afterwards ...this causes death. And it’s terrifying! *I: So she got sick and thereby did not fast.* S: That’s right. And I know my grandma would give her all that was the greasiest and the best. The soup’s bouillon, she [grandma] would give to her, because it [the bouillon] is strong.”

Although religious tradition condones fasting among children older than 7 years of age (Alexiev et al., 2008) and a few participants, including Sofiya (81), recalled fasting in their childhood, some interviewees willingly relaxed fasting rules for their *children*, because they believed fasting was inappropriate for them. One such interviewee, Polina (29), who admitted to fasting non-religiously, explained:

POLINA (29): “P: ... The hardest part was choosing a menu for 40 days. Because...imagine having to feed a family of four! You have to take this into account. *I: So when you fasted you included the entire family?* P: Well, yeah. But for the kids—eggs, cheese, I didn’t see it as necessary for them to fast in the same fashion as myself. *I: How about your husband?* He can

do whatever the heck he wants. He has lunch on his own. In the evening there's beans! *I see. But he didn't fast along with you.* No, but I was considerate of their menus. But on the whole, for these 40 days my entire family consumed much less meat. I had none.”

One interviewee added that *athletes* and people who endure *strenuous physical activities* were excused from fasting, which she believed was part of religious dogma. Formal sources, however, state that athletes are not excused from fasting (Alexiev, 2008). These were perhaps the reasons she relaxed her practice to cater to her occupation as a group exercise instructor:

MONIKA (52): “M: In the Bible itself, in the Gospels, it's stated that a person who strenuously exercises or performs some kind of intense physical labor, he or she can be excused totally freed from fasting, but it's nice to cleanse the body...”

Overall, the finding that women mentioned so very few exemptions to fasting had much to do with the widespread notion that fasting was a generally safe and healthy dietary activity. Indeed, participants' narratives confirmed my impressions of overwhelmingly positive attitudes toward fasting among Bulgarians (see “Prerequisites: Attitudes towards fasting”).

7.3.7. OUTCOMES: BENEFITS AND DETRIMENTS OF FASTING

Fasting behavior was associated with a number of outcomes—positive or negative consequences that women experienced (in the case of fasters) or imagined they would experience (in the case of non-fasters) as a result from fasting. Outcomes perceived as positive by these participants were labeled as benefits, whereas negative outcomes were labeled as detriments. The weighing of benefits over detriments played a major role in the decision-making process behind fasting. Whenever a woman believed that the benefits of fasting outweighed its detriments, these imagined benefits served as a motivation for her fasting behavior (see “Prerequisites: Motives for fasting”). Not surprisingly, the kind of outcomes a woman anticipated from fasting depended on the meaning she vested in fasting (see “Prerequisites: Meaning of fasting”), as well as her inner motivation to practice. As a consequence, fasting outcomes varied in nature from mostly physical to mostly spiritual.

7.3.7.1. Fasting Benefits

Fasting outcomes that were reported to have benefited a woman's body or appearance made up the physical benefits category. The following physical benefits were cited by the interviewees: increased *energy*, *sensation of lightness*, *disease prevention* and *health promotion*, improved *quality of life*, *being fit*, improved *complexion*, *longevity*, and *fresh appearance*. *Cleansing and purification of the body* was seen as a major benefit from fasting and thereby a fasting motive for a large proportion of these interviewees, regardless of whether they had fasted or not. In fact, for many women fasting meant cleansing one's body from toxic accumulations (see "Personal beliefs: Nutrition and health") by giving it a physical *break*—time to rest and recharge (see "Prerequisites: Motives for fasting"). Cleansing the body was indeed the basis for all other physical benefits of fasting. Having a "clean" body was indicated by a *fresh appearance*, a beautiful, glowing *complexion*, and the *sensation of lightness*. A refreshed body was also linked to maintaining a shapely figure (i.e., *being fit*):

SVETLA (18): " S: I know that fasting is being used to cleanse [purify] the body....[] I: ...*You mentioned cleansing of the body, that's how you understand fasting. What kind of cleansing do you have in mind?* S: Well, I think, for instance, about cleansing the body from toxins, from accumulated food. Something like that...[] And perhaps because of this cleansing [as a reason for fasting], because afterwards you have a fresher appearance. I: *Fresher appearance? In what sense?* S: Well, like, as far as I know your skin gets more luminous and...like...you feel somehow lighter. I: *Uhhh. So you wouldn't say there are particular spiritual reasons for your fasting, it's rather the physical factor.* S: [Nods]. I: *Alright. Now I'd like to ask you about some effects that fasting might have on your figure and body. You said you'd usually lose a kilo or two [while fasting], but otherwise there's no notable effects.* S: Nothing drastic. I: *And [you mentioned] getting a more luminous complexion...* S: Yes. I: *...and feeling lighter and better. And these you consider benefits from fasting.* S: Well, of course. I do."

YOANA (19): "I: *Describe some of the effects you think fasting may have on your figure or weight?* []...for a person who generally eats lots of meat, it's really nice to have a period within the year—a large one—in which meat is not consumed so that the body cleanses and purifies itself. []...[A benefit is to] remain in good shape, because each change in your dietary regimen somehow refreshes your body."

Similarly to Svetla (18), a few more women mentioned experiencing a *sensation of lightness* as a consequence of their fasting. One of these women—who referred to her own experiences, as well

as her observations of her father's fasting—described the sensation of lightness as a subtle, almost imperceptible by others feeling of wellbeing, which she compared to having an “aura”:

SILVA (19): “I: Describe some of the effects that fasting may have on your figure, weight, appearance; whatever you think may be affected by fasting? [] Yes, we’re talking about benefits. S: Well, I think you’d feel—it’s not even an outward change—but you feel better. [] I: So did he [your father] really feel better afterwards? S: Well, we didn’t discuss it, but it was obvious, he felt better, I think, yes. I: You mean in terms of appearance or? S: No, like his face...his aura, you know, he felt calmer, looked better.”

A pleasant sensation of lightness attested by her mother served to inspire Gergana (28) to begin fasting. This interviewee cautioned against extremes in fasting, which she thought would compromise any of its benefits. Interestingly, she associated the sensation of lightness she gained by fasting with feeling physically energized and *spiritually liberated* (see “Outcomes: Fasting benefits and detriments; Benefits, spiritual”):

GERGANA (28): “G: ... my mom had started [fasting] earlier and she said she felt great and I decided to try it. [] What I’ve observed in general, since I started fasting, is that it’s good for me....so, I’ve began eating very little meat since then, I just don’t feel the need for it...I try to get in touch with my body, see what its needs are, so... I: Could you explain what you mean by saying ‘it’s good for me’...in what ways? G: When you’re not being drastic, because if you fast for 40 days, sometimes this can be hard. You should be careful how you fast and what you do, what foods you include or eliminate, but it [fasting] does have an effect, because I feel lighter, more liberated. [] But in the end, the result from this fasting is that you feel much more energetic, it’s much lighter and pleasant, and you realize that you really didn’t need some foods.”

Along with Gergana (28), a few other women believed in the energizing effects of fasting, including interviewees—like Nelly (44)—who were non-fasters:

DANIELA (28): “D: I definitely feel better [during a fast], [] I definitely feel more active. I: More lively....D: More lively...more energetic. []... I have more energy. I: More energy. D: I feel more active, that’s what I’d say, I’d mark this [option] for myself.”

NELLY (44): “N: ...you just feel more exuberant...here it is—to have more energy...”

MILENA (77): “M: And I felt more energized. I: Uhmm. M: Even during the fast. [] When I used to fast, I felt my energy, even when...I: Yes. Although at the end you were feeling weak at the knees? M: It was only at the end when it got me...[laughing]. I: To have enough energy...so once you completed the fast your energy came back? M: I got it [the energy], yes...”

A number of related fasting benefits were those concerning women's *health, quality of life, and longevity*. Almost all interviewees agreed that fasting could benefit health by preventing future diseases, or as Daniela (28) tried to explain, at the very least contribute to *disease prevention*:

DANIELA (28): “D: Well, I’d say that in terms of disease prevention and similar areas...disease prevention is perhaps a bit too strong, but doing something for...like a precaution...for lowering cholesterol and so on...here it is, I see it in the list...You know about free radicals, deep-fried foods, preservatives, and other junk... I definitely agree with this [that disease prevention is a benefit from fasting]. I: *So what you’re talking about is disease prevention in a sense that you take some type of precaution...*D: Precaution, yes, not prevention...I: *Alright...we talked about this [going over the interview script].* D: ...because ‘prevention’ in this case [of diseases] is too strong of a word.”

SOFIYA (81): “S: On the one hand, it’s healthy. Because it’s very good to fast, you know, you cleanse your organism. [] I: *I see. But overall what is your attitude towards fasting? As something good, positive?* S: Yes, yes....”

Moreover, a sizable proportion of interviewees believed fasting would improve their *quality of life*, while a few women thought it would also help with *longevity*. The beneficial nature of fasting was conditional upon the extremity of a woman’s practice (e. g., if “done right” meaning that “you don’t get into extremes”), as well as on her overall health-consciousness:

NELLY (44): “N: A better quality of life; quality of life in terms of energy—a sensation maybe...”

YOANA (19): “Y: Better quality of life, I agree with this one as well, because the sheer fact that you’ve decided to fast, I think, means that you’re generally interested in what you eat and for sure this would have a positive influence on you.”

MILENA (77): “I: *To live longer?* M: Who doesn’t want this?! I: *But does fasting help you with it?* M: It does help you.”

All interviewees listed multiple physical benefits from fasting (out of those described thus far). When asked to rate one benefit among their selections as the most personally significant for them, the majority of women chose *health*-related benefits of fasting, for instance several women saw *disease prevention* as most important. For one of these women—Eva (28)—being *disease prevention* and *longevity* were equally important:

EVA (28): “I: *From the two benefits you mentioned [living longer and disease prevention], which one is most significant to you?* E: Well, they’re connected. I: *So you wouldn’t define one as more important than the*

other? E: Well, in general ‘living longer’ depends on how you’re living your life, I mean, if I live long but I’m sick, this wouldn’t be very nice... I: *Uhhh, but if you live a long and healthy life, this would be best...* E: Oohh, yes, naturally!”

Experiencing a better *quality of life* and having higher *energy* levels were mentioned second as fasting benefits of personal significance—both outcomes were cited by a couple of women. Some women, like Kama (18) and Gergana (28), saw these benefits as equally important. Kama (18) proceeded to explain that an improved *quality of life* for her meant an overall sensation of wellbeing:

KAMA (18): “I: *If you could pick only one—the most personally important—benefit, what would it be? What in your opinion would be the most important benefit from fasting?* K: A better quality of life, meaning... I would feel better.”

GERGANA (28): “I: *Among the benefits you mentioned, which one is the most important to you...the biggest benefit, in your opinion?* G: I’m hesitating between ‘having more energy’ and ‘a better quality of life’...I think these are equally important.”

Aside from physical benefits of fasting, women mentioned outcomes that benefited their spiritual wellbeing. Such spiritual benefits were *building a moral character* and feeling *spiritually liberated* from physical dependences. Like bodily cleansing and purification, *spiritual cleansing and purification* was simultaneously a motive and a meaning of fasting behavior, as well as the root cause of all spiritual benefits from fasting (see “Prerequisites: Meaning of fasting” and “Prerequisites: Motives for fasting”). As women’s level of spirituality increased, the allure of spiritual benefits as motives for fasting intensified. For instance, Gergana (28)—an active believer—explained that she was initially drawn to fasting by a desire for experimentation with her body, but later on experienced both physical and spiritual benefits from fasting. Along with cleansing her body, Gergana purified her spirit, which she defined as feeling “more humble” and “more liberated” from the temptation of “all things one is addicted to,” in her case, chocolate:

GERGANA (28): “G:...you feel lighter, more liberated...[]...and you realize that you never needed certain foods....[]...afterwards you feel liberated from that chocolate.”

The idea that fasting humbles the spirit and frees it from dependences was closely related to the concepts of *abstinence from pleasure* and the *building of a moral character*. For a number of participants, fasting was an exercise in abstinence that helped an individual *strengthen her willpower*.

POLINA (29): “P: Fasting...that is related to challenging the body. It’s considered to be abstinence from some kind of pleasure—spiritual and physical—for the purpose of cleansing and purification—spiritual and physical.”

MONIKA (52): “M: By depriving yourself from some sort of pleasure, like gluttony...you harden your willpower.”

Having strong willpower was, in turn, considered a morally superior feature of one’s character. As some of the interviewees explained, fasting played a major role in the processes of *building a moral character*.

GERGANA (28): “G: Fasting is rather related to cleansing and purifying of one’s character— if there’s anything you’re addicted to, you should give it up within these 40 days...[]...you try to do things that change you, not so much eating per se, but the features of your character that will build you as an individual...that’s for the most part the effect, in my view that’s the hardest aspect [of fasting].”

SOFIYA (81): “S: Look, Rosa, others may be... not only the person him- or herself...but also other people think of him or her as, above all, a good person. I: *Ummm. When you fast you’re thought of as a good person.* S: Yes, a good person, a person with principles. After all, to decide to do something and do it with confidence... I: *Ummm. So, [a faster is] a person that has willpower.* S: Yes, mostly willpower. I: *Some kind of an inner strength, is that right?* S: Yes, yes!”

7.3.7.2. Fasting Detriments

In addition to benefits, fasting behavior was reported to be accompanied by several detriments—negative outcomes—that were predominantly physical in nature—harmful to a person’s body, appearance, or physical health. Interestingly, no interviewees saw fasting as harmful in a spiritual sense. Moreover, the detriments from fasting that participants cited were largely outnumbered by the perceived benefits. In fact, a large proportion of women believed “there shouldn’t be any detriments” from fasting, especially when “done right” (see “Prerequisites: Attitudes towards fasting”). This included women of all age cohorts and both fasters and non-fasters.

Despite the finding that fasting was seen as beneficial overall, few interviewees thought so without reservations. Most women believed under certain circumstances fasting could have a number of negative outcomes, including feeling physically *weak*, *deprivation and exhaustion of the organism* from nutrients, including *protein deprivation*, *decreased immunity*, and *appearance deterioration*. All of these were considered detrimental for *health*. To begin with, Milena (77) reported feeling *weak* at the end of her prolonged fasting practice, despite the fact that she did not perceive fasting harmful as a whole:

MILENA (77): “M: At the end I, my legs almost went weak at the knees...I: *At the 40th day?*
M: [Smiling] Yes.”

Similarly, Monika (52) reported feeling less energetic during fasting, while Kama (18), who did not fast traditionally, commented that fasting depleted one’s *energy* (especially if a person was highly physically active), due to a lack of key nutrients contained in meat. Like a few other participants, Kama also believed that this lack of *energy* was a sign of potentially more serious health detriments of fasting:

KAMA (18): “K: ...Be successful in sports or have enough energy: if a person is involved in sports and etc., he needs, like, nutrients that meat provides....and so this [fasting] wouldn’t make him more energetic. [] I: *Can you tell me about some of the detriments from fasting? How could fasting be harmful for a person? In what ways do you think it could be detrimental, or it isn’t?* K: Well, in terms of detriments—it’s one thing not to eat, yet another to fast. I mean a fast... this depletes much more the nutrients your body needs, in a sense that it could lead to diseases, problems...Like, I’ll cite here...you don’t feel so energetic, you know...”

MONIKA (52): “M: ...I feel more exhausted...[]...personally, I lack energy...”

Likewise, although Daniela (28) had never experienced negative effects from fasting, she nevertheless believed that prolonged fasting could deplete and *exhaust her body*, and recommended that fasting be terminated under such circumstances:

DANIELA (28): “I: *Please describe some of the potential effect of fasting on health. Could you comment on the health properties of fasting?* D: Well... I: *By effects I mean detriments.* D: I understood you, yes...well...if it [fasting] is overdone, maybe if it continues too long or if a person starts feeling bad during a fast...feeling light-headed and so on, stopping is the proper thing to do, because this is extreme deprivation in terms of...I: *Nutrients...*D: ...nutrients that a person

needs in any case but...*I: Has this ever happened to you, personally?* D: No it hasn't happened, it definitely hasn't happened to me."

Protein deprivation and avitaminosis were specific forms of nutrient depletion that, according to some participants, resulted from fasting and compromised one's health. Yoana (19), a non-faster, thought fasting could deprive her body from protein and other key nutrients, while Monika (52), a faster, observed that her husband's somewhat extreme practice may have undermined his immunity. In both cases, the interviewees implied that this purported lack of nutrients was a direct consequence of decreases in food variety during a fast:

YOANA (19): "*I: How about detriments—can you think of any?* The body needs the proteins in meat, as well as tremendous amount of nutrients in foods, so prolonged deprivation from such nutrients can lead to some kind of detriments. I can't tell exactly what they'd be, but it's certainly possible."

MONIKA (52): "M: My husband gets sores in his mouth every year during the long, 45-day fast, which is perhaps avitaminosis. [] Quality of life...no [it is not improved during a fast], because dietary intake is less diverse..."

Very few women discussed potential effects of fasting on one's appearance. One of them, Yoana (19), imagined that in addition to compromised health, nutrient deprivation during a fast might also harm one's appearance. Alternately, for Eva (28) the effects of fasting on appearance appeared trivial compared to upkeep of good *personal hygiene*. Not surprisingly, this participant was a non-faster:

YOANA (19): "*I: Alright. I understood that the main detriment from fasting—so you mentioned—is protein deprivation, a health detriment. But in terms of appearance, do you think fasting could be harmful?* Y: Well, different foods definitely affect the skin, the healthfulness you radiate. *I: How do you think one looks when fasting—better or worse?* Y: What can I say, it depends. If you eat absolutely no animal products, you surely can't look too great, because they [animal products] are important for the body and for appearance."

EVA (28): "*I: Alright, how about...thus far we spoke about fasting and health, how about the effects of fasting on one's appearance, does fasting benefit appearance in any way?* E: No, I think you can achieve anything with good hygiene. *I: You mean?* E: Well, I mean that if a person has good personal hygiene, s/he would...*I: I see, you're saying that if he maintains this regimen...*E: Yes, even if you ate as healthily as possible—following all rules, with fasting, without fasting—if you get under the shower once a week, you know, there's no point [smiling with irony]."

7.3.8. PREREQUISITES: ATTITUDES TOWARDS FASTING

As evident from the section above (see “Outcomes: Benefits and detriments of fasting”), most interviewees believed the outcomes from fasting—whether positive or negative—were *conditional*, i.e. fasting was beneficial or “good for you” when “done right,” but detrimental when “abused.” What participants meant by proper (i.e., “done right”) fasting differed slightly among women, depending on whether they gave special importance to the physical or the spiritual aspect of fasting. For most women, it was violating the physical rules of fasting that compromised its beneficial effects. Extended periods of fasting were considered pointless and harmful. Moreover, fasting while feeling physically weak was seen as unnecessary—participants believed that if an individual was *nutritionally depleted*, any fasting could be too harsh on the body:

DANIELA (28): “D: I understood you, yes...well...if it [fasting] is overdone, maybe if it continues too long or if a person starts feeling bad during a fast...feeling light-headed and so on, stopping is the proper thing to do, because this is extreme deprivation in terms of...*I: Nutrients*...D: ...nutrients that a person needs in any case but...”

GERGANA (28): “*I: Your attitude towards fasting is positive, because you think it is healthy and it made you feel energized.* G: I’m ‘for’ fasting if a body isn’t hyper exhausted during a fast... It depends tremendously on the organism, getting into extremes is completely pointless. [] ...If you don’t get into extremes it [fasting] can benefit your health status. *I: What do you mean by ‘getting into extremes’?* G: What I mentioned earlier. If your organism is exhausted, but you nevertheless fast, you don’t...”

MONIKA (52): “M: ...I even feel what he’s doing [fasting for 45 days] is a bit...excessively long... [] ...but It’s nice to cleanse and purify the body...[]...I think it’s good to fast, but only around 20 days or so.”

Additionally, according to one interviewee fasting was beneficial only to certain “intoxicated” individuals who needed it the most. Otherwise, the practice was deemed unnecessary and optional. This reflected a widespread belief among these participants that *animal products* and especially *meat* were somehow *toxic* to the human body (see “Personal beliefs: Nutrition and health”):

YOANA (19): “Y: The overconsumption of meat, I think, is not very healthy, similarly to the overindulgence in any kind of food. However, for a person who generally eats lots of meat, it’s really nice to have a period within the year—a large one—in which meat is not consumed so that the body cleanses and purifies itself. But if a person is like me, for instance, and

doesn't eat too much meat, I don't consider fasting a mandatory factor. But otherwise it truly does cleanse the body somehow."

Conversely, for some interviewees disrespecting or *disregarding the spiritual* aspects of fasting was what transformed fasting from a positive into a negative experience:

NELLY (44): "N: But fasting is explained at church, I think. However, nowadays there happen to be many girls that say 'I'm going to fast', just because it's like...perhaps...fashionable to say that, but at the same time they don't do it [fasting] properly. And this [fasting] is related to faith, in my opinion, and should not be abused. *I: And you think they abuse it.* N: Yes, absolutely [upset]! [] *I: But overall, what is your attitude towards fasting, it seems like it's rather positive...that you view proper fasting in a positive way.* N: Fasting? When it's done right it's great, I think. *I: About most Bulgarians....* N: But when it's done because...just to say you've fasted... *I: Yes, that you fast, yes...? You think it could be harmful in terms of health?* N: Absolutely!"

Intriguingly, regardless of participants' level of faith, there was a tendency among women to attribute the positive health effects of fasting to a purported *spiritual wisdom* governing its design. That is, women believed fasting was wisely designed by religion to follow the so-called "biological clock"—i.e., nature's *cycles and rhythms*—and thereby benefit *health*:

NELLY (44): "*I: Meaning mostly healthy, even...* N: Absolutely, in my view it [fasting] is absolutely healthy. *I: If fasting is done right, would there be any detriments?* N: No, there shouldn't be detriments, I think. There shouldn't be detriments, because if you think about it...when did they fast back in time?...[]...They'd slaughter pigs the whole winter, eat meat. Then they'd cleanse, they'd cleanse in the spring, let's put it this way. And then in summertime they'd start with vegetables and fruit...eating more...*I: So it's meant for cleansing of the body...for health.* N: Well, yes. Heck yeah! It's just logical. *I: Alright....And...there aren't harmful effects, if done the way it should be.* N: It shouldn't be harmful if done properly."

MONIKA (52): "M: People rather want to cleanse their bodies. And there's so much logic and wisdom in this. I think religion itself, centuries ago...that's where this [fasting] came from. In ancient times, for the duration of wintertime people were eating lard, meats... and when spring came around, before Easter, their bodies would get clogged and need cleansing... So humans eventually acquired knowledge that they must cleanse and purify [their bodies], and consequently this [knowledge] got ingrained in religious dogma... That's how I think it happened."

Along with sharing personal views on fasting, women expressed opinions about societal attitudes at large (of course, these were likely colored by interviewees' own beliefs about fasting). Although fasting was generally perceived as positive and healthy, when asked about societal attitudes towards fasting a few interviewees contended that Bulgarians were generally uninterested in proper

fasting (or interested for the ‘wrong’ reasons) as they lacked enthusiasm and *awareness* with regards to nutrition and health:

KAMA (18): *“I: But you see fasting in positive light when it comes to health. K: That’s right. [] I:…But overall what is Bulgarians’ attitudes towards fasting—rather positive, customary, or rather negative? K: It’s customary for someone to fast, but most people don’t deprive themselves from the…the steak, the vodka… especially around holidays. I: So overall there isn’t a negative attitude…it’s considered healthy. K: Well, yeah. I mean… there isn’t a negative attitude, many people do fast.”*

NELLY (44): *“I: I understand… I see… alright. How about Bulgarians’ attitudes…when someone says ‘I’m fasting’, you mentioned this was like a fashion trend…does this mean fasting is admired and seen in positive light or not? What are Bulgarians’ attitudes towards fasting—positive or negative? N: They’re different. I: But as a whole? Is it considered healthy or not? N: Well, people don’t think too much whether it’s healthy or not. That’s how I see it. Whether it’s healthy or not doesn’t matter so much, what matters is to do something that at the moment is… trendy… I: Trendy in a way…? N: Yes, yes… I: I see. There’s not much awareness… N: No. There’s little awareness about such issues… very few people are thoughtful about their eating habits.”*

For the most part, however, attitudes towards fasting were overwhelmingly positive—the benefits from fasting (when “done right” physically and/or spiritually) greatly outnumbered its detriments. Thus, in the minds of these interviewees, fasting designated a beneficial, health-promoting behavior.

7.3.9. WEIGHT ISSUES AND FASTING

Weight control issues came up most often in discussions of the meaning, motives, or outcomes of fasting. As described previously (see “Prerequisites: Meaning of fasting; Alternative meanings”), a number of dietary regimens—aimed at cleansing and purification of the body, but also weight loss—could on occasion pass as fasting in the minds of interviewees or the people they knew or had heard of. Some of the interviewees admitted to actually trying traditional fasting because they anticipated weight loss as a “bonus” outcome (see “Prerequisites: Motives for fasting”). Moreover, most participants shared stories about the weight related effects of fasting, which they based on direct or indirect experiences. In trying to understand the factors influencing fasting behavior, I

needed to know whether participants thought fasting: 1) could result in weight loss, and 2) could be used successfully as a weight loss strategy.

7.3.9.1. The Effects of Fasting on Weight

The majority of fasters among interviewees, reported either a minimal *weight loss*, or *none whatsoever* as an outcome of their fasting. A few women remembered losing (or believed to have lost) a little bit of weight while practicing:

SILVA (19): “I: *Did you weight change in any way—did you lose weight, did you gain weight, or?* S: Nope. I: *No? You don’t have any observations.* S: Well, maybe I’d lose a kilo or two, but it hasn’t been ... notable.”

MILENA (77): “I: *Did your weight change in any way when you were fasting?* M: A little. I: *How?* M: Downwards...[chuckles]. A bit downwards.”

One interviewee described a weight change that began with an initial gain and ended in an ultimate loss of weight as her body adapted to the fasting regimen. She contended that a few of her female coworkers had also observed the same *weight trajectory* in their fasting:

GERGANA (28): “G: I even have [female] coworkers and I’ve noticed the same for myself, in the first 2-3 weeks you gain weight—you’ve eliminated certain things from your menu and you’ve replaced them with other foods, and your organism as a whole gets adjusted to this. [] I: *You said earlier that at the beginning [of fasting] you’d gain weight, did your weight change in any ways afterwards, after completing the fast?* G: At the beginning you gain kilograms, afterwards you lose them—you definitely lose weight.”

For the remaining women there were no weight changes following fasting:

DANIELA (28): “D: I can’t say I lose weight while fasting, my weight stays the same...”

In summary, fasting had a minimal reported effect on fasters’ weight, which was at best a small weight loss. I therefore asked participants whether they thought fasting could be used as weight loss strategy.

7.3.9.2. Effectiveness of Fasting as a Weight Loss Strategy

Even though a few women claimed to have witnessed weight loss motivated fasting (see “Prerequisites: Motives for fasting”) and actual weight loss as a result from fasting in others, only

two women believed fasting was (or could be used) an effective strategy for weight loss. For instance, Milena (77) believed most contemporary practitioners used fasting for its added benefits of *weight control*, though she distinguished these fasters from a subgroup of religious fasters for whom fasting was an overtly spiritual act:

MILENA (77): “*I: Overall, is fasting effective for weight loss? M: That’s how it’s seen. I: That’s how it’s seen. Who sees it this way? M: Those who fast. I: So that’s an additional reason for their fasting? M: Yes. I: Both to give their body a break and to lose weight? M: Yes. I: Ummm. M: Those who are religious do not do it for... [weight loss]...they do it for their faith. I: For their faith, yes. M: However, this is reflected in their physique. I: I see, I see. So those who are not religious do it for weight loss and to give the body a break. M: Yes. I: □ To control your weight—is this a benefit from fasting? M: It is a benefit.*”

Similarly, Polina (29) considered *weight loss* and *improved metabolic performance* to be *health* benefits from fasting:

POLINA (29): “*I: So you consider dropping weight and improving one’s metabolism [via fasting] as positive developments? P: Yes, of course. I: How about health-wise? P: Yes, yes, naturally, indeed excellent I’d say.*”

However, for the remaining women in this sample, fasting was not an effective strategy for weight loss. There were a number of explanations that women provided in support of this belief. Some interviewees were skeptical about the weight loss effects of fasting, precisely because it did not produce dramatic weight changes. For instance, Yoana (19) noted no weight changes following her mother’s practice, despite an initial interest in weight loss. Likewise, Svetla (18) believed there were alternative, more efficient ways to lose weight compared to fasting and attributed her minimal weight loss to intrinsic factors, such as being naturally thin:

SVETLA (18): “*I: Did your weight change in some way when you fasted? S: No. I’ve always been thin and haven’t had much to lose. At most it would change by, say, a kilo or two. I: In which direction—on or off? S: Off. But I’ve always hovered around 45 kg. If I’d gain a little it would be 2 kg on, if I’d lose... it would be 2 kg off. And that’s about it. □ I: Do you think some girls you know may be using fasting for weight loss? □ S: If a person wants to lose weight, as you would during fasting, it is not mandatory to always follow the fasts, she or he can do it like...” I: I see, yes...can do it in another way, it’s not necessary to fast. S: Yes.*”

Gergana (28) had a similarly skeptical outlook on the link between fasting and weight loss. She was convinced that weight loss could be sustained only if a faster exercised *moderation*—not only during, but also following a fast. This interviewee’s weight control strategy was not limited solely to fasting, but relied on a *structured* day-to-day dietary lifestyle:

GERGANA (28): “*I: Do you think fasting is an effective method for weight loss?* G: No, I don’t think so, because this depends a lot on a person’s character, because 40 days...after completing the fasts there come big holidays. So, at the beginning when I fasted I’d personally compensate for not all, but most of the kilos I had melted. Nowadays, it’s different. When I complete the fast I switch to a regimen that I’ve developed for myself. But this isn’t a regimen that I’m forced to follow...I think this is what’s most important for maintaining one’s weight.”

A number of participants thought that fasting was ineffective and even counterproductive with regard to weight loss, because it depleted one’s body of nutrients, stimulated appetite, and led to an *overconsumption* of food similar to that of *yo-yo dieting*. Since Lenten food was traditionally rich in *carbohydrates* and low in proteins, some women also believed overconsumption of carbohydrates was to blame for any consequent weight gain (or lack of weight loss) during fasting. Clearly, women’s perceptions about fasting and its effects on weight had a lot to do with their overall beliefs and behaviors concerning nutrition and health (see “Personal beliefs: Nutrition and health”). Moreover, *increased hunger* and *weight gain* were viewed negatively, as potentially detrimental outcomes of fasting. Women held such beliefs regardless of their fasting experiences. For instance, among fasters:

SILVA (19): “*I: Ummm, do you think some people fast in order to lose weight?* S: Well, no. There probably are [such people], but I haven’t heard of any. But I don’t think you can lose weight if you fast. *I: Why is that?* S: Well, because you are practically eating, again a lot, for instance...you eat rice, you eat peas in larger amounts, so that you fill in the void left by meat and similar products, so you compensate with something else.”

DANIELA (28): “*I: In terms of weight you said...*D: No, there’s no effect. It’s more likely that for a person to gain weight during fasting, rather than losing weight. *I: Why do you think people would gain weight during fasting?* D: Well, precisely because of eating cleaner, the psychological moment that you haven’t had enough to eat if you didn’t eat meat, so you just eat a bit more during a meal, as well as between meals. *I: The psychological moment of restriction...*D: It’s a strong moment, yes.”

MONIKA (52): “I: *Do you think it [fasting] is an effective strategy for weight loss?* M: No, it isn’t. [] I: *How about just in terms of physique—did your weight change as a result of fasting?* M: First of all, you get hungry more quickly...[]...I: *How about in terms of weight?* M: I’m careful not to gain weight, because I normally eat more meat...[]...When you fast you gain 1-2 kilos...Because they [fasters] are hungry and have to eat more bread or rice, after all that’s carbohydrate.”

Likewise, among non-fasters:

EVA (28): “I: *And in terms of figure and weight, what’s the effect of fasting?* E: Potatoes and rice are certainly bad for your weight...I: *So you can’t decide whether your weight would go down or up... if you were to... [fast]?* E: I think it would rather go up. [] I: *Ah, do you think some people do it [fasting] for weight loss? Not so much for spiritual...* E: Well, probably. I don’t know. Although if you don’t eat meat or other things, your body is hungry for these things, it craves these things, and you perhaps start to stuff yourself with potatoes and whatever else you’re allowed to eat there, I don’t know.”

NELLY (44): “I: *A fashion trend—is it linked to weight reduction or something else?* N: They [other women] usually gain weight... [laughs mockingly]...[] Yes...yes. That’s precisely why they start doing this [fasting], so that they lose weight...however, in the aftermath it becomes clear that they’ve gained instead of lost weight [laughing]...[]...So the chicks...we’ve got our little gang in Bistritsa [suburban town near Sofia where the interviewee lives]...*Ummm...* we gather, like, in the evenings sometimes...and most say they’ve gained afterwards [laughing], not that they’ve lost weight. [] So this [fasting] is...you simply make up a diet for yourself—20 days you diet, 5 days you eat like you’re insane [laughing], ’cause you’re just so very hungry [laughing].”

7.3.10. PERSONAL BELIEFS: NUTRITION AND HEALTH

There were three key themes concerning participants’ nutrition and health beliefs that clearly impacted their fasting attitudes and practices. First and foremost, there was the idea of *intoxication* that drove individuals to fast in order to rid their bodies of toxins and harmful accumulations. According to interviewees intoxication did not require extreme lifestyles or advanced age to occur. Toxins accumulated as part of normal day-to-day existence, regardless of age, as a result of *overindulgence* in food, in general, and in *meat* products (including *lard*), in particular. Moreover, intoxication could occur from a *lack of physical activity* and spending time in overcrowded, loud, smoky *environments*, like cafes or clubs, especially during the wintertime (see *seasonality*). Importantly, participants thought their bodies required a mandatory, periodic cleanse in which to take a break

from functional overload, purify, and restart anew and refreshed. There seemed to be an implication that one's organism could not handle intoxication if not given a cleansing break.

The theme of intoxication was related to the second common nutrition and health beliefs theme that permeated narratives, that of *seasonality*. In short, participants believed fasting was designed to be a particularly effective period for bodily cleansing from toxic accumulations that accompany seasonal changes in lifestyle. As mentioned previously, women believed religion had very wisely devised fasting to follow such natural “cleansing” cycles and benefit one's health (see “Prerequisites: Attitudes towards fasting”). Interestingly, such beliefs held even among participants who were not religious.

Lastly, a third important theme dealt with perceived properties of certain foods that in turn determined the ways in which participants imagined fasting would affect their *appearance, figure, or health*. For instance, women believed fasting could lead to weight gain due to overconsumption of *carbohydrates* that were perceived as fattening. Moreover, women thought that severe lack of proteins or other nutrients during fasting might negatively impact one's appearance. Oftentimes women set fasting or cleansing routines emphasizing the consumption of certain foods they considered to be *lighter* and therefore “cleansing”. Certain foods like raw fruits, vegetables, salads, soups, bouillons, and tea were considered conducive to bodily cleansing and purification.

Below is a quote by one of the non-religious participants that summarizes all three interrelated themes of *intoxication, seasonality, and food property*:

KAMA (18): “K: Everybody does this, every organism needs cleansing...for instance I do it for 2-3 days. I mean, you know, simple things such as salads, and similar...like, teas, for as long as the organism takes a break from the seasons. Because every season has... is straining somehow. I: *So, in the fall or in the spring, these are necessary periods for cleansing?* K: Yes, especially in the spring, you know, after all in the wintertime a person is more or less inactive, one doesn't have that much of an opportunity to go here and there. Even when it comes to going out with friends, it's unpleasant...I mean, you got to get yourself stuck in some café or a similar hangout, you know, where there's too many people, too much

music... not that there's anything wrong with this, but this can't be your daily experience. []
I: When you engaged in this 2-3-day light regimen, what was your motivation—to cleanse your body or? K:
Yes, in a way...especially in the wintertime...in the fall and spring when seasons change...I
mean, in the wintertime a person is really inactive. Then there's Christmas holidays...the
body itself is strained by having to digest all these foods and drinks, etc. It should be given a
break! [] *I: You are not motivated by ... I mean you said you didn't do it [cleansing] for weight loss, but
simply to give your body a break, to somehow restart your body.* K: Yes, that's right.”

7.3.11. LIFETIME CHANGES: TRANSITIONS AND TRANSFORMATIONS IN THE PRACTICE OF FASTING

A number of narratives indicated that fasting beliefs and practices were not fixed in time. In fact, they changed both within an individual's lifespan, as well as among generations. As explained previously (see “Prerequisites: Meaning of fasting”), women's definitions of fasting became more “holistic in nature” (i.e., a synergy of physical and spiritual meanings) as their experience with fasting increased. Moreover, there seemed to be a shift in the meaning of fasting among different generations of women—older women tended to emphasize spiritual aspects of fasting, whereas younger women were preoccupied with the physical side of the behavior. Even though the majority of these participants (both fasters and non-fasters, young and old) acknowledged fasting as a prominent *cultural tradition*, most believed only older people fasted for overtly religious reasons in keeping with traditional customs and rituals and explained this with the *secularization* of the communist period:

SVETLA (18): “S: Well, I think very few people fast these days. If there's anyone fasting it would be mainly older people and they follow the rituals. Conversely, my peers and people younger than me are not religious and they don't keep up with church holidays, so that's that...[] It [fasting] is entangled within rituals.”

MILENA (77): “M: There are believers... *I: OK?* M: They are mostly from the older generations. *I: Older people.* M: Older people. They hold their religious beliefs firmly. *I: Alright. How old are these people?* M: Sixty and above.”

SOFIYA (81): “*I: Do you think Bulgarians as a whole...what is their attitude toward fasting? Again, do they view it in a positive light?* S: Yes, even men used to fast. *I: How about now?* S: Now I don't know of a single man that fasts. *I: Why is that so?* S: Because the communists turned us into atheists. They forced us to give up on everything.”

Aside from religion and spirituality that explained older women's fasting, participants tended to describe modern fasting practices—especially those among younger Bulgarians—in physical (i.e.,

related to the body) terms. Detoxifying the body by giving it a break to cleanse, purify, and thereby become healthier was among the most widespread reasons for fasting:

MILENA (77): *“I: And could you please comment on whether the majority of the population in Bulgaria fasts mostly religiously, or mostly to give their body a break...in your opinion? M: Mostly to give their body a break. I: To give the body a break. Alright.”*

Improving one’s *appearance* and in particular by exercising *weight control* was the second most frequently cited explanations of fasting among younger women. The perceived role of weight loss as a motivator for fasting increased as women’s age decreased:

KAMA (18): *“I: Do you suspect some Bulgarians who fast may be doing it for...what do you think are the reasons behind people’s fasting—spiritual or physical reasons for fasting? K: Well, especially young people... most of us aren’t very religious, most of us haven’t been brought up like that. Now, the older generation fasts for religious reasons. Whereas the younger either doesn’t fast at all, or if it does, it fasts exactly for the purposes of weight loss. I: This is their main motivation? K: Well, yeah. Many of my acquaintances...I’ve overheard, you know...I tell them ‘Oh come on, why do you fast, are you believers?’ and they’d answer ‘well, ’cause we figured we can lose weight this way’. I: It’s interesting that you say this. Do they actually lose weight? K: Well, yeah, that’s true. Yes...meaning they lose weight, but this, you know, is only during the period in which they fast. Afterwards they start [eating whatever] all over again. I: So this means they don’t build permanent habits, but rather for the momentary... K: Nope [shakes head]. I: ...quick satisfaction of your goals.”*

Interestingly, only a few women admitted to having an interest in fasting for weight loss reasons, while most spoke of purification, cleansing, and health. The latter, however, did not stop participants—regardless of age and fasting experience—from believing that fasting was a trendy weight loss strategy among younger women.

7.3.12. USE OF THE MODEL TO GAIN AN UNDERSTANDING OF FASTING BELIEFS AND BEHAVIORS

Four cases are shown in Figures 7.2, 7.3, 7.4, and 7.5 to describe the elements of the model and their interactions discussed above. The idea behind the selection of these cases was to demonstrate the shift from spiritual to physical understanding of fasting from older to younger cohorts. Thus, these cases were selected to represent the four different cohorts of women in the current study—teenagers (Svetla, age 18, in Figure 7.2), young adults (Daniela, age 28, in Figure 7.3),

middle-aged adults (Monika, age 52, in Figure 7.4), and elderly (Milena, age 77, in Figure 7.5)—while their level of faith was held constant (all four women were passive believers). Additionally, all women had direct personal experiences of fasting in that they had practiced at least once in their lives with three of them fasting “sometimes” (Svetla, Daniela, and Monika) and one no longer engaging in fasting (Milena).

7.3.12.1. Fasting According to a Teenage Woman

Figure 7.2 presents an 18-year-old woman, Svetla, who at the time of interviewing reported fasting only “sometimes.” Svetla attributed an overwhelmingly physical meaning to fasting, which she saw as a way of cleansing and purifying her body from toxic accumulations. In agreement with this physical meaning, Svetla’s motives for fasting were also physical, i.e. cleansing and purification of the body to rid it from intoxication. Overall, her attitude towards fasting was positive—she saw fasting as healthy, though considered its benefits conditional upon the types of foods being restricted. This positive predisposition to fasting was associated with Svetla’s interest in learning about fasting. According to her passive believer upbringing, she learned about fasting not in church, but in the family context by direct instruction from her mother and grandmother who were both non-fasters, but had some knowledge of religious traditions and rituals. Svetla pointed out that only her low oral control (i.e., her perceived inability and lack of desire to restrict her diet’s variety) was a barrier for participating in prolonged fasting episodes. Indeed, her practice was relaxed in duration and frequency in that she fasted only for a couple of days and not during every traditional fasting episode. The fasting rules she followed were relaxed also in terms of the food types that she consumed—she emphasized fluids and lighter foods (which she considered *cleansing*), such as fruit, bouillons, soups, and salads, but did not strictly restrict animal products, even though she knew that in theory she is supposed to eliminate such foods when fasting. In line with her physical perspective on fasting, since Svetla’s fasting practice seemed to be centered around physical purification and

cleansing, it was not a surprise that she perceived the benefits from fasting as physical in the sense of cleansing and purification of the body, which she linked to a fresh appearance (e.g., glowing complexion and the sensation of lightness). Additional benefits of fasting were improved quality of life, health promotion, and increased energy, of which health promotion was the most personally significant to Svetla. She saw no detriment from fasting if “done right” as in avoiding extremes. This reinforced her positive attitude towards fasting. In terms of weight control, Svetla reported none or minimal weight loss while fasting, which she later regained. Thus, she considered fasting an ineffective strategy for weight loss. Svetla had started fasting in her early to mid adolescence (when she was about 15 years old), which constitutes a relatively short practice with no room for personal lifetime transitions in fasting. Despite her young age, however, she claimed to have observed societal transitions in the practice and understanding of fasting, from spiritual to physical. Svetla thought that contemporary Bulgarians, especially young people, fasted for physical reasons, because they are not religious and therefore have no knowledge of religious traditions. The few young people that fasted did it for weight loss purposes, according to Svetla. In her view, only older generations of Bulgarians were religious and fasted for religious purposes. As she considered Bulgarians to be mostly secular, Svetla thought fasting was a rare practice in contemporary Bulgaria. Although Svetla self-identified as a passive believer (believing in God, but being non-observant), she did not seem overtly religious and made no spiritual references when talking about any of the aspects of fasting. Her narrative only vaguely suggested recognition of a religious origin to fasting. Moreover, her nutrition and health belief that food consumption leads to toxic accumulations marked the ways in which she understood, found motivation for, practiced, and valued the outcomes of fasting.

7.3.12.2. Fasting According to a Young Adult Woman

Figure 7.3 presents a 28-year-old woman, Daniela, who reported fasting only “sometimes.” Daniela attributed a holistic meaning to fasting, which she saw as governed by equally important physical (cleansing and purification of the body) and spiritual (an exercise in humility) principles. In agreement with her currently holistic views about fasting, Daniela’s internal motives for fasting were both physical and spiritual at the time of the interview. Additionally, she was externally motivated to fast by societal catalysts, such as the beginning of a traditional fasting episode. She admitted that in her teens she had an overwhelmingly physical (e.g., cleansing and purification of the body) view of and internal motivation for fasting, which she at present qualified as “childishly unaware.” Although Daniela acknowledged that others might fast for weight loss, she thought this to be an “erroneous idea.” Overall, her attitude towards fasting was positive—she saw fasting as healthy, though considered its benefits conditional upon fasting duration. Her positive predisposition to fasting was linked to her interest in learning about fasting. In line with her being a passive believer, she learned about fasting not in church, but in the family context by direct instruction from her sister who had researched information on how to fast. Daniela mentioned that in her teens she learned about fasting passively by virtue of being part of Bulgarian culture. She mentioned no aids or barriers for fasting. Because she saw no difficulties in fasting, her practice was rather strict in that she completely eliminated all animal products. Her fasting was relaxed only in the sense that she fasted less frequently than yearly and then only during the most popular fasts (e.g., before Christmas and Easter). Daniela was aware of the existence of less popular fasts, but could not name any concrete rules surrounding them, suggesting that she learned about fasting from non-religious sources. Even though Daniela’s current understanding of fasting was holistic, her narrative focused only on the physical benefits of fasting, such as increased energy, health promotion, and disease prevention, of which increased energy was most important to her. She discussed a number of physical detriments

of fasting, such as increased hunger leading to more frequent eating and therefore possible weight gain. Moreover, she believed extended episodes of fasting could lead to deprivation and exhaustion of the organism. Nevertheless, Daniela had not personally experienced either bodily exhaustion or weight gain. Indeed, she reported no weight change during or after fasting. She considered fasting an ineffective strategy for weight loss due to the aforementioned increases in appetite. Daniela had started fasting in her late adolescence (when she was about 17 years old), which meant she had a relatively long experience with fasting. Thus, she had been able to observe personal transitions in her practice, from physical (for cleansing and purification of the body) in her teens to holistic (adding spiritual elements to fasting) in her late 20s. Although Daniela self-identified as a passive believer (believing in God, but being non-observant), she seemed more spiritual than religious and made no references to religious doctrine when talking about any of the aspects of fasting. Lastly, her nutrition and health beliefs marked the ways in which she understood, found motivation for, practiced, and valued the outcomes of fasting. She considered carbohydrates—the staples of fasting—not to be “filling” foods, which in addition to the “psychological moment” of not eating meat in her view led to overindulgence in allowed foods and therefore weight gain. Moreover, she believed in intoxication of the body, specifically that meat is intoxicating, hence the cleansing and purifying effects of not eating meat during fasting.

7.3.12.3. Fasting According to a Middle-Aged Adult Woman

Figure 7.4 presents a 52-year-old woman, Monika, who reported fasting only “sometimes.” Monika attributed a holistic meaning to fasting, which she saw as governed by equally important physical (cleansing and purification of the body) and spiritual (abstinence from pleasure and spiritual challenge) principles. Based on her observations of others’ fasting, she named two alternative meanings of fasting—fasting pills and compartmentalized eating. In agreement with her holistic views about fasting, Monika’s internal motives for fasting were also holistic, e.g. bodily and spiritual

cleansing and purification. Her husband acted as an external personal catalyst for her fasting. Although Monika believed that young girls might fast for weight loss as part of a fashion craze, she thought fasting for cleansing and purification of the body is more common (compared to religious fasting). Overall, Monika's attitude towards fasting was positive—she saw fasting as healthy, though considered its benefits conditional upon fasting duration. She saw fasting for weight loss as wrong, but fasting for cleansing and purification of the body as right. Her positive predisposition to fasting was linked to her interest in learning about fasting. In line with her being a passive believer, she learned about fasting not in church, but in the family context via direct instruction by and modeling of her husband's strict, spiritual practice. Monika's fasting food type rules varied from relaxed (eliminating only meat) to strict (eliminating all animal products, as well as vegetable oil during the last week of fasting). The duration of her fasting was relaxed in the sense that she fasted only for about 10 days. The frequency of her fasting, however, was strict—she fasted a few times per year almost every year. Monika reported alternative fasts—the aforementioned fasting pills (the most relaxed form of fasting reported in the study) and compartmentalized eating. Her husband's 45-day-long fasting is the longest reported duration rule in the present study. Monika also mentioned two exemptions from fasting—for athletes and people under strenuous physical activities. Since she was a group fitness instructor, she justified relaxing the rules of her fasting. In line with Monika's holistic understanding of fasting, her narrative focused on both physical (cleansing and purification of the body linked to glowing complexion; disease prevention; being fit) and spiritual benefits from fasting (strengthening one's willpower en route to building a moral character). Disease prevention was the most personally significant benefit from fasting according to Monika. She had experienced a number of physical detriments from fasting, including lack of energy, weight gain, and increased hunger. Additionally, she had observed deprivation and exhaustion of the organism in her husband (e.g., avitaminosis and compromised immunity). She reported minimal weight gain while fasting due

to overconsumption of carbohydrates. Thus, she considered fasting an ineffective strategy for weight loss. Monika had started fasting in her late 20s and early 30s, which meant she had an even longer experience with fasting than Daniela. Consequently, she reported variations in her fasting over the years. More importantly, she had been able to observe societal transitions in the practice, from spiritual to physical. She believed there was a recent (within the last 5-6 years) interest in the physical aspects of fasting in the form of a fashion craze for weight loss among young girls. Nevertheless, she thought fasting for cleansing and purification of the body (as opposed to religious reasons) was the norm among younger Bulgarians, which she approved. Although Monika self-identified as a passive believer (believing in God, but being non-observant), she seemed more spiritual than religious. Yet she made a few references to religious doctrine when talking about the aspects of fasting. She expressed a belief in the spiritual wisdom of the way fasting is designed around the issue of seasonality. Lastly, her nutrition and health beliefs marked the ways in which she understood, found motivation for, practiced, and valued the outcomes of fasting. She considered carbohydrates—the staples of fasting—to be fattening foods. Moreover, she believed in intoxication of the body and in seasonality. For Monika, healthy eating meant eating a little of everything and exercising. She believed compartmentalized eating to be unhealthy.

7.3.12.4. Fasting According to an Elderly Woman

Figure 7.5 presents a 77-year-old woman, Milena, who no longer fasted, though had fasted once previously in the past. Milena attributed a holistic meaning to fasting, though she saw the spiritual principles behind fasting as dominating over the physical (cleansing and purification of the body and giving the body a break). In agreement with these views, Milena reported fasting for spiritual motives, e.g. as an emotional coping mechanism. Nevertheless, she believed most contemporary fasting is done for non-religious purposes—to give the body a break (with the exception of religious fasters, whom she believed were few in number). Moreover, she

acknowledged that some non-religious fasters might fast for weight loss, which she did not judge as right or wrong. Overall, Milena's attitude towards fasting was positive—she saw it as healthy, “beneficial” and “normal.” Her positive predisposition to and spiritual need for fasting was related to the way in which she learned to fast. Being a passive believer, she learned about fasting in church via direct instruction by a priest and through modeling the fasting of the devout. She honed her knowledge of fasting by reading relevant literature. Milena mentioned neither aids nor barriers for fasting. In accordance with her spiritual beliefs and the way she learned how to fast, Milena referred to religious dogma when it came to fasting rules. Her fasting was among the strictest in terms of food type in that she eliminated all animal products, as well as vegetable oil during the last week of fasting. The duration of her fasting was also strict in the sense that she fasted for the full 40 days of the fast. She only moderately relaxed the amount of food she ate while fasting—although her food amount was not restricted, overeating was discouraged. Even though Milena had fasted only once, she appeared to be quite knowledgeable about fasting and knew even about less popular fasts, such as fasting twice a week (which she considered strict fasting). Despite her overwhelmingly religious perspective about fasting, Milena mentioned only physical benefits from fasting, such as increased energy, longevity, weight control, health promotion, disease prevention, being fit, and improved quality of life. Of all of these, she saw disease prevention as the most personally significant. She maintained that there were no detriments to fasting, despite reporting temporary decreases in energy while fasting. Milena experienced weight loss, though minimal, while fasting, therefore she considered fasting effective as a strategy for weight loss. Milena believed fasting was inevitably reflected in fasters' physique, even when their goal was not necessarily weight loss. Because she reported fasting once in her early 20s, she qualified as having personal experiences with the practice. By virtue of having lived long, she reported societal transitions in the practice of fasting, from the spiritual to the physical. For instance, Milena believed that fasting in the past was done for religious

purposes, whereas contemporary Bulgarians (with the exception of older generations who are truly religious) fast for physical reasons—to give the body a break. Milena self-identified as a passive believer (believing in God, but being non-observant), yet she seemed more religious than spiritual in her approach to fasting. Indeed, she made multiple references to religious doctrine when talking about the various aspects of fasting. Lastly, her nutrition and health belief marked the ways in which she understood, found motivation for, practiced, and valued the outcomes of fasting. Specifically, she expressed a belief in the intoxication of the body and that moderation in eating was key to health.

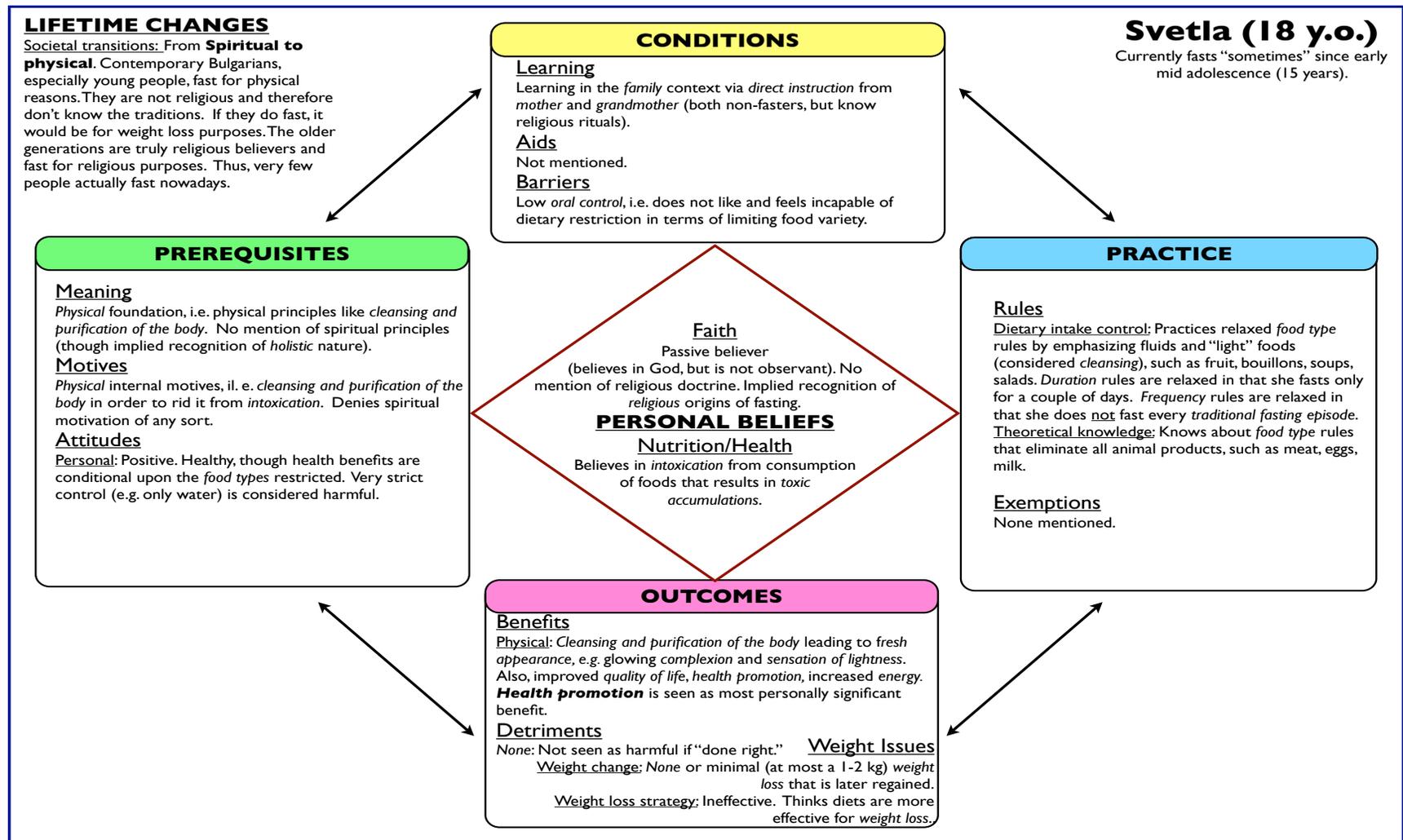


Figure 7.2. Fasting according to a woman from the teenage cohort: Svetla, Age=18 years.

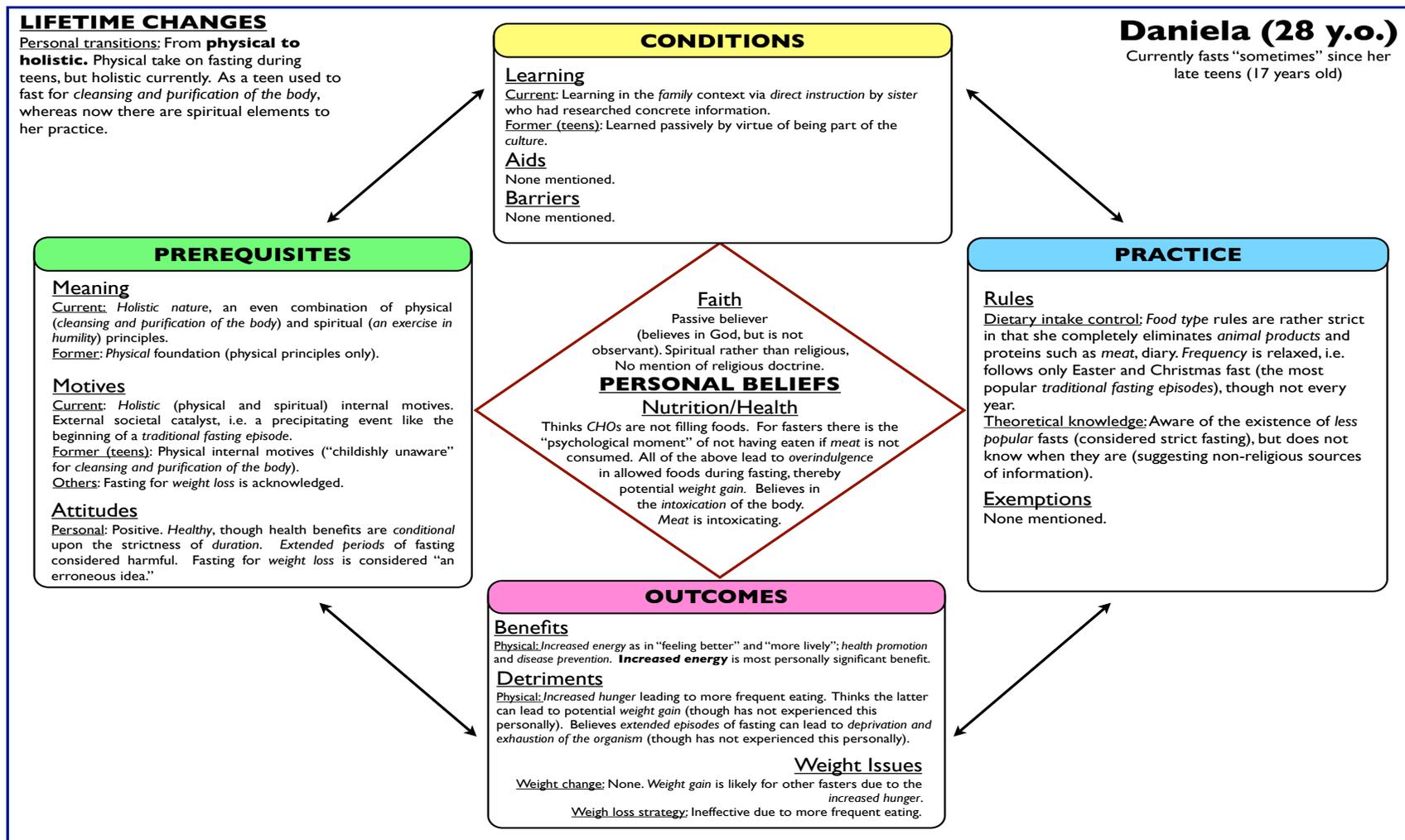


Figure 7.3. Fasting according to a woman from the young adult cohort: Daniela, Age=28 years.

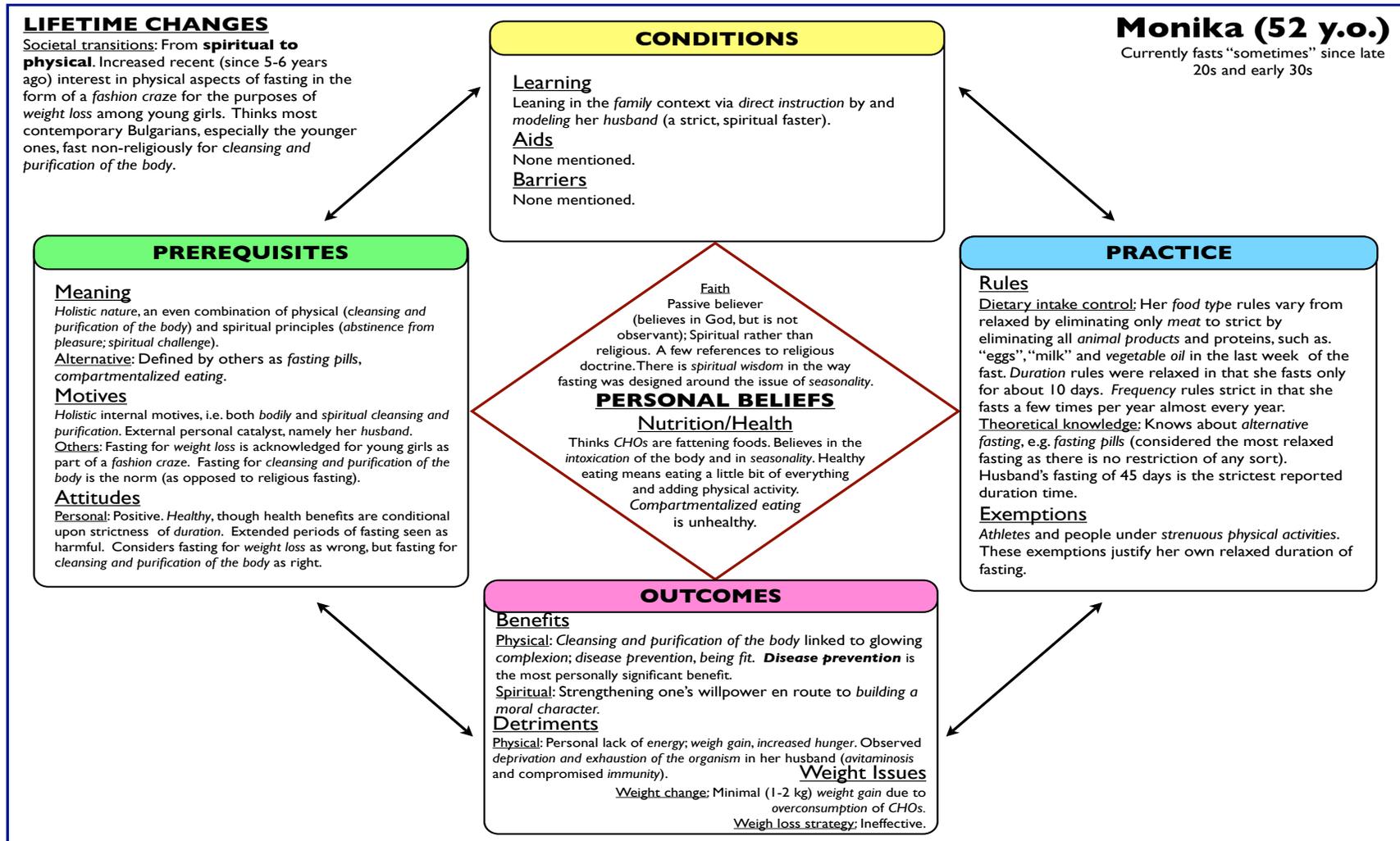


Figure 7.4. Fasting according to woman from the middle-aged adult cohort: Monika, Age=52 years.

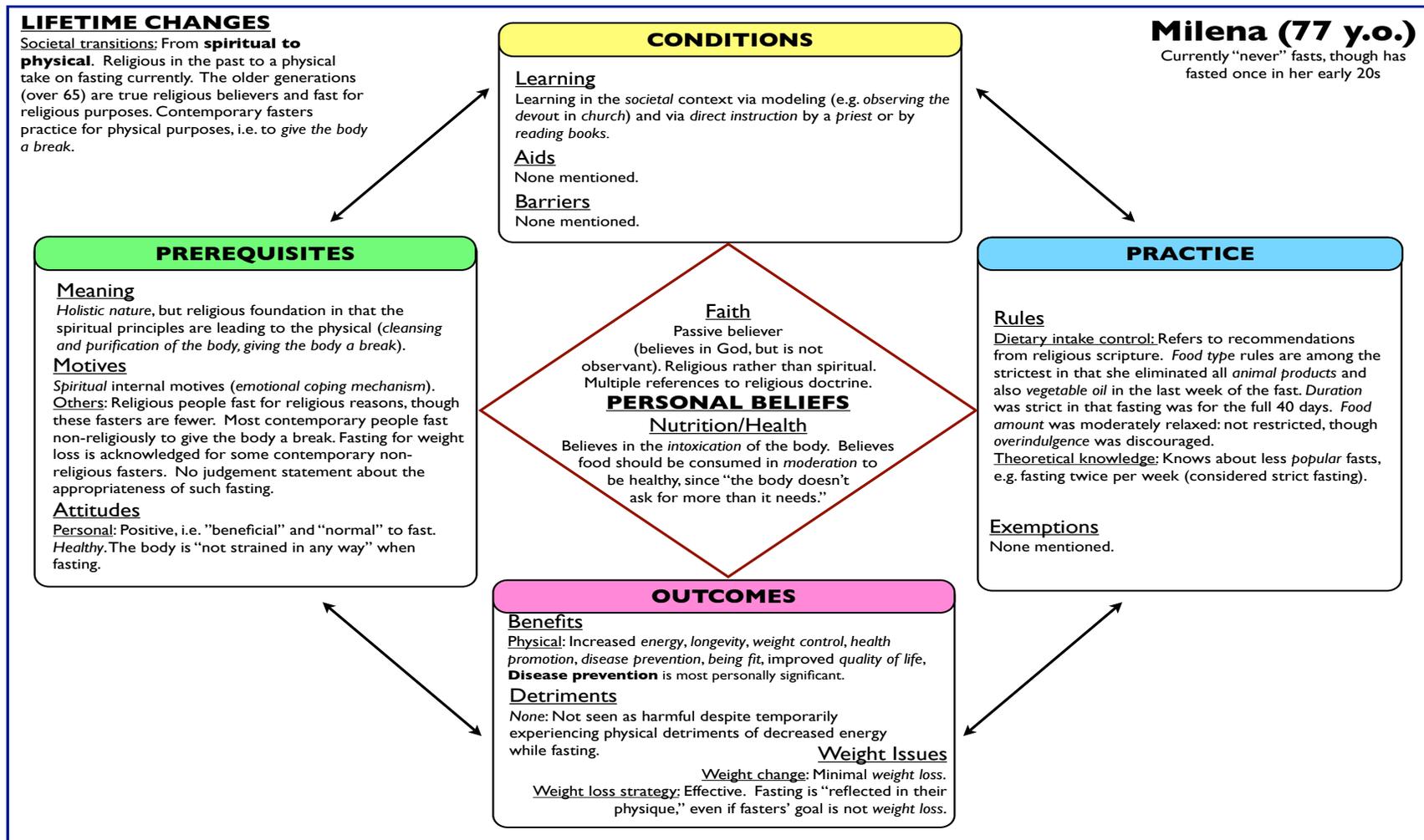


Figure 7.5. Fasting according to woman from the elderly cohort: Milena, Age=77 years.

7.4. DISCUSSION

The purpose of this study was to develop an understanding of fasting beliefs and behaviors in a sample of urban Bulgarian women living in the city of Sofia. Particularly, I was interested in exploring the relationships between: fasting and religiousness (spirituality), and fasting and body image (weight loss and the achievement of a thin-ideal figure), all the while searching for additional factors that might explain fasting among urban Bulgarian women. The use of a constructivist approach and qualitative research methods allowed for a plausible explanatory framework about an unfamiliar phenomenon based on participants' distinctive, rich, and diverse narratives (Corbin & Strauss, 2008). To the best of my knowledge, no other study has attempted to explain fasting beliefs and behaviors that seemed neither overtly religious (e.g., fasting of holy women, or *anorexia mirabilis*), nor pathological (e.g., fasting of anorexic women, or *anorexia nervosa*). Moreover, unlike previous research, I focused my attention on a fasting tradition rooted in non-Western (i.e., Orthodox) Christianity, in a corner of the world that has thus far received little attention with regard to body image and disordered eating issues.

7.4.1. ELEMENTS OF FASTING

The conceptual framework that emerged from the data contained several elements that described and explained fasting behavior—prerequisites, conditions, practice, outcomes, lifetime changes, and personal beliefs. This framework allowed me to characterize individual women's fasting, as well as to compare and contrast the fasting beliefs and behaviors of different women (e.g., fasters vs. non-fasters, believers vs. non-believers, younger vs. older women). Moreover, the rich descriptions on which this conceptual model was built allowed me to address the study's main research question, namely: What were the factors influencing fasting in this sample of urban Bulgarian women? In particular, I was interested in determining whether spirituality, body image, or other unknown factor(s) played a role in women's fasting practices.

The *prerequisites* of fasting consisted of conditions that predisposed women to engage in fasting behavior. Such predispositions included core concepts like the *meaning* ascribed to fasting and the women's personal *motives*, as well as their overall *attitude* towards the practice. The prerequisites of fasting determined what intervening factors, or *conditions* a woman perceived as conducive to practicing fasting. These intervening conditions were certain *barriers* and *aids* that hindered or helped women's fasting. *Learning* about fasting further enabled women's fasting behavior. If prerequisites and intervening conditions were favorable, a woman could proceed with an actual fasting behavior, i.e. *practice* by following a number of dietary or non-dietary *rules*. However, if conditions for fasting were not advantageous, a woman could apply certain *exceptions*, i.e. rules, which justified the lack of a fasting practice. The practice of fasting could result in various *outcomes*—*benefits* and *detriments*—depending on whether a woman valued such outcomes as positive or negative. Whenever benefits outweighed detriments in a woman's mind, such positive perceptions translated into favorable attitudes toward fasting, which served as reinforcing factors for further fasting behavior. Fasting also produced weight-related outcomes (*weight issues*), which women valued differently depending on their personal beliefs and fasting experiences. Women's *personal beliefs*—*faith*, as well as their *nutrition and health beliefs*—influenced, in fact, all of the above-described four major components of fasting behavior. Moreover, all elements of the conceptual model along with their interactions were dynamic in that they were marked by constant *lifetime changes* and evolution throughout an individual's existence, as well as among successive generations of women.

7.4.2. FACTORS INFLUENCING FASTING

Understanding the factors influencing fasting in a sample of Bulgarian women had its many challenges as these findings revealed fasting to be a complex, multifaceted, and dynamic behavior. Since fasting is a central tenet of Orthodox Christianity, it appeared logical that most women in this sample—who self-identified as Orthodox by denomination—would either fast for religious

purposes or not fast at all, depending on their level of religiousness. The findings of the present study, however, confirmed suspicions that the relationship between fasting and religiousness in the Bulgarian context was not nearly so straightforward. For one thing, it was common for non-religious interviewees of any age to engage in fasting, while at the same time there were religious women who had never fasted in their life. Moreover, passive and even active believers could practice fasting for non-spiritual reasons. Fasting in the sense of voluntary dietary restriction has been linked to body image and eating disturbances in the past (Nejad et al., 2005; Stice et al., 2005; Viner et al., 2006). Thus, I wondered whether a non-spiritual reason for fasting among Bulgarian women could be achievement of a thin-ideal figure. All the while, I was looking for additional factors that could explain fasting among these urban Bulgarian women.

7.4.2.1. Relationship Between Faith and Fasting

With regard to fasting there seemed to be a process of gradual historical dissociation between practice and spiritual belief, and this rift intensified over time among successive generations of women. This temporal transformation of fasting from an overly spiritual to a predominantly physical experience was a major theme in this study. This theme crystallized not only in the descriptions participants gave for the meaning and motives of fasting, but also in the strategies and rules they used to learn and practice fasting, as well as the outcomes they anticipated from practicing. Although interrelated, the concept of *motive* did not follow straightforwardly from the concept of *meaning* (or definition). For instance, while most women included a spiritual element in their definition of fasting, only a few were actually driven to fast by truly spiritual motives. Among the four cohorts of women that were included in this sample—teenagers, young adults, middle-aged adults, and the elderly—the two elderly women—Milena (79), a passive believer, and Sofiya (81), an active believer—had the most genuinely spiritual outlook on fasting. In other words, these women's fasting most closely resembled the fasting defined in religious scripture, namely the spiritual *exercise*

in humility by abstaining from all forms of earthly pleasure for the purposes of fighting sin and nurturing love towards God and humankind (Alexiev et al., 2008). That fasting was an expression of religious morality was evident in the concepts these women used to characterize fasting and its *benefits*—e.g., *spiritual cleansing and purification, building a moral character, spiritual sacrifice, spiritual challenge*. Though physical concepts like *cleansing and purification of the body* and *giving the body a break* also came up in narratives, these women's primary motive for fasting was undoubtedly spiritual—Milena (77) fasted to cope with deep emotional trauma, while Sofiya (81) fasted to prove God she was a moral person deserving of good fortune and health. Indeed both women stated that the spiritual principles of fasting dominated over the physical. An obvious explanation for Milena (77) and Sofiya (81)'s spiritual take on fasting was that these women grew up and came of age before the height of communism, at a time when Bulgarian society was much more traditional and religious (Kanev, 2002). They learned traditional (i.e., religious) fasting within contexts—at *church* and in the *village*—and from sources—a *priest* or a devout *grandmother*—historically known as bearers and transmitters of Bulgarian cultural tradition (Elenkov & Daskalov, 1994; Genchev, 1987). Even though both women spent most of their adult lives under the communist regime when religious expression was prohibited and persecuted (Serafimova, 2007), their understanding and knowledge of fasting nevertheless remained intricate and inherently spiritual in nature. Their descriptions of fasting rules, exceptions, and rituals about fasting tended to be the most detailed (in the entire sample), *strictest* in character, and closest to religious scripture.

In juxtaposition, the younger participants ascribed a much more physical meaning to fasting and this emphasis on body and appearance as focal points of fasting seemed to be most intense among teenagers. The latter lacked deep knowledge of religious customs and rituals (including fasting) outside of major church celebrations like Christmas or Easter that had become culturally (rather than religiously) habitual. If teenage women fasted, they tended to follow rules that deviated

at times substantially from religious scripture thereby resembling time-limited dietary regimens. Spiritual tenets of fasting among teenage participants were, in fact, distinctly abstract and removed from women's actual experiences—women were intellectually aware of the religious basis for fasting, but it failed to personally motivate their practice. Instead, all four teenage women, Svetla (18), Kama (18), Silva (19), and Yoana (19), regardless of their level of spirituality or experience with fasting, viewed fasting and any potential purposes for it in overwhelmingly physical terms, using concepts like *cleansing and purification of the body* from toxins and *giving the body a break* to allow it to purify for the ultimate benefit of good health. As with elderly women, teenage women's understanding of fasting was to a large extent a function of their upbringing. Even though they had come of age over a decade after the fall of communism, at a time of spiritual and religious freedom, these women's spirituality was in all likelihood a direct product of the societal *secularization* during the communist period—they were brought up by secular parents in a secular, modern society.

Unlike teenagers and elderly women, the rest of the participants had come of age either during communism—Nelly (44) and Monika (52)—or directly after its fall—Eva (28), Daniela (28), Gergana (28), Polina (29) and Lina (31). Most of these women, even those who self-identified as active believers, were not deeply religious. For instance, I was able to find only one active believer, Gergana (28) between the ages of 29 and 52, a person who nevertheless did not always follow religious scripture in her everyday life. There were passive believers—Eva (28) and Daniela (28) who claimed belief in God, but were not observant (did not pray, go to Church regularly, etc.). Eva (28), in fact, felt quite uncomfortable discussing religious matters, including fasting. Two women, Polina (29) and Nelly (44), were agnostic and one, Lina (31) reported having faith but at the same time being non-religious. None of these women, however, failed to make at least a general reference to the spiritual side of fasting. In fact, their discussions of the spirituality behind fasting were much more elaborate than the teenagers'. Similarly, young and middle-aged and adults (i. e., non-teenage,

non-elderly) women's motives to fast were more spiritual. Unlike elderly women, however, most young adult and middle-aged women reported a stronger interest in the physical aspects of fasting. For these women the spiritual aspects of fasting were never more important than the physical. It is possible that these participants' religious feeling intensified over time, thereby prompting them to fast for increasingly spiritual reasons. Several studies have reported an age-related increase in women's religiousness that was independent of period effects (Argue et al., 1999; Halman & Draulans, 2004). According to Argue et al. (1999) this increase in women's religiousness was steepest between 18 and 30 years of age. Interestingly, two interviewees, Daniela (28) and Gergana (28)—a passive believer and an active believer, both in their late 20s, claimed that the spiritual aspect of their practice intensified with age to match the physical aspect. These women described their first fasting experiences as decidedly non-spiritual as opposed to their currently more *holistic* (both physical and spiritual) practice. However, such a shift in meaning and motivation did not exist for the elderly participants (also a passive believer and an active believer) for whom fasting had always been an act of piety. Therefore, any possible increases in spiritual motivation across the lifespan among the women in this sample may be secondary to powerful cohort effects.

7.4.2.2. Relationship Between Weight Control and Fasting

As the rift between fasting and religiousness deepened in younger generations, the perceived physical benefits of fasting came to characterize and motivate the behavior. Because fasting requires dietary restraint, a very obvious physical effect of fasting would be to lose weight. Thus, I asked participants to elaborate on the relationship between fasting and weight maintenance. That weight loss was a desirable outcome for women was evident. Regardless of fasting expertise or age, most women valued "increased appetite" and "gained kilograms" negatively. Indeed, a number of interviewees believed weight loss was a viable reason for fasting. However, only one interviewee, Polina (29), admitted to being personally motivated to fast by the prospect of weight loss. The rest

based their opinions on observations of fasting among family, friends, or acquaintances. Overall, women claimed that fasting for weight loss occurred primarily among younger women, who did not have a thorough knowledge or understanding of the spiritual principles behind fasting and instead used it as a fad diet or a *fashion craze* for fasting, as a number of participants put it. This is consistent with the idea of cohort effects in the degrees to which women attribute spiritual meaning to fasting. However, it is also possible that women in this sample denied having fasted for weight loss and proclaimed such fasting “an erroneous idea” to avoid the stigma of being labeled as anorexic. Based on my field observations at the time of interviewing, eating disorders and particularly anorexia nervosa were attracting a lot of negative attention in Bulgarian media, with messages about the perils of non-eating saturating the public space. This increase in attention was accompanied by a growth in awareness about such conditions and a deepening of the social stigma associated with them. Indeed, research has demonstrated that for non-clinical populations the self-reporting of body image and eating problems is negatively impacted by measures of social desirability (Miotto et al., 2002; Preti et al., 2009).

Even though young Bulgarian women were suspected to fast for weight loss, the majority of these interviewees (especially the younger ones) deemed fasting an ineffective long-term strategy for weight loss. Narratives were quite consistent in this point, thus it was unlikely that all women provided socially desirable responses. There were several reasons for such attitudes among the interviewees. First, these women believed that carbohydrate-rich food typically consumed during a fast to be fattening, a perception perhaps compounded by a recent spike in popularity of low-carb diets—e.g., Dr. Pierre Dukan’s protein rich French diet (Dukan, 2006)—in media at the time of data collection. Second, perhaps due to a perceived lack of limitations on the amount of food consumed during a fast, younger women believed weight loss during a fast could not be as dramatic as the one achieved by regular diets. It is important to mention, however, that these women had come to such

conclusions precisely because they had tried fasting for weight loss or observed others try it with the same goal in mind. Interestingly, some women spoke of fasting in the same manner one would describe yo-yo dieting—as a time-limited period of dietary restraint followed by overconsumption of “prohibited food” after the completion of the fast. Because the metabolic changes associated with dietary restriction during a diet make weight loss difficult to achieve and maintain, many women repeat weight loss attempts ultimately resulting in yo-yo dieting and weight cycling (Germov & Williams, 1996). Some women also commented that the “psychological moment” of dietary restraint makes fasters overindulge in “allowed food” during the fast itself, thereby compromising weight loss or even possibly leading to weight gain. Clearly, these women implied that cognitive restraint was a large part of fasting behavior very much like it is a part of regular dieting. Thus, fasting was seen as ineffective for weight loss for the same reasons that ordinary dieting is considered ineffective—because it often leads to a “yo-yo” cycle of weight loss and regain that originates from the negative feedback exerted by cognitive restraint on weight during dietary restriction (Goldbeter, 2006). Consistent with other views that a major issue of weight control is not so much weight loss, but preventing relapse by adopting lifestyle dietary changes (Goldbeter, 2006; Foster et al. 1996; Stunkard et al., 1979), fasting was seen as a good strategy for weight loss by the present interviewees only if complemented by a sustainable, long-term, moderation-based dietary regimen. In support of the latter, Gergana (28) explained that she used to experience weight cycling when at the beginning of her practice until adopting a long-term dietary regimen, which she believed was “what’s most important for maintaining one’s weight.” In summary, weight loss seemed to be a major goal of fasting only for a small subgroup of women—usually teenagers or young adults. For the majority of women, however, weight loss appeared to be somewhat of a secondary concern or a bonus “side” effect of the practice of fasting.

7.4.2.3. Fasting and the Desire for Purity

If fasting was practiced neither for particularly spiritual (or religious) purposes, nor as a pivotal weight loss strategy—the two most apparent and commonly researched reasons in other contexts—then there must be other, more compelling bases for this kind of dietary behavior. The findings of the current study revealed that such a reason for fasting was in fact *cleansing and purification of the body*. The desire for physical purity was an overwhelmingly prominent concept throughout fasting narratives. It was linked to women’s common belief that modern day existence inevitably leads to bodily intoxication and that the body is incapable of effectively ridding itself of toxins. Thus, fasting stepped in as a natural method for assisting the body in cleansing and purifying. In turn, a clean body fostered good health and thereby an attractive appearance and a desirable slender figure.

The idea that the human body experiences “autointoxication” can be found as far back in time as ancient Egypt where healers believed food residues in the gut caused putrefaction and thereby disease (Acosta & Cash, 2009). This concept of putrefaction was picked up and expanded by the ancient Greeks to include residues of bodily fluids like blood, bile, and phlegm in the development of their humoral theory of disease (Acosta & Cash, 2009). The belief that autointoxication was the root of disease and that cleansing and detoxification promoted health and well-being remained powerful in Western (especially North American) medicine until the 1920-1930s when it fell into disrepute due to a lack of scientific evidence to support it (Acosta & Cash, 2009; Chen & Chen, 1989). It would appear, however, that such a shift in attitudes never occurred in Bulgaria, which, as one of the most loyal Soviet satellites, followed the Soviet health care model and remained severely isolated from international developments in the post-World War II period (Cockerham, 1999; Danichevski, et al., 2007; Koulaksazov et al., 2003). Scientific isolation and the absence of evidence-based medicine have been known to result in widespread use of ineffective

medical therapies (e.g. magnetic, electrical, light devices, etc.) resulting in the poor health status of the population, as in the case of the former USSR (Danichevski, et al., 2007), and a general disappointment with standard medicine among the lay population (Brown & Rusinova, 2002). Such similarly developed distrust in standard medicine was likely exacerbated during the turbulent and economically unstable transitional period in Bulgaria, and could help explain why so many Bulgarians, including many of this study's interviewees, would rather trust dubious "alternative" healing and health promoting methods than a medical doctor. In this light these interviewees' powerful desire to cleanse and purify their body (irrespective of age or actual health status) can be viewed as an extension of their drive to control health while avoiding dealing with the medical establishment.

It is easy to see how fasting would fit in very naturally as a method for achieving this goal to cleanse and purify, given that it is already a long-held and widely accepted tradition in Bulgaria, and one associated with bodily purification and health promotion. Indeed non-extreme fasting as part of numerous religious doctrines has been known to counteract "autointoxication" for as long as this concept has existed. However, it was not until the mid 1800s that some forms of fasting began attracting attention as weight-loss and health-promoting procedures rather than religious experiences (Kerndt et al., 1982). This health-related view of fasting was likely the consequence of a number of societal transformations, including industrialization, increasing obesity rates, the growing precedence of science over religious superstition, and the evolution of medicine (Bemporad, 1996; Brumberg, 1998 & 2000; Johnstone, 2007). The current analysis revealed that the act and perception of fasting among Bulgarian women seemed to follow a similar trajectory, from a strictly religious experience before the onset of communism to a predominantly physical, health-boosting practice in modern, secular, post-communist times.

In all, fasting was regarded as a socially sanctioned, traditional, health-promoting dietary behavior by all current participants. It was viewed not only as a safe and generally healthy experience, but also as a dietary behavior superior to regular dieting in that it provided spiritual or moral benefits.

It is important to mention that the concept of cleansing and purification extended beyond the practice of traditional fasting to include a number of “alternative fasts”, i.e. *periodic cleansing fasts*, such as *lite regimens*, *weekly cleanses*, *wheat regimen*, *moon cycle fast*, and *fasting pills*. As it was clear that people did not fast for overtly spiritual reasons, they seemed driven to fast by the perceived health benefits of physical cleansing and purification as opposed to simple weight loss. The fact that these interviewees seemed more preoccupied with a desire for purity and cleanliness than weight loss per se while fasting was interesting in itself. In historical analyses tracing the links between ascetic fasting and modern-day anorexia nervosa in the West, a number of authors contend that due to a number of societal transformations—e.g. industrial revolution, fragmentation of the family, sex-role upheaval, etc.—women’s voluntary self-starvation slowly transitioned from the spiritual into the physical realm (Bell, 1985; Bemporad, 1996; Brumberg, 1998 & 2000; Bynum, 1988). Fasting for spiritual perfection and moral beauty evolved into fasting for bodily perfection and physical beauty as changing cultural norms shaped women’s long-standing propensity to ascertain personal agency by exercising control over their bodies. In a similar fashion, the ascetic principle of spiritual purity appeared to migrate from the spiritual into the physical realm from older to younger generations of women in this sample. The only difference was that according to the current interviewees, physical perfection seemed more centered in bodily purity and cleanliness than weight or figure shape. Indeed, the women I interviewed did not express nearly as intense a fear of fatness as one would expect in a sample of Western women, but rather feared bodily intoxication. In other words, it could be that for Bulgarian women, the concepts of “body image” and “body ideal” may carry

different connotations than in the West, i.e. they may imply “bodily purity” as a sign of perfection rather than “bodily thinness.” In this sense I conclude that fasting according to these Bulgarian women was in fact driven by body image, but in this case body image was understood as bodily purity. Fasting for bodily purity still clearly involves dietary restraint, which has been previously linked to disordered eating (including eating disorders). Thus, while Bulgarian women are no less susceptible to disordered eating (see Chapter 6), it seems plausible that disordered eating in these Bulgarian women center on a phobia of intoxication (or “impurity”) and not a phobia of fatness. Indeed, in a number of non-Western samples women with eating disorder symptoms have been found to lack fat phobia or a drive for thinness (Miller & Pumariega, 2001; Vetrone et al., 2006). Instead, some of these women’s non-eating has been reported to be motivated by “eccentric nutritional ideas” (Castillo, 1997). Clearly, this idea requires further investigation in the Bulgarian context.

While appreciating these moral and health reasons for fasting, fasting behavior may have provided the perfect alibi for dietary restraint and could therefore be seen as the logical starting point for certain individuals (i.e., younger, less religious Bulgarian women) who wished to seriously limit their food intake. In this respect fasting characterized by women in this sample resembled to a large extent the practice of vegetarianism as described by Sullivan and Damani (2000). These authors contend that since there is at least a passing association between vegetarianism and dietary restraint, and possibly eating disorders; a vegetarian diet may allow a fledgling disordered eater to exercise more control over their food intake possibly without the social censure of more general restriction associated with attempted slimming (Sullivan & Damani, 2000). Alternatively, choosing a vegetarian diet may in some cases result in disordered eating as an individual is introduced to the concept of dietary restraint (Sullivan & Damani, 2000). Interestingly, a link between fasting and vegetarianism was established in the analyses of younger women’s narratives. For instance Kama

(18) transitioned into non-ethical vegetarianism, because she had already begun restricting meat-based foods as she claimed to not “like” them much. She saw fasting not as a spiritual practice, but as a form of dietary restraint resembling vegetarianism, thus she thought traditional fasting for her was unnecessary as she already restricted the same foodstuffs. Nonetheless, despite her “clean” diet and young organism she thought it necessary to engage in “alternative” (or non-traditional) fasting episodes aimed at bodily cleansing. In short, this young woman seemed to have adopted a number of socially appropriate dietary rules to restrict a greater range of foods. The same tendency of some younger women to adopt fasting for ulterior motives like weight control (as opposed to spirituality) was discussed by a number of other interviewees. Moreover, the perceived lack of ability for oral control (i.e., low dietary restraint) was considered a barrier to fasting, whereas the exercise of willpower over dietary intake was a prerequisite for fasting. Based on these results, I do not believe that fasting led to more disordered eating, even though it introduced women to the concept of dietary restraint. Rather, it appeared that similarly to vegetarianism, the social sanction of fasting in some cases allowed it to function as a cover for pre-existing disordered eating among some younger Bulgarian women. The current findings suggest that under certain circumstances, individuals with inherent predispositions to restrict might start out fasting with “good” intentions of attaining health, but could begin to fast fanatically to achieve a perfectly pure and clean body. Such behavior may not be stigmatized, given the generally accepted and overly positive bases for fasting described above.

There were several limitations to this research. First, this was a small, non-representative sample of white, ethnically Bulgarian women who lived in one urban region of Bulgaria—the city of Sofia—who had moderate to high educational status, and were willing to participate in an in-depth study of their food and nutrition habits. Hence these interviewees were self-selected in that they were sufficiently interested in food and eating in order to provide their contact information on

surveys (see Chapters 5 and 6 for more detail about the survey). Interviewees also had the confidence to discuss personal issues in detail with an unfamiliar researcher. Those who were uninterested or not comfortable with the topics of this study were likely not represented in the sample. Therefore, these findings cannot be generalized beyond the current study participants and particularly not to other Bulgarian women having different socio-demographic backgrounds.

An additional limitation was that this study is based on self-report data, i.e. participants may have forgotten to include relevant information in their narratives or, on the other hand, may have been inclined to embellish the health conscious side of their dietary attitudes and behaviors, including their ideas about the practice of fasting. The latter was indeed hinted by the fact that women tended to speak much more negatively about other women's fasting attitudes and habits than about their own.

Lastly, due to the interpretive nature of qualitative research—in which the researcher constantly interacted with interviewees to guide data collection and analyses—it is inevitable that qualitative findings are somewhat susceptible to sampling bias as well as to being influenced by the researcher's field experiences (Barbour, 2001; Lincoln & Guba, 1985). Indeed, qualitative research implies a constructivist approach in which knowledge is constructed “by the researchers out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves” (Corbin & Strauss, 2008). Thus, alternative interpretations of qualitative data are possible.

Nevertheless, the use of a constructivist approach and qualitative research methods in the second phase of research allowed me to build a plausible explanatory framework about an unfamiliar and understudied phenomenon (i.e., fasting in a sample of urban Bulgarian women) based on participants' distinctive, rich, and diverse narratives (Corbin & Strauss, 2008). Since representation is not an issue in qualitative sampling, the use of intentional and purposive sampling was, in fact, a

plus for this research. The goal of purposive sampling was to obtain maximum variation in a set of desirable characteristics (e.g., age group, fasting experience, spiritual belief). This type of sampling allowed for identification of as many specifics of interviewees' fasting-related experiences as possible (Lincoln & Guba, 1985).

Moreover, the credibility of qualitative analyses was strengthened by congruence in the reports from women of various ages, religious beliefs, and fasting experiences, as well as by member checking in the sense of the interviewer paraphrasing, summarizing, and restating information received during a conversation to make sure that it is heard or understood correctly. The latter was done throughout both interviews. Additionally, the second interview was used to formally follow up on questions and topics from the first interview, as well as ask interviewees to confirm, clarify, and comment on emerging concepts and themes. However, special effort was made to refrain from the dangers of "romanticizing respondents' accounts" (Atkinson, 1997; Barbour, 2001). Qualitative research credibility was also enhanced by the scrutiny and constant comparisons of data from multiple sources (e.g., interview recordings, observations, written documents, field notes, pilot data, etc.) as part of the process of triangulation. Moreover, field notes, reflexive journals, interview transcripts, and all documentary analyses are open to independent inspection as part of an audit trail (Erlandson et al., 1993).

7.5. CONCLUSION

In conclusion, qualitative analyses revealed fasting in these women to be a complex, multifaceted behavior involving three major factors—women's religiousness (level of spirituality of the faster), body image (the faster's interest in weight loss), and the desire for physical purity and health. Women's fasting could be linked to a combination (of one to all three) of the aforementioned factors, though they differed in the degree to which they were personally important to the faster. There was a general trend of dissociation between fasting and religiousness with

younger generations of women fasting for increasingly physical rather than spiritual reasons. Only elderly women seemed to fast for overtly religious reasons. While it was true that some younger women fasted for the physical benefits of weight control, for most women in this sample fasting was a health promoting behavior that could benefit their body by cleansing and purifying it from toxic accumulations. Weight control was seen as a consequence of bodily cleansing and purification—at best as a bonus of fasting, though not necessarily its focus. Since fasting was universally accepted as both a healthy and a morally superior dietary behavior compared to regular dieting, it seemed that it acted as a disguise for potentially serious disordered eating, particularly among certain young women.

Analyses suggested that even if women were not interested in fasting for weight loss per se and engaged in fasting with “good” intentions of achieving a perfectly pure, clean, and healthy body, if turned extreme, such fasting could have potentially the same health consequences as clinical eating disorders, especially anorexia nervosa, the difference being in the motivation behind dietary restraint. This idea requires further investigation and could have implications for the way eating pathology is diagnosed, treated, or prevented in Bulgarian populations.

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CHAPTER 8

GENERAL DISCUSSION

The overall purpose of this research was to explore the ways in which external forces of Westernization (via media) and local socio-cultural factors (faith and fasting) interact to affect body image and eating disturbances in a sample of urban Bulgarian women.

8.1. OVERVIEW OF THE RESEARCH QUESTIONS

With the fall of communism in 1989, Bulgaria embarked on a rapid and turbulent journey of societal transformation as the state began transitioning from totalitarianism to capitalism, a process not yet completed. This socio-cultural transition was arguably most intense in the mid to late 1990s when problems of economic and political instability were at their peak. According to a number of authors, women have a tendency to respond to times of socio-cultural, political, and economic unrest with increases in body image and eating problems (Katzman & Lee, 1997; Meehan & Katzman, 2001; Nasser & Katzman, 1999). In fact, the socio-cultural models of eating disorders postulate that body image, body dissatisfaction, and disordered eating issues in non-Western societies emerge as a reaction to the processes of Westernization and modernization in an increasingly complicated world. In the socio-cultural models, mass media eagerly transmit and “sell” Western culture, including the ideal of ultrathin female beauty prevalent in the West. Indeed, a number of anecdotal reports by Bulgarian medical professionals and clinicians (Boyadjieva, 2008; Kerekovska, 2006; Popov, 2008), as well as the extraordinary attention to body image, weight control strategies, and eating disorders in the media that I observed first-hand in the field, suggested that negative body image and disordered eating might be a soaring concern for Bulgarian women. Thus, in the first quantitative study (see Chapter 5) I set out to investigate the levels of disordered eating attitudes and behaviors in this sample of urban Bulgarian women. In particular, I was

interested in comparing Bulgarian women's disordered eating attitudes and behaviors to the levels of disordered eating among their Western counterparts by using a common psychometric tool, the long-version of Garner and Garfinkel's (1979) Eating Attitudes Test (EAT-40). Since participants' age was considered a viable proxy for socio-cultural transition, I also wanted to see whether socio-cultural transition had any effect on women's disordered eating attitudes and behaviors. For that purpose I sampled participants from a wide range of ages, who had experienced adolescence (the developmental period in a woman's life when eating disorders are most likely to occur) at different historical periods—before 1989 (when media-based Westernization was virtually non-existent); during the height of transition in the mid to late 1990s (when Westernization was most intense due to media's novelty and its consumers' naiveté), and after the peak of transition (when Westernization was more subdued as Bulgarians got accustomed to the novel media environment).

In addition to thoroughly exploring disordered eating attitudes and behaviors in a sample of urban Bulgarians, in the second quantitative study (see Chapter 6) I focused on the effects of Westernization on the beauty norms and body image of urban Bulgarian women. In particular, I wanted to know whether these women idealized thinness and experienced normative levels of body dissatisfaction, similarly to their Western counterparts, and whether the socio-cultural models for body dissatisfaction and disordered eating based on Western media's thin images applied to the Bulgarian context. At the same time, since a growing body of literature emphasizes the importance of culture-specific factors that may moderate the effects of foreign cultural forces to produce unique expressions of body image and eating disturbance (Cashel et al., 2003; Lee, 2001), I looked into two local cultural factors—faith and fasting—peculiar to Bulgaria. Indeed, religious (or spiritual) beliefs and practices are two socio-cultural factors that have received considerable attention, as they have been found instrumental in women's non-eating and dietary restraint behaviors throughout history: recall the voluntary self-starvation of “fasting girls”—medieval female saints like St. Catherine of

Sienna, St. Wilgefortis, and St. Lidwina, or Victorian era's "miraculous maids" (Bell, 1985; Brumberg, 2000; Lacey, 1982). Importantly, religious asceticism continues to provide meaning for the extreme fasting practices of modern women with anorexia nervosa, especially those from conservative fundamentalist traditions (Banks, 1996). Even patients who do not identify as religious in the traditional sense may explain and/or justify their unhealthy eating in spiritual terms (Dell & Josephson, 2007). In short, the presence of extreme religious belief and/or severe fasting practice have been linked to the etiology of clinical eating pathology. Given that fasting has had a long history in Bulgaria—being a major tenet of Orthodox Christianity since its adoption in 865—I wondered whether local cultural factors like faith and fasting might play a role in the schema of body dissatisfaction and disordered eating among urban Bulgarian women.

Originally a part of religious doctrine, fasting has become deeply ingrained into the cultural traditions, customs, and way of life of Bulgarians, which in part explains why so many contemporary Bulgarians continue to fast, despite being mostly secular. In the second study, 40% of women engaged in some form of fasting, while only 7% were actually religious (active believers). As church participation in Bulgaria was actively suppressed during the communist period, a number of researchers point out that the religious feeling of modern Bulgarians is rather weak. In fact, the country ranks 17th among the 50 most atheistic states in the world, the top 20 of which are predominantly European (Ghodsee, 2009; Zuckerman, 2006). Nevertheless, an overwhelming proportion of Bulgarians (about 84% of the country's population) would claim affiliation with the Bulgarian Orthodox Church. This apparent disconnect between stated and actual religiousness prompted the Bulgarian scholar Petar Kanev (2002) to conclude that for Bulgarians religiousness had little to do with believing in God, but much to do with asserting cultural and ethnic identity. According to Bogomilova (2004), Bulgarians' religious feeling is at best "hesitant," in that it lacks true insight into Church doctrine. Considering these circumstances, I suspected that fasting for

Bulgarians was no longer a strictly religious rite, but had rather become a culturally unique tradition, a custom performed without thorough understanding of its spiritual fundament. Thus, in the third study (see Chapter 7) I set out to make sense of faith-based fasting among predominantly secular individuals by employing qualitative research techniques. Qualitative methodology was particularly appropriate for this purpose, as it allowed me to gain a deeper understanding of Bulgarian women's fasting beliefs, attitudes, and practices. Specifically, I was interested in exploring possible factors influencing fasting perceptions and practice, the two most obvious ones being religiousness (or spirituality) and body image (the desire for weight loss and achievement of a thin-ideal figure). Simultaneously, I searched for additional factors that might explain fasting among urban Bulgarian women.

8.2. OVERVIEW OF RESEARCH DESIGN AND METHODS

The overall research presented in this dissertation employed a mixed method approach—a combination of quantitative and qualitative techniques—to study issues of body image and eating disturbance in a sample of urban Bulgarians. Although both men and women were sampled during data collection, the current dissertation focuses only on women as they presented an intriguing picture. Not surprisingly, women's levels of body dissatisfaction and disordered eating were much higher than that of men (data on disordered eating for men was presented in Study 1 (presented in Chapter 5), therefore statistically significant associations between disordered eating attitudes and behaviors and the remaining variables of interest were more likely to be found. As men generally display lower levels of body image and disordered eating symptoms, a much larger sample of men (i.e., more statistical power) would have been necessary to detect body image and eating problems among urban Bulgarian men. The first phase of research, represented by Studies 1 and 2 (see Chapters 5 and 6, respectively), was quantitative, using a standard survey approach. Convenience and snowball sampling were employed to recruit a wide age range of individuals (of both genders)

from the population of Sofia (the largest metropolitan area and capital of Bulgaria). Participants were invited to leave their contact information on the front or back of the 10-page survey booklet if they wished to partake in the qualitative interview process as part of the second phase of research. Based on information provided in their survey, a sample of interviewees (of both genders) was purposively selected to include individuals of various ages, media consumption habits, and fasting experiences. These individuals participated in two consecutive, semi-structured qualitative interviews at a time and place of their choosing. Data from the qualitative phase of research concerning women are presented in Study 3 (see Chapter 7). Survey data were analyzed via a number of quantitative techniques, including descriptive statistics, paired t-tests, Student's t-tests, Fisher's exact test, Analysis of Variance (ANOVA), simple and multiple linear regression, partial correlation analysis, Principle Components Analysis (PCA), and Classification and Regression Trees (CART)/recursive partitioning analysis. In turn, interview recordings were transcribed and analyzed qualitatively using the grounded theory approach. Qualitative analyses were enhanced by participant observations, which were used to deepen the investigator's understanding of the phenomena of interest. Lastly, quantitative findings were used as part of the data reduction process to inform qualitative analyses and narrow their scope (Miles & Huberman, 1994).

8.3. SUMMARY OF FINDINGS

Study 1's findings (see Chapter 5) revealed levels of disordered eating attitudes and behaviors among sampled women that were as high as those observed in Western cultures, if not higher, especially considering that the studied Bulgarian women had a much older mean age than most Western samples, as it excluded individuals at the height of eating disorders—those younger than 18 years (American Psychiatric Association, 2000; Preti et al., 2009). Moreover, close to two-thirds of women displayed subclinical levels of disordered eating by scoring at least 10 points on the EAT-40. These results were particularly striking, given that female participants were also on average thinner

than their Western counterparts. Contrary to what the literature predicts, levels of disordered eating attitudes and behaviors did not decline with age. I believe that this lack of decline was likely due to cohort effects reflecting historical changes in the beauty ideal associated with societal transformation, as opposed to naturally occurring age-related developmental processes. Women currently in their 30s and 40s were adolescents and young adults during the peak of socio-cultural transition, thus held attitudes towards the body and eating that were possibly more disturbed than women who formed their self-concept before or after the transition. Due to scarcity of research in this area, it was hard to deduce whether disordered eating attitudes and behaviors had increased, decreased, or remained the same in Bulgaria since the peak of socio-economic transition in the early to mid 1990s. Nevertheless, it seemed plausible that disordered eating attitudes and behaviors had remained relatively unchanged over the past 15 or so years, as individuals growing up at the time peak of transition had likely retained their presumably more disordered eating attitudes and behaviors into their adulthood, leading to cohort effects as opposed to true increases in disordered eating. Lastly, findings from this study clearly challenged the validity of the full EAT-40 in mature populations. Unlike younger women, the elderly tended to score high on the EAT, not because of true disordered eating, but likely due to conditions and behaviors typical of old age, such as dental problems (requiring cutting food into small pieces), lack of novelty seeking (low food exploration), and age-related depression, among others.

Findings from Study 2 (see Chapter 6) revealed remarkable levels of body dissatisfaction among urban Bulgarian women—almost two-thirds of them desired to be thinner, despite most being of normal weight. Even underweight women—a good 30% of them—wanted to be thinner while the majority (55%) were in fact happy to be ultrathin. In other words, the sampled women experienced normative body dissatisfaction of magnitude that was comparable to the West, if not higher, given participants' older mean age and lighter weight status. Not only did these women

idealize a thin figure, they actually acted on their desire for thinness. Great measures were taken to alleviate body dissatisfaction by engaging in alarming rates of dieting comparable to the West (60-80% of female samples), even though Bulgarian women were on average much lighter than the typical Western woman. In short, thinness was a highly desirable and enthusiastically pursued aesthetic ideal for these Bulgarian women. Since most fasters also dieted (fasting and dieting were inter-correlated) and a large number of them fasted despite being non-religious, it seemed reasonable that fasting played a role in the above processes by serving as a strategy for dietary restraint in pursuit of an ideal figure.

In accordance with the socio-cultural models, Western media influences explained *some* of the body image problems in this sample. The more media women consumed, the more accepting they were of the societal thin-beauty norms, and the more they experienced normative body dissatisfaction. Interestingly, media exposure was positively associated with disordered eating attitudes and behaviors. However, Western media influences did not explain *all* body image and eating problems in this sample. For one, there was a surprising lack of direct association between body dissatisfaction and disordered eating attitudes and behaviors, which was possibly due to high levels of body dissatisfaction among these women. Moreover, the direct association between media exposure and disordered eating attitudes and behaviors disappeared in regression analyses, indicating that thin ideal awareness and internalization, and dietary restraint behaviors were the key intermediaries in the complex pathway from media influences through body dissatisfaction into disordered eating. Indeed, dietary restraint behaviors seemed to trigger the progression of body dissatisfaction into disordered eating. Since fasting (a culture-unique factor) was one of these dietary restraint behaviors, I surmised that culture specific factors could be involved at this level. Moreover, the most spiritual participants in the sample also displayed the most dietary restraint, thus it seemed possible that faith influenced disordered eating attitudes and behaviors indirectly—at the level of

dietary restraint. As fasting (although related) was not exclusive to spirituality, I needed to understand the individual roles of dieting and fasting in the schema of body image and disordered eating among the women in this sample. In other words, I looked into the factors describing each of the two dietary restraint behaviors.

CART/recursive partitioning analysis uncovered three main factors describing dietary restraint behaviors among these Bulgarian women: body dissatisfaction, faith, and media exposure. Dieting was the restraint behavior intervening in the pathway from media influences to disordered eating for all participants. With respect to faith and fasting, however, women could be divided into two groups who behaved differently based on their levels of disordered eating attitudes and behaviors. For women with *high* EAT-40 scores, faith seemed to have *harmful* effects, perhaps by virtue of motivating dietary restraint. Moreover, some of these women tended to use fasting to maintain and/or reinforce pre-existing disordered eating. Thus, for women with elevated EAT-40 scores fasting was likely but one strategy for weight management and the achievement of a desired thin figure consistent with the socio-cultural models. In contrast, among women with low EAT-40 scores, faith seemed to have a *protective* effect against excessive dieting. These women were more likely to use fasting in the way intended by religious scripture—for faith-related reasons.

Consistent with these results, study 3's (see Chapter 7) analyses found fasting to be a complex, multifaceted, and dynamic behavior, which varied among different groups of women. There were three major factors—religiousness (level of spirituality of the faster), body image (the faster's interest in weight loss), and the desire for physical purity and health—that simultaneously provided motivation for fasting, though the personal importance of each individual influencing factor differed among women. There seemed to be a disconnect between religious belief and the practice of fasting, which intensified in younger generations of women, in other words, there were clear cohort effects by which only elderly women fasted for predominantly religious reasons,

whereas younger women (especially teenage and young adult women) tended to understand and value fasting for its physical benefits. Of the physical benefits that fasting provided, fasting for weight control interested a subgroup of younger women. Overall, however, fasting seemed to be primarily driven by an overwhelming desire for physical purity with the goal of attaining a perfectly clean and healthy body. Weight control was seen as a consequence of bodily cleansing and purification—at best as a bonus of fasting, though not necessarily its focus.

8.4. LIMITATIONS OF THE OVERALL STUDY

There were several overall limitations to this research, pertaining to either its quantitative or qualitative side. First, a potential weakness was that survey participants were not recruited randomly. Instead, convenience and snowball sampling techniques were used. Although an effort was made to find individuals of various age groups and socio-economic backgrounds, young (high school and college students) and highly educated women were overrepresented in the final survey sample. Moreover, the participants were all residents of the major metropolitan area of Sofia in Western Bulgaria. For these reasons, this sample of individuals cannot be seen as representative of other populations or of the Bulgarian population as a whole, a weakness that can be avoided by sampling randomly throughout the country in future studies. Since the sub-sample of interviewees studied in the second phase of research was purposively selected from the larger survey sample, issues of non-representation and generalizability to other populations also apply to qualitative findings.

Second, the cross-sectional nature of this research did not allow for strong causal inferences and may not have adequately reflected the temporal associations among the variables (Stice et al., 1994). A well-controlled, longitudinal study would have been ideal for closely tracking the evolution of disordered eating and body image disturbances; alas, it is now too late for such a study.

Third, the reliance on measures that were self-reported and highly face-valid may have introduced self-presentational bias in both quantitative and qualitative data. Due to recent increases

in media attention on eating disorders—observed firsthand by me while in the field—accompanied by a growth in awareness about these conditions and a deepening of the social stigma associated with them, certain participants may have been reluctant to disclose body image and eating problems, resulting in potentially erroneous reporting. Furthermore, willingness to participate in research about body image and eating habits may have been an issue for individuals with serious eating problems or overt eating disorders, who would have been less likely to fill out the survey or volunteer for in-depth interviewing. However, the fact that there was a higher than expected rate of disordered eating attitudes and behaviors among women militates against this being a significant problem. In fact, interview participants had to be particularly confident and willing to discuss personal issues in detail with an unfamiliar researcher. Additionally, consent to participation in surveys and interviews may have been based on the extent to which the study topics were of interest or relevance to potential research participants.

A number of study limitations also stem from the choice of psychometric instruments for the assessment of media consumption, body image, and disordered eating attitudes and behaviors in the survey sample. It should be noted that the EAT detects only current disordered eating and is not able to uncover past issues with eating, nor predict the development of such issues in the future. Therefore, any conclusions about the rates of disordered eating attitudes and behaviors in this sample—extending beyond the point in time when data collection occurred—should be made with caution. Furthermore, the EAT was developed to measure symptoms of anorexia nervosa at a time when bulimia nervosa and binge eating disorder had not been yet classified. Thus, it is possible that the EAT may not be as sensitive an instrument among participants with attitudes and behaviors typical of bulimics or binge eaters. Moreover, because the prevalence of a disorder must approach 20% for a test to be efficient in detecting it, the EAT is not very effective in screening for eating disorders that have very low prevalence (2-4% for young women) in the general population

(Garfinkel & Newman, 2001). Indeed, the EAT works best for populations at “risk,” such as adolescents and young adults. As study 1 revealed, the EAT had questionable utility in elderly populations. Moreover, due to the exploratory nature of this study I used rather simple measures of dieting behavior, faith-based practice (fasting behavior), and spiritual belief (faith) to look for novel trends and associations in the data. Indeed, fasting and dieting were assessed using a single item, providing little information about the nature or intensity of each restrictive dietary behavior. Similarly, spiritual belief was measured by a single question focusing on the level of faith participants experienced, while other important features of spirituality—e.g., the importance of faith in one’s life, the consolation power placed in faith or the spiritual community, intrinsic vs. extrinsic reasons for engaging in spiritual practices, and the role of spirituality in coping with body image or eating issues—were not addressed in this pilot survey study. A more comprehensive assessment of dietary restraint and spirituality, possibly via the use of standardized measurement tools adapted to the Bulgarian situation and informed by the results of the qualitative study, can add to the understanding of the culture-specific (faith and fasting) idioms of body image and eating distress among women in future samples. Although quantitative findings on body image seemed congruent among themselves, as well as with similar Western data, the validity of instruments measuring media consumption, figure dissatisfaction, and thin-ideal adoption remains to be confirmed in Bulgarian populations.

Moreover, no retrospective data were available to me concerning Bulgarian women’s body image and eating disturbances during the communist period, thus I was not able to ascertain the temporal trends in the prevalence of these disturbances and the factors involved in their progression. It is possible that body image issues and disordered eating were prevalent in Bulgarian society even before the massive influx of Western cultural influences and before individuals were free to openly express their spirituality, thus an entirely different set of cultural factors may be

implicated in the development and maintenance of body dissatisfaction and disordered eating among Bulgarian women.

Lastly, due to the interpretive nature of qualitative research—in which the researcher constantly interacted with interviewees to guide data collection and analyses—it is inevitable that qualitative findings are somewhat susceptible to sampling bias as well as to being influenced by the researcher’s field experiences (Barbour, 2001; Lincoln & Guba, 1985). Indeed, qualitative research implies a constructivist approach in which knowledge is constructed “by the researchers out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves” (Corbin & Strauss, 2008). Thus, alternative interpretations of qualitative data are possible.

8.5. STRENGTHS OF THE OVERALL STUDY

Despite these limitations, the current research also has many notable strengths. First, although quantitative sampling was not random, it was nevertheless suitable, because it provided a sample of educated, urban Bulgarians who were most likely to have experienced the effects of socio-cultural transition. Participants were skilled at Western-European languages, thus highly receptive to Western cultural influences. They were also highly literate, therefore able to follow written instructions and complete a questionnaire of unfamiliar format with minimal errors. Moreover, Sofia was an excellent choice of location for this dissertation study, being the country’s capital and therefore major point of influx for Western cultural influences (including the Western thin ideal) and media. Since representation is not an issue in qualitative sampling, the use of intentional and purposive sampling was a plus for the qualitative side of this research. The goal of purposive sampling was to obtain maximum variation in a set of desirable characteristics (e.g., age group, fasting experience, spiritual belief). This type of sampling allowed for identification of as many specifics of interviewees’ fasting-related experiences as possible (Lincoln & Guba, 1985).

Second, the cross-sectional nature of this investigation was a good choice keeping in mind its exploratory, hypothesis-generating nature. This cross-sectional design provided an inexpensive and quick way of determining the prevalence of body image and eating issues among the women in this sample, and was useful to highlight interesting associations that could be further explored using more rigorous study designs.

Third, given that participation was anonymous and confidential, and no personal identifying information was recorded on the survey booklets, the perceived pressure to provide socially desirable responses should have been kept at a minimum. Moreover, I tried to curtail erroneous reporting by being, whenever possible, physically present at the site and time of survey administration to address participants' questions or concerns. If the latter was not feasible, participant's inquiries were addressed by study liaisons—high-school teachers, university professors, or other contact individuals—who had previously filled out the survey, were familiar with its content, and were trained by me to answer survey-related questions. Even though self-selection was inevitable, I attempted to minimize it by titling the study and promoting its topic in rather general (less face-valid) terms as a study of “the food and eating habits of modern Bulgarians.” By not formally measuring weight and height in this study, participation bias towards individuals comfortable with their bodies was restricted, as taking formal anthropometric measurements often makes individuals hesitant to partake in a study (Twamley & Davis, 1999). In addition, during survey recruitment, the researcher (myself) or a contact intermediary who was not a stranger established a personal contact with the participants, which may have fostered their trust and willingness to disclose sensitive information, including struggles with eating and body image. When it came to the qualitative side of this research, self-presentation bias and erroneous reporting during the interview process were offset by my prolonged engagement with study participants (starting with collecting the survey and continuing with two consecutive in-depth interviews), as well as my

cultural and linguistic competence, which provided scope and facilitated trust despite the relatively short duration of fieldwork (Lincoln & Guba, 1985).

Additionally, variables like media consumption, figure dissatisfaction, thin-ideal adoption, and disordered eating attitudes and behaviors were assessed using well-established psychometric instruments that had been previously studied in samples of urban Bulgarian (e.g., my own pilot study in summer 2008, Boyadjieva & Steinhausen, 1996) and Ukrainian women (Biloukha, 2000; Bilukha & Utermohlen, 2002). This is one of a few studies to assess the psychometric properties of the EAT across different age groups and especially with mature non-clinical populations. The latter represents a significant strength given that the EAT is one of the most frequently used instruments to assess disordered eating attitudes and behaviors across a wide range of populations from diverse cultural backgrounds. Regardless of its many shortcomings, the EAT is still a highly standardized and valid tool for the assessment of disordered eating and its use allowed for meaningful trans-cultural comparisons of quantitative results.

Lastly, the use of a constructivist approach and qualitative research methods in the second phase of research was well suited for this project, because it allowed me to build a plausible explanatory framework about an unfamiliar and understudied phenomenon (i.e., fasting in a sample of urban Bulgarian women) based on participants' distinctive, rich, and diverse narratives (Corbin & Strauss, 2008). The credibility of qualitative analyses was strengthened by congruence in the reports from women of various ages, religious beliefs, and fasting experiences, as well as by member checking in the sense of the interviewer paraphrasing, summarizing, and restating information received during a conversation to make sure that it is heard or understood correctly. The latter was done throughout both interviews. Additionally, the second interview was used to formally follow up on questions and topics from the first interview, as well as ask interviewees to confirm, clarify, and comment on emerging concepts and themes. However, special effort was made to refrain from the

dangers of “romanticizing respondents’ accounts” (Atkinson, 1997; Barbour, 2001). Qualitative research credibility was also enhanced by the scrutiny and constant comparisons of data from multiple sources (e.g., interview recordings, observations, written documents, field notes, pilot data, etc.) as part of the process of triangulation. Moreover, field notes, reflexive journals, interview transcripts, and all documentary analyses are open to independent inspection as part of an audit trail (Erlandson et al., 1993).

Overall, the use of a mixed method approach in this dissertation project was a definite plus, since it allowed for corroboration of evidence obtained in the quantitative and qualitative phases of research. Quantitative findings informed and focused the scope of qualitative analyses, which considerably reduced analytical labor, facilitated a clear research direction, and helped with avoiding what Barbour (2001) called the “near mysticism” of grounded theory approach. Integrating results obtained with different analytical methods (qualitative and quantitative) complemented the data triangulation process in order to validate and confirm the findings from this research, thereby ensuring its quality.

8.6. INTEGRATION OF MAJOR CONCLUSIONS

This dissertation research focused on studying body image and eating distress in a sample of urban Bulgarian women, aged 18-81 years, living in the metropolitan area of Sofia. The overall research began with Study 1 in which I quantifying disordered eating attitudes and behaviors in a sample of Bulgarian women. Once the prevalence of disordered eating was established and put into perspective by comparisons with other Western and Bulgarian samples, Study 2 sought to explore the multitude of possible explanations for the high levels of disordered eating among these Bulgarian women. Specifically, Study 2 looked into the “glocalization” of disordered eating attitudes and behaviors in the Bulgarian context, or in other words, the merging of foreign (Western) and local cultural influences to produce a culturally unique expression of body image and disordered eating

distress among the surveyed urban Bulgarian women (Ritzer, 2003). A socio-cultural model for eating disorders based on Western media influences explained some, though not all, of the body image and eating distress in this sample. Surprisingly, body dissatisfaction was not directly associated with disordered eating attitudes and behaviors. Instead, dietary restraint behaviors (fasting and/or dieting) served as intermediaries for the effects of Western media on the studied women's disordered eating attitudes and behaviors. Faith, a culture-specific factor, was associated with disordered eating attitudes and behaviors at the level of dietary restraint. That two local culture-specific factors—fasting, a dietary restraint behavior, and faith seemed to play a role in these Bulgarian women's eating distress was a novel finding. To further explore this possibility, Study 3 zoomed in on the fasting beliefs, attitudes, and behavior of these Bulgarian women. The goal of this qualitative study was to develop an understanding of the factors motivating fasting behavior. Consistent with Study 2's findings, faith was associated with fasting behavior, though it was not a decisive factor in distinguishing fasters from non-fasters. Moreover, consistent with quantitative data from Study 2 body, dissatisfaction (the desire for thinness and weight loss) provided motivation for fasting only among some young women. For most women, however, fasting was related to the desire for bodily purity rather than the desire for thinness. As corroborated by qualitative analyses, fasting was universally accepted as both a healthy and a morally superior dietary behavior compared to regular dieting. Thus, it seemed plausible that for certain women fasting served as a cover for potentially problematic eating—these women may have engaged in fasting with “good” intentions of achieving a perfectly pure, clean, and healthy body. Fasting for bodily purity still clearly involves dietary restraint, which has been previously linked to disordered eating (including eating disorders). If extreme, such fasting could have potentially the same health consequences as clinical eating disorders, especially anorexia nervosa, the only difference being in the motivation behind dietary

restraint. Figure 8.1 summarizes the conceptual model explaining disordered eating among the studied urban Bulgarian women based on findings from the three studies.

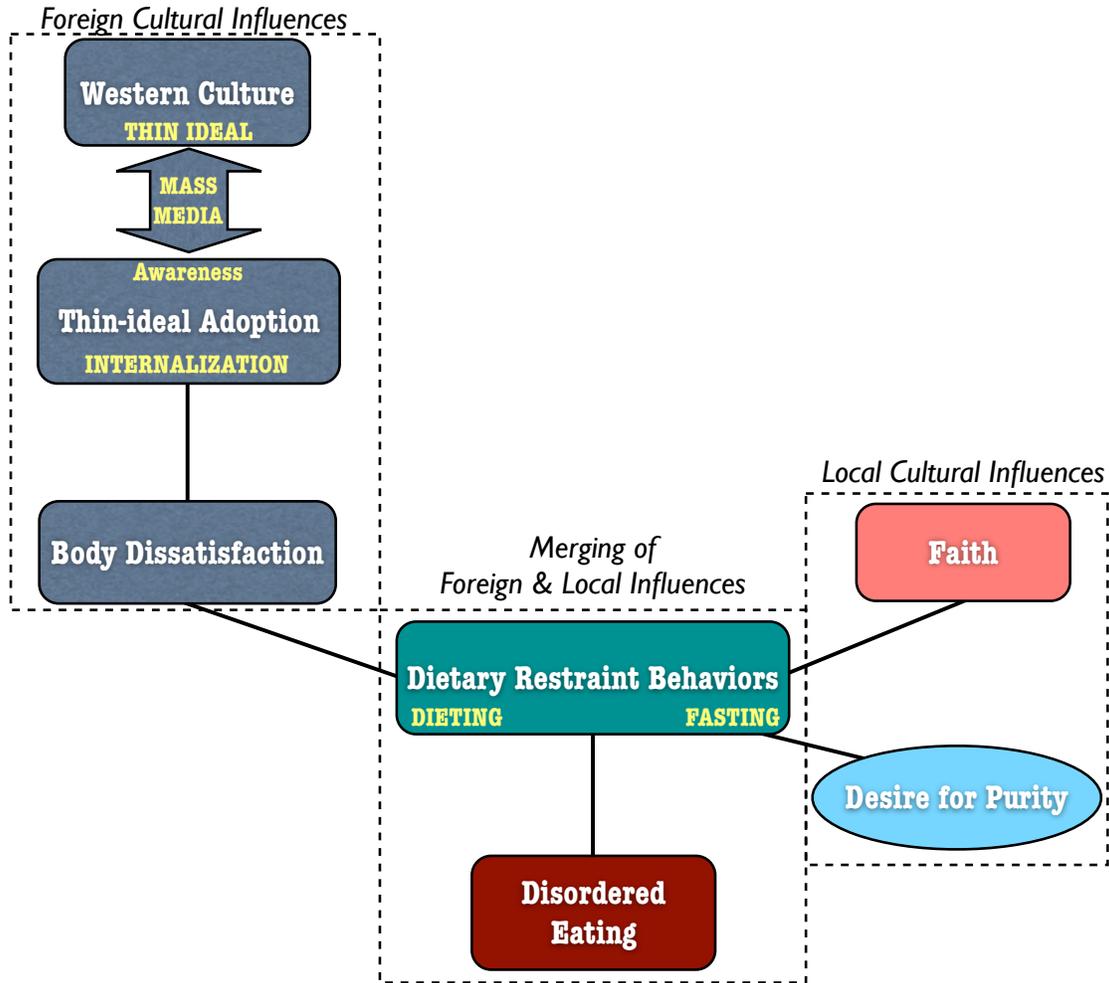


Figure 8.1. Conceptual model illustrating integration of research findings.

8.7. SIGNIFICANCE AND IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

This research contributes to the literature on body image and disordered eating by reporting on a transitional country from an understudied region of the world. Indeed, Bulgaria presents a unique opportunity for studying possible socio-cultural factors affecting body image and eating behavior during a major socio-cultural transition. Because body image and related attitudes and

behaviors are a reflection of the sociological, economic, as well as the psychological status of the individual, these are likely to change in response to external conditions. Thus, it was possible to explore the spread of Western thin-beauty ideal and its effect on eating behavior in a sample of Bulgarian women as the country became more integrated into the European Union, which it joined in January 2007.

Study 1 is the second study and the first in recent years to report in English on disordered eating attitudes and behaviors in a community sample of Bulgarian women. Findings from this study suggest that disordered eating may be a serious problem in Bulgarian women, thereby providing a starting point for determining the true prevalence of eating disorders among women in post-communist Bulgaria. The time seems ripe for conducting randomized, multiphase epidemiological studies addressing eating disorders in the Bulgarian population in order to gauge the magnitude of this problem and respond to it with the most effective prevention and treatment options. Additionally, findings from Study 1 raised the issue of validity of the EAT-40 questionnaire in elderly women. Thus, future research should focus on developing age-appropriate tools for assessing eating-related problems in elderly populations.

To the best of my knowledge, Study 2 is the first to report on body dissatisfaction and its correlates in a sample of Bulgarians, and to apply a socio-cultural explanation to body dissatisfaction and disordered eating in these Bulgarians. In addition to providing support for the socio-cultural models for the spread of disordered eating in transitional countries based on the impact of Western media influences, Study 2 contributes to the eating disorder literature by emphasizing the importance of local, culture-specific factors that may trigger the progression of body dissatisfaction into overt eating distress. Future studies should seek to investigate the exact roles of faith and fasting in the etiology, maintenance, or recovery from body image and eating pathology in Bulgarian women by using more sophisticated, culturally appropriate measurement instruments.

Understanding local cultural factors in the progression of body image distress and eating disorders is also a key step towards designing culturally appropriate interventions and public health policies aimed at preventing such conditions in the Bulgarian population.

Lastly, Study 3 adds to the cross-cultural literature on eating disorders by suggesting an alternate motivation for eating distress in a sample of Bulgarian women. This study proposes that dietary restraint and consequently eating disorders in Bulgarian women may be motivated by a desire for bodily cleansing and purification instead of the desire for thinness. This idea requires further attention—if corroborated, it could have implications for the way eating pathology is diagnosed, treated, or prevented in Bulgarian populations.

The overall study's value lies in its timeliness, as eating disorders are at present considered to be a socially significant problem by Bulgarians due to, among other things, the large numbers of “official registered cases” (Kerekovska, 2006). However these claims have not been supported by any recent concrete evidence. Similarly, there is a lack of sufficient understanding of body image and disordered eating in Bulgaria, coupled with a lack of scientific attention to these conditions, a lack of data and of research and the funding for it, a lack of cooperation among professionals, a lack of specialized treatment programs, and a lack of treatment facilities (Kerekovska, 2006). Importantly, research of the specific (i.e., local) socio-cultural factors related to body image and disordered eating conditions within the Bulgarian context is absent, as is research and understanding of the specific, local meanings of beauty and non-eating. Consequently, culturally unsuitable or irrelevant treatment methods are being used for the prevention or treatment of eating disorders, making recovery all the more difficult. This is partly due to the fact that the state policy and healthcare provisions for clinical eating disorder cases are still highly inadequate (Kerekovska, 2006). At the same time, however, these conditions are attracting the public's attention, for example through a recent nationwide campaign to combat anorexia sponsored by a popular magazine. Also,

the number of individual specialists dealing with these issues seems to be growing (Boyadjieva, 2008). As a result there may be interest in and application for the research presented here, as it was aimed at understanding the processes and influences affecting the development of eating disorders in the Bulgarian context. The current research can be of use in helping formulate a special national policy and program focused on eating disorders.

To sum up, the present dissertation research provides an opportunity for a closer look at possible causes of body image and disturbed eating attitudes and behaviors in Bulgaria. Its contribution to research lies in its potential for hypothesis development for future studies, for the development of culturally relevant and therefore more effective approaches to preventing and treating body image and eating disorders, and for the development of culture-specific means for promoting healthy ideals. Widening the scope of application, this study added to the understanding of body image and disordered eating in the trans-cultural context.

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APPENDIX 1:
RECRUITMENT BROCHURE
(IN BULGARIAN AND ENGLISH)

FOOD AND EATING HABITS:

ARE BULGARIANS CHANGING?



We invite you to take part in a study of the nutritional habits of contemporary Bulgarians.

Your opinion is valuable to us!

For more information contact:

ROSA ANGELOVA

Work: (02) 8668635

Mobile: (0895) 119656

Email: raa29@cornell.edu

TELL US ABOUT YOURSELF:

- ~What are your food habits and preferences?
- ~How have they changed since childhood?
- ~What does healthy eating mean to you?
- ~What do you think affects your eating?

All your answers will be completely confidential!

To participate, please contact:

ROSA ANGELOVA

PhD Candidate

Division of Nutritional Sciences

CORNELL UNIVERSITY

Work: (02) 8668635

Mobile: (0895) 119656

Email: raa29@cornell.edu



APPENDIX 2:
SURVEY QUESTIONNAIRE BOOKLET
(IN BULGARIAN AND ENGLISH)

ХРАНА И ХРАНИТЕЛНИ НАВИЦИ НА СЪВРЕМЕННИТЕ БЪЛГАРИ (АНКЕТА)

ДИСЕРТАЦИОННО ИЗСЛЕДВАНЕ

НА

РОЗА АНГЕЛОВА • ДОКТОРСКИ КАНДИДАТ • УНИВЕРСИТЕТ КОРНЕЛ

ВАЖНО: Формуляр за информирано съгласие е прикачен най-отгоре върху тази книжка

ВАЖНО!

**МОЛЯ ПРОЧЕТЕТЕ И РАЗПИШЕТЕ ФОРМУЛЯРА ЗА ИНФОРМИРАНО СЪГЛАСИЕ, ПРЕДИ ДА
ПРОДЪЛЖИТЕ:**

- ▶ НЕ пишете името си никъде
- ▶ Отправайте въпросите към Роза в момента или на: (02) 8668635, (0895) 119656, raa29@cornell.edu
- ▶ Четете внимателно и спазвайте инструкциите за въпросите
- ▶ Отговорете на ВСИЧКИ въпроси, като изберете опцията(ите), която(ито) Ви описва(т) най-добре
- ▶ Можете да пишете бележки където и да било върху анкетата
- ▶ Върнете обратно ВСИЧКИ листа

Здравейте! Казвам се Роза Ангелова и съм докторски кандидат по хранене в университета Корнел в САЩ. Тази анкета е част от работата по докторската ми дисертация. Целта ми е да науча повече за хранителните Ви навици, вярвания и нагласи, както и за мнението Ви за определени видове медии.

Уверявам Ви, че по никакъв начин няма да давам оценка или съдя личните Ви вярвания, мнения, нагласи, постъпки или навици, споделени в тази анкета. Вашите отговори са уникални и еднакво важни за мен. Анкета е напълно **поверителна** и **анонимна**.

АКО ИСКАТЕ ДА ОБСЪДИТЕ РЕЗУЛТАТИТЕ СИ, МОЛЯ ОСТАВЕТЕ ИНФОРМАЦИЯ ЗА ВРЪЗКА ТУК:

Телефон: _____ Най-подходящо време за връзка: _____

Мобилен: _____ Най-подходящо време за връзка: _____

Друго: _____

БЛАГОДАРИЯ!

Къде се намирате в момента (на училище, на работа, вкъщи и пр.)? _____

Каква дата е? _____ Ден _____ Месец 20 _____ Година Колко е часът? _____ Сутрин / Следобед / Вечер

В момента тежа около _____ КГ при ръст _____ СМ (Загради едно)

При сегашния ми ръст, най-малкото ми тегло е било около _____ КГ, а най-голямото около _____ КГ

Дата и Място на Раждане	Месец: _____ Година: _____ Роден(а) съм в (град/село), уточни: _____ Израсъл(ла) съм в (град/село), уточни: _____	
Пол (загради едно)	Мъж / Жена	
Раса, Произход, и Религия (загради едно)	Раса: Бяла / Друго (уточни): _____ Произход: Български / Турски / Ромски / Друго (уточни): _____ Религия: Източно Православие / Друго Християнство (уточни): _____ / Друго (уточни): _____	
Владеене на Езици (загради подходящите)	Чета и разбирам говорим: _____ Английски / _____ Френски, Немски, Испански, или Италиански	
	НЕ чета и НЕ разбирам говорим: _____ Английски / _____ Френски, Немски, Испански, или Италиански	
Законно Семейно Положение (отбележи едно със знак X)	<input type="checkbox"/> Никога неомъжвана/неженен <input type="checkbox"/> Омъжена/женен, първи и единствен брак <input type="checkbox"/> Омъжена/женен отново <input type="checkbox"/> Разделен(а) или разведен(а) <input type="checkbox"/> Овдовял(а) <input type="checkbox"/> Друго (уточни): _____	
Работно Положение (отбележи едно със знак X)	<input type="checkbox"/> Ученик/студент <input type="checkbox"/> Работещ ученик/студент <input type="checkbox"/> Безработен(на) <input type="checkbox"/> Работещ(а) (включително "работя за себе си" или "работя на свободни начала") <input type="checkbox"/> Пенсионер <input type="checkbox"/> Работещ пенсионер <input type="checkbox"/> Друго (уточни): _____	
Професионална Категория (отбележи едно със знак X)	<input type="checkbox"/> НЕ се отнася за мен >>> ПРЕСКОЧИ "Професионална Категория"	
	<input type="checkbox"/> Бизнес, финанси, счетоводство и банково дело <input type="checkbox"/> Комуникации, медии и маркетинг <input type="checkbox"/> Архитектура и инженерство <input type="checkbox"/> Строителство и поправка на сгради <input type="checkbox"/> Здравеопазване и право <input type="checkbox"/> Услуги и туризъм <input type="checkbox"/> Образование, академия, науки и изследвания <input type="checkbox"/> Търговия и продажби <input type="checkbox"/> Изкуства и занаяти <input type="checkbox"/> Друго (уточни): _____	<input type="checkbox"/> Управител/професионалист <input type="checkbox"/> Среден мениджър <input type="checkbox"/> Нисш мениджър <input type="checkbox"/> Работник <input type="checkbox"/> Друго (уточни): _____

Ученик/Студент в Моментa (отбележи едно със знак X)	___ НЕ се отнася за мен >>> ПРЕСКОЧИ "Ученик/Студент в Моментa"		
	___ Гимназиално (9ти клас и нагоре) ___ Полу-висше (Колеж или еквивалент) ___ Висше (Университет или еквивалент) >>> Това Магистър или нагоре ли е? Да ___ Не ___ ___ Друго (уточни): _____		
Най-високо Ниво на Завършено Образование (отбележи едно със знак X)	___ Начално (До 4ти клас включително) ___ Прогимназиално (До 8ми клас включително) ___ Гимназиално (9ти клас и нагоре) ___ Полу-висше (Колеж или еквивалент) ___ Висше (Университет или еквивалент) >>> Това Магистър или нагоре ли е? Да ___ Не ___ ___ Друго (уточни): _____		
	Имате ли повече от едно висше образование? Да ___ Не ___ НЕ се отнася за мен ___		
Допълнително Образование/ Специализация (отбележи едно със знак X)	___ НЕ се отнася за мен >>> ПРЕСКОЧИ "Допълнително Образование/Специализация"		
	___ Имам малко допълнително образование или професионално обучение/училище ___ Имам завършено поне едно допълнително образование или професионално обучение/ училище ___ Друго (уточни): _____		
Общ Месечен Доход на Домакинството и Месечен Разход на Домакинството за Храна (отбележи едно със знак X)	(Този 1 ред е само за изследователя >>> лв./USD обменен курс днес е: _____)		
	Общ доход на домакинството Ви (груба сметка): ___ Под 400 лв. месечно ___ 400 до 699 лв. месечно ___ 700 до 999 лв. месечно ___ 1000 до 1299 лв. месечно ___ 1300 до 1599 лв. месечно ___ 1600 до 1899 лв. месечно ___ 1900 лв. и нагоре месечно	Брой хора, които този приход издържа (груба сметка): а. Брой възрастни (18 г. и нагоре): _____ б. Брой деца (под 18 г.): _____	Разход на домакинството за ХРАНА като % от общия доход на домакинството Ви (включи безалкохолни напитки в грубата сметка): ___ Под 10% месечно ___ 10 до 29% месечно ___ 30 до 49% месечно ___ 50 до 69% месечно ___ 70% и нагоре месечно
Вяра (отбележи едно със знак X)	___ Атеист (Мисля, че Господ не съществува) ___ Агностик (Нито вярвам, нито отричам Господ) ___ Пасивно вярващ(а) (Вярвам в Господ, но НЕ практикувам стриктно) ___ Активно вярващ(а) (Вярвам в Господ И практикувам стриктно) ___ Без определени вярвания (Имам вяра, но НЕ съм религиозен/на) ___ Друго (уточни): _____		
Постя (загради едно)	Никога / Понякога / Редовно / НЕ се отнася за мен / Друго (уточни): _____		

МЕДИЙНО ИЗЛОЖЕНИЕ

Моля отговорете на следните 2 въпроса, като заградете най-подходящите за Вас отговори.

Колко часа на ден средно гледате телевизия? (загради всички подходящи отговори)	Обикновено гледам телевизия: Активно / Като фон Делник: Под 30 мин / 30 мин – 1 ч. / 1–3 ч. / 3–5 ч. / Над 5 ч. Празник: Под 30 мин / 30 мин – 1 ч. / 1–3 ч. / 3–5 ч. / Над 5 ч. ___НЕ се отнася за мен (отбележи със знак X)
Колко часа на ден средно прекарвате в интернет? (загради всички подходящи отговори)	Обикновено съм в интернет: По работа / За лично забавление или информация Делник: Под 30 мин / 30 мин – 1 ч. / 1–3 ч. / 3–5 ч. / Над 5 ч. Празник: Под 30 мин / 30 мин – 1 ч. / 1–3 ч. / 3–5 ч. / Над 5 ч. ___НЕ се отнася за мен (отбележи със знак X)

Моля използвайте долната скала, за да отговорите на следващите 7 въпроса. Посочете този номер от скалата (от 1 до 7), който Ви описва най-добре.

1- Ведж годишно или по-рядко (или никога)	2- Няколко пъти годишно	3- Веднъж месечно	4- Няколко пъти месечно	5-Веднъж седмично	6-Няколко пъти седмично	7- Веднъж дневно или по-често (или непрекъснато)
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- Колко често разглеждате женски списания (тези за красота и мода)?
Вземете предвид всякакви печатни медии или интернет източници. **№** _____

- Колко често разглеждате мъжки списания (тези, които показват жени: Playboy, Maxim, FHM и пр.)?
Вземете предвид всякакви печатни медии или интернет източници. **№** _____

- Колко често разглеждате каталози за красота и мода?
Вземете предвид всякакви печатни медии или интернет източници. **№** _____

- Колко често гледате западни филми?
Вземете предвид ТВ/кабел, DVD, VHS, интернет, кино. **№** _____

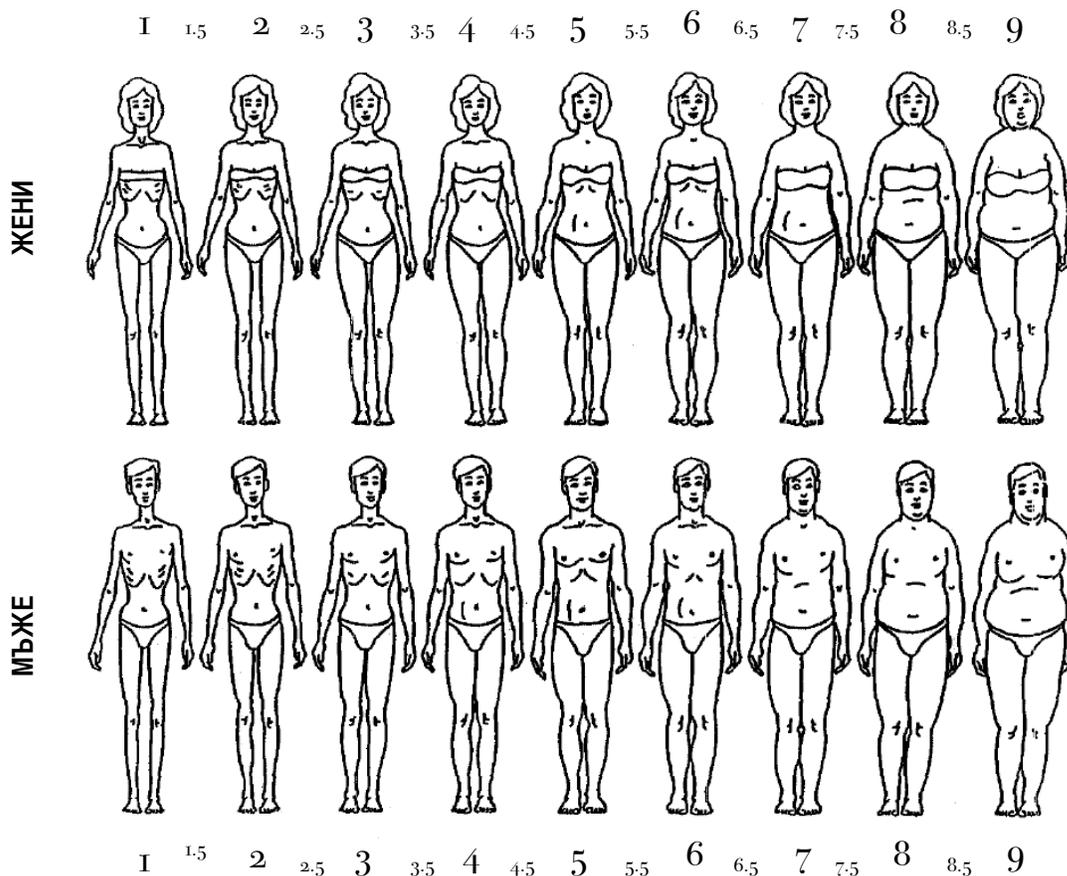
- Колко често гледате западни сериали (сапунки, Сексът и Града, и пр.)?
Вземете предвид ТВ/кабел, DVD, VHS, интернет източници. **№** _____

- Колко често гледате западни музикални клипове (като тези по MTV, VH1 и пр.)?
Вземете предвид ТВ/кабел, интернет източници. **№** _____

- Колко често гледате западни програми (за мода, красота, 'риалити' по fTV, MTV и пр.)?
Вземете предвид ТВ/кабел, интернет източници. **№** _____

СКАЛИ ЗА ОЦЕНКА НА ФИГУРАТА

Разглеждайки долните силуети, моля отговорете на следните въпроси, като изберете номера на силует от подходящата скала.



1. Смятам, че **силует №**___ съответства най-близо със сегашната ми фигура (по форма, размер или тегло).
2. Смятам, че **силует №**___ съответства най-близо с фигурата, която желая да имам.
3. Смятам, че жената със **силует №**___ е с най-добро здраве.
4. Смятам, че мъжът със **силует №**___ е с най-добро здраве.
5. Когато теглото ми е било най-малко, изглеждах като **силует №**___.
6. Когато теглото ми е било най-голямо, изглеждах като **силует №**___.
7. Знам, че фигурата ми е като **силует №**___, но понякога се чувствам като **силует №**___.
8. Знам, че фигурата ми е като **силует №**___, но мисля, че другите хора ме виждат като **силует №**___.

ВНИМАНИЕ: ДА СЕ ПОПЪЛНИ САМО ОТ ЖЕНИ
ОБЩЕСТВЕНИ НАГЛАСИ ЗА ВЪНШНОСТТА

По скала от 1 (най-слабо) до 5 (най-силно), моля посочете нивото си на съгласие със следните твърдения.

1- Пълно несъгласие	2- Повече несъгласие , отколкото съгласие	3- Нито съгласие, нито несъгласие	4- Повече съгласие, отколкото несъгласие	5-Пълно съгласие
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1. Жените, появяващи се в ТВ шоута и във филмите, имат външния вид, който аз целя да имам. **№** _____

 2. Вярвам, че дрехите изглеждат по-добре върху тънки модели. **№** _____

 3. Музикални видеоклипове, показващи тънки жени, ме карат да ми се иска да бях по-тънка. **№** _____

 4. Нямам желание да изглеждам като моделите в списанията. **№** _____

 5. Склонна съм да сравнявам тялото си с хората в списанията и по телевизията. **№** _____

 6. В обществото ни днес дебилите хора са считани за **не**привлекателни. **№** _____

 7. Снимки на тънки жени ме карат да ми се иска да бях по-тънка. **№** _____

 8. Привлекателността е много важна, ако искаш да се издигнеш в обществото ни днес. **№** _____

 9. Важно е хората да работят усилено над фигурата/физиката си, ако искат да успеят в днешното общество. **№** _____

 10. Повечето хора вярват че колкото си по-тънка, толкова по-добре изглеждаш. **№** _____

 11. Хората мислят че колкото си по-тънка, толкова по-добре изглеждаш в дрехи. **№** _____

 12. В днешното общество е важно да изглеждаш винаги привлекателно. **№** _____

 13. Ще ми се да изглеждам като модел на бански костюми. **№** _____

 14. Често чета списания като Cosmopolitan, Vogue, Glamour и т.н., и сравнявам външността си с моделите. **№** _____
- Допълнителни модни списания, които четете: _____

ХРАНИТЕЛНИ НАГЛАСИ

Моля, поставете знака (X) в колонката, която най-точно съответства на Вашето положение по отношение на изброените твърдения:	ВИНАГИ	МНОГО ЧЕСТО	ЧЕСТО	ПОНЯКОГА	РЯДКО	НИКОГА
1. Приятно ми е да се храня с други хора.						
2. Приготвям храна за другите, но не ям от нея.						
3. Непосредствено преди хранене ми е тревожно и напрегнато.						
4. Ужасявам се от възможността да напълнея.						
5. Избягвам да ям всеки път, когато изпитвам глад.						
6. Премного се ангажирам с мисли за храната.						
7. Случва ми се да ям ненаситно, с чувство че не мога да се спра.						
8. Нарязвам (начупвам, надробявам) храната на малки части.						
9. Обръщам внимание на калорийното съдържание на храните.						
10. Отбягвам тестени храни						
11. Имам чувство за надутост (подпухналост) след хранене.						
12. Мисля, че околните биха искали да ям повече.						
13. Повръщам след хранене.						
14. Имам чувство за неблагополучие (вина, нещастност, тъга) след нахранване.						
15. Имам силно желание да бъда по-слаб(а).						
16. Занимавам се с физическа дейност (включително гимнастика), за да изразхода калории.						
17. Меря теглото си по няколко пъти на ден.						
18. Обичам дрехите ми да са плътно прилепнали по тялото.						
19. Ям с удоволствие месо.						
20. Събуждам се рано сутрин.						

ХРАНИТЕЛНИ НАГЛАСИ (ПРОДЪЛЖЕНИЕ)

Моля, поставете знака (X) в колонката, която най-точно съответства на Вашето положение по отношение на изброените твърдения:	ВИНАГИ	МНОГО ЧЕСТО	ЧЕСТО	ПОНЯКОГА	РЯДКО	НИКОГА
21. Ям едни и същи храни дни наред.						
22. Докато се движа или правя гимнастика си мисля за калориите, които ще изразходя.						
23. САМО ЗА ЖЕНИ! Имам редовна менструация.						
24. Другите хора мислят, че съм прекалено слаб(а).						
25. Мисля, че имам излишни тлъстини по тялото си.						
26. Храня се по-бавно от другите.						
27. С удоволствие се храня в ресторанти.						
28. Използвам слабителни средства или медикаменти.						
29. Избягвам храни, съдържащи много захар.						
30. Ям диетични храни.						
31. Имам чувството, че храната контролира моя живот.						
32. Проявявам самоконтрол по отношение на храненето.						
33. Другите хора ме карат да ям повече.						
34. Храната заема прекалено много от моето време и мисли.						
35. Страдам от запек.						
36. Чувствам се некомфортно след ядене на сладкиши.						
37. Пазя диети.						
38. Обичам стомахът ми да е празен.						
39. Прави ми удоволствие да опитвам нови храни.						
40. Имам непреодолимо желание (порив, нужда) да повърна след нахранване.						

ВАЖНО!

ПРЕДИ ДА ВЪРНЕТЕ АНКЕТАТА:

- 1. Моля, не забравяйте да прочетете и разпишете най-горната страница (формуляра за информирано съгласие).**
- 2. Не забравяйте да върнете ВСИЧКИ листа.**
- 3. Ако желаете да обсъдите резултатите си, оставете информация за връзка тук:**

Телефон: _____ Най-подходящо време за връзка: _____

Мобилен: _____ Най-подходящо време за връзка: _____

Друго: _____

БЛАГОДАРЯ ЗА УЧАСТИЕТО!

**FOOD AND EATING HABITS
OF
MODERN BULGARIANS
(QUESTIONNAIRE)**

A DISSERTATION STUDY

BY

ROSA ANGELOVA • PHD CANDIDATE • CORNELL UNIVERSITY

Rosa Angelova • email: raa29@cornell.edu • BG work: (2)8668635 • BG cell: (0895)119656 TURN PAGE OVER

IMPORTANT: Consent form stapled on top of this booklet

IMPORTANT!

PLEASE READ AND SIGN THE INFORMED CONSENT FORM BEFORE YOU PROCEED:

- ▶ DO NOT write your name anywhere
- ▶ Ask Rosa any questions now or at: (02) 8668635, (0895) 119656, raa29@cornell.edu
- ▶ Read carefully and follow the instructions to the questions
- ▶ Answer ALL questions by choosing the option(s) that best describe(s) you
- ▶ You can write notes anywhere on the questionnaire
- ▶ Return ALL sheets

Hello! My name is Rosa Angelova and I am a nutrition PhD Candidate at Cornell University in the USA. This questionnaire is part of the work for my doctoral dissertation. My goal is to learn more about your eating habits, beliefs and attitudes, as well as your opinion regarding certain types of media.

I assure you that I will not evaluate or make any judgments about your personal beliefs, opinions, attitudes, practices, or habits shared within this questionnaire. Your answers unique and equally important for me. This questionnaire is absolutely **confidential** and **anonymous**.

IF YOU WISH TO DISCUSS YOUR RESULTS, PLEASE LEAVE YOUR CONTACT INFORMATION HERE:

Phone: _____ **Best time to call:** _____

Cell: _____ **Best time to call:** _____

Other: _____

THANK YOU!

Where are you located right now(at school, work, home, etc.)? _____

What date is it? _____ Day _____ Month 20____ Year _____ What time is it? _____AM _____PM

At the moment I weigh about _____KG at a height _____CM

At my current height, my lightest weighed was about _____KG, and at my heaviest was about _____KG

Date and Place of Birth	Month: _____ Year: _____ I am born in (town/village): _____ I grew up in (town/village): _____	
Gender (circle one)	Male / Female	
Race, Ethnicity, & Religion (circle one)	Race: White / Other (specify): _____ Ethnicity: Bulgarian / Turkish / Roma / Other (specify): _____ Religion: East-Orthodox / Other Christian (specify): _____/Other (specify): _____	
Language Skills (circle all applicable)	I read and understand spoken: English / French, German, Spanish, or Italian	
	I DO NOT read nor understand spoken: English / French, German, Spanish, or Italian	
Legal Marital Status (check one)	<input type="checkbox"/> Never married <input type="checkbox"/> Married, first and only marriage <input type="checkbox"/> Remarried <input type="checkbox"/> Separated or divorced <input type="checkbox"/> Widowed Other (explain): _____	
Employment Status (check one)	<input type="checkbox"/> Student <input type="checkbox"/> Working student <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed (including self-employed or freelance) <input type="checkbox"/> Retired <input type="checkbox"/> Working retired Other (explain): _____	
Occupational Status (check one)	<input type="checkbox"/> Not Applicable >>> SKIP "Occupational Status"	
	<input type="checkbox"/> Business, finance, accounting, and banking <input type="checkbox"/> Communications, media, and marketing <input type="checkbox"/> Architecture and engineering <input type="checkbox"/> Building construction and repair <input type="checkbox"/> Healthcare and legal <input type="checkbox"/> Services and tourism <input type="checkbox"/> Education, academia, sciences, and research <input type="checkbox"/> Trade and sales <input type="checkbox"/> Arts and crafts Other (explain): _____	<input type="checkbox"/> High manager/professional <input type="checkbox"/> Intermediate manager <input type="checkbox"/> Lower manager <input type="checkbox"/> Worker Other (explain): _____

Currently Student (check one)	<input type="checkbox"/> Not Applicable > > > SKIP “Currently Student”		
	<input type="checkbox"/> Upper Secondary (9th grade and above) <input type="checkbox"/> Semi-Higher (College or equivalent) <input type="checkbox"/> Higher (University or equivalent) > > > Is this a Master’s or above? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Other (explain): _____		
Highest Completed Education (check one)	<input type="checkbox"/> Primary (Up to 4th grade inclusive) <input type="checkbox"/> Lower Secondary (Up to 8th grade inclusive) <input type="checkbox"/> Upper Secondary (9th grade and above) <input type="checkbox"/> Semi-Higher (College or equivalent) <input type="checkbox"/> Higher (University or equivalent) > > > Is this a Master’s or above? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Other (explain): _____		
	Do you have more than one higher education? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Additional Education/ Specialization (check one)	<input type="checkbox"/> Not Applicable > > > SKIP “Additional Education/Specialization”		
	<input type="checkbox"/> Have some continuing education or vocational training school <input type="checkbox"/> Have completed at least one continuing education or vocational training school <input type="checkbox"/> Other (explain): _____		
Total Monthly Household Income & Monthly Household Food Expenditure (check one)	(DO NOT complete the following > > > lv./USD exchange rate today is: _____)		
	Total income of your household (estimate roughly): <input type="checkbox"/> Less than 400 lv. per month <input type="checkbox"/> 400 to 699 lv. per month <input type="checkbox"/> 700 to 999 lv. per month <input type="checkbox"/> 1000 to 1299 lv. per month <input type="checkbox"/> 1300 to 1599 lv. per month <input type="checkbox"/> 1600 to 1899 lv. per month <input type="checkbox"/> 1900 lv. & above per month	Number of people that this income supports (estimate roughly): a. Number of adults (18 & above): _____ b. Number of children (Less than 18): _____	Household FOOD expenditure as a % of your household’s total income (include non-alcoholic beverages in your rough estimate): <input type="checkbox"/> Less than 10% per month <input type="checkbox"/> 10 to 29% per month <input type="checkbox"/> 30 to 49% per month <input type="checkbox"/> 50 to 69% per month <input type="checkbox"/> 70% and above per month
Faith (check one)	<input type="checkbox"/> Atheist (I think God does not exist) <input type="checkbox"/> Agnostic (I neither believe nor disbelieve in God) <input type="checkbox"/> Passive believer (I believe in God, but am NOT observant) <input type="checkbox"/> Active believer (I believe in God AND am observant) <input type="checkbox"/> Without definite beliefs (I have faith, but am NOT religious) <input type="checkbox"/> Other (explain): _____		
I Fast (circle one)	Never / Occasionally / Regularly / NOT Applicable / Other (explain): _____		

MEDIA EXPOSURE

Please answer the following two questions, by circling the most appropriate for you answers.

<p>How many hours/day on average do you watch TV? (circle <u>all</u> applicable)</p>	<p>I usually watch TV: Actively / As a background Week day: Below 30 min / 30 min-1 hr / 1-3 hrs / 3-5 hrs / Above 5 hrs Weekend: Below 30 min / 30 min-1 hr / 1-3 hrs / 3-5 hrs / Above 5 hrs</p>
<p>How many hours/day on average do you spend online? (circle <u>all</u> applicable)</p>	<p>I usually use the internet for: Work / Personal entertainment or info Week day: Below 30 min / 30 min-1 hr / 1-3 hrs / 3-5 hrs / Above 5 hrs Weekend: Below 30 min / 30 min-1 hr / 1-3 hrs / 3-5 hrs / Above 5 hrs</p>

Please use the scale below to answer the following 7 questions. Indicate the number from the scale below (1 through 7) that describes you the best.

1- Once per year or less (or never)	2- A few times per year	3- Once per month	4- A few times per month	5- Once per week	6- A few times per week	7- Once a day or more (or constantly)
-------------------------------------	-------------------------	-------------------	--------------------------	------------------	-------------------------	---------------------------------------

- How often do you look at women’s (beauty and fashion) magazines?
Consider any print media or online sources. **No.** ____

- How often do you look at men’s magazines (those featuring women: Playboy, Maxim, FHM, etc.)?
Consider any print media or online sources. **No.** ____

- How often do you look at beauty and fashion catalogues?
Consider any print media or online sources. **No.** ____

- How often do you watch western movies?
Consider TV/cable, DVD, VHS, online, cinema. **No.** ____

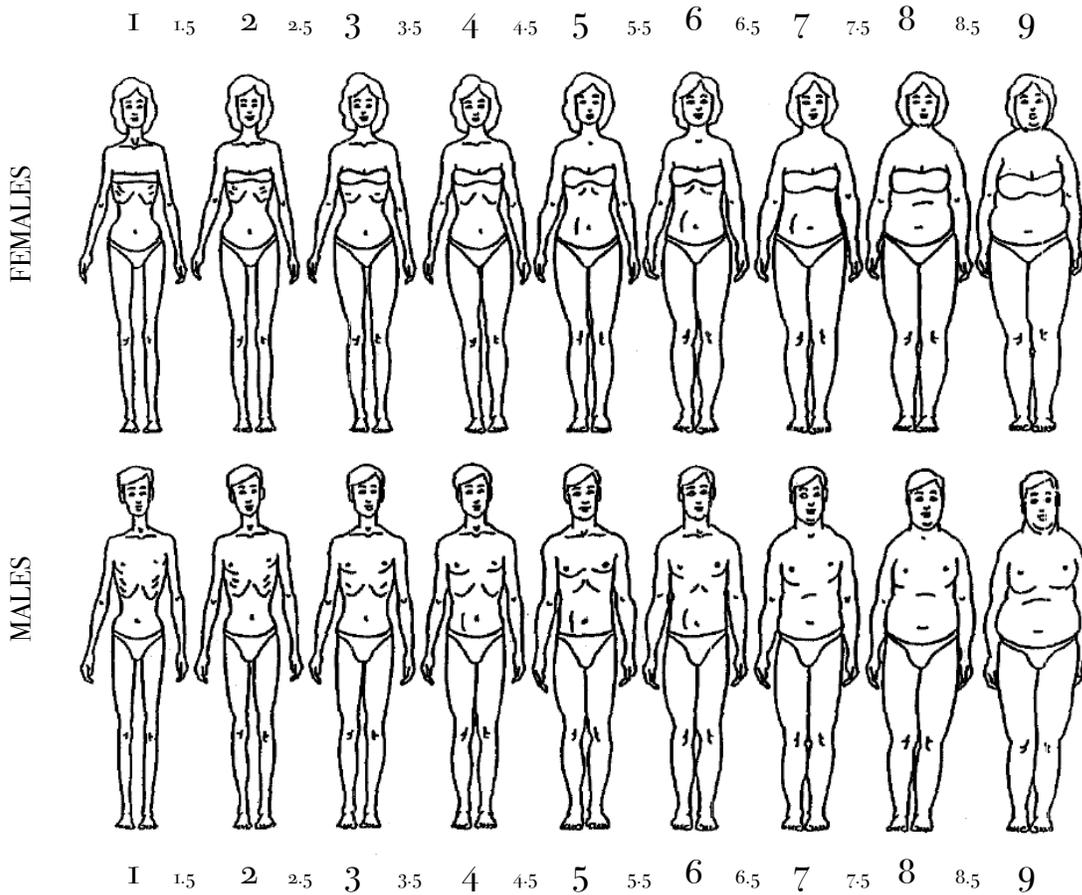
- How often do you watch western serials (soaps, Sex & The City, etc.)?
Consider TV/cable, DVD, VHS, online sources. **No.** ____

- How often do you watch western music videos (like those on MTV, VH1, etc.)?
Consider TV/cable, online sources. **No.** ____

- How often do you watch western programming (fashion, beauty, reality on fTV, MTV, etc.)?
Consider TV/cable, online sources. **No.** ____

FIGURE RATING SCALES

Looking at the figures below please answer the following questions by choosing the silhouette number from the appropriate scale.



1. I think **silhouette No.**____ most closely corresponds to my current figure (shape, size, or weight).
2. I think **silhouette No.**____ most closely corresponds to the figure I want to have.
3. I think the woman with **silhouette No.**____ is the healthiest.
4. I think the man with **silhouette No.**____ is the healthiest.
5. When I was at my thinnest I looked like **silhouette No.**____.
6. When I was at my heaviest I looked like **silhouette No.**____.
7. I know that my figure is like **silhouette No.**____, but I sometimes feel like **silhouette No.**____.
8. I know that my figure is like **silhouette No.**____, but I think other people see me as **silhouette No.**____.

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ATTENTION: TO BE FILLED OUT ONLY BY WOMEN

SOCIAL ATTITUDES TOWARD APPEARANCE

On a scale from 1 (weakest) to 5 (strongest), please indicate your level of agreement with the following statements.

1- Disagree completely	2- More disagree than agree	3- Neither agree, nor disagree	4- More agree than disagree	5- Agree completely
------------------------	-----------------------------	--------------------------------	-----------------------------	---------------------

1. Women who appear in TV shows and in movies project the type of appearance that I see as my goal. **No.**____

2. I believe that clothes look better on thin models. **No.**____

3. Music videos that show thin women make me wish that I were thinner. **No.**____

4. I do not wish to look like the models in the magazines. **No.**____

5. I tend to compare my body to people in magazines and on TV. **No.**____

6. In our society today fat people are regarded as unattractive. **No.**____

7. Photographs of thin women make me wish that I were thinner. **No.**____

8. Attractiveness is very important if you want to get ahead in our society today. **No.**____

9. It is important for people to work hard on their figures/physiques, if they want to succeed in today's society. **No.**____

10. Most people believe that the thinner you are, the better you look. **No.**____

11. People think that the thinner you are, the better you look in clothes. **No.**____

12. In today's society it is important to always look attractive. **No.**____

13. I wish I looked like a swimsuit model. **No.**____

14. I often read magazines like Cosmopolitan, Vogue, Glamour, etc. **and** compare my appearance to the models. **No.**____
Additional fashion magazines you read: _____

EATING ATTITUDES

PLEASE PLACE AN (X) UNDER THE COLUMN WHICH APPLIES BEST TO EACH OF THE NUMBERED STATEMENTS:	ALWAYS	VERY OFTEN	OFTEN	SOME-TIMES	RARELY	NEVER
1. Like eating with other people.						
2. Prepare foods for others but do not eat what I cook.						
3. Become anxious prior o eating.						
4. Am terrified about being overweight.						
5. Avoid eating when I am hungry.						
6. Find myself preoccupied with food.						
7. Have gone on eating binges where I feel that I may not be able to stop.						
8. Cut my food into small pieces.						
9. Aware of the calorie content of foods that I eat.						
10. Practically avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.)						
11. Feel bloated after meals.						
12. Feel that others would prefer if I ate more.						
13. Vomit after I have eaten.						
14. Feel extremely guilty after eating.						
15. Am preoccupied with a desire to be thinner.						
16. Exercise strenuously to burn off calories.						
17. Weigh myself several times a day.						
18. Like my clothes to fit tightly.						
19. Enjoy eating meat.						
20. Wake up early in the morning.						

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EATING ATTITUDES (CONTINUED)

PLEASE PLACE AN (X) UNDER THE COLUMN WHICH APPLIES BEST TO EACH OF THE NUMBERED STATEMENTS:	ALWAYS	VERY OFTEN	OFTEN	SOME-TIMES	RARELY	NEVER
21. Eat the same foods day after day.						
22. Think about burning up calories when I exercise.						
23. Have regular menstrual periods.						
24. Other people think that I am too thin.						
25. Am preoccupied with the thought of having fat on my body.						
26. Take longer than others to eat my meals.						
27. Enjoy eating at restaurants.						
28. Take laxatives.						
29. Avoid foods with sugar in them.						
30. Eat diet foods.						
31. Feel that food controls my life.						
32. Display self control around food.						
33. Feel that others pressure me to eat.						
34. Give too much time and thought to food.						
35. Suffer from constipation.						
36. Feel uncomfortable after eating sweets.						
37. Engage in dieting behavior.						
38. Like my stomach to be empty.						
39. Enjoy trying new rich foods.						
40. Have the impulse to vomit after meals.						

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IMPORTANT!

BEFORE YOU RETURN THE QUESTIONNAIRE:

1. Please do not forget to read & sign the cover page (the informed consent form).
2. Please do not forget to return ALL sheets.
3. If you wish to discuss your results, leave your contact information here:

Phone: _____ Best time to call: _____

Cell: _____ Best time to call: _____

Other: _____

THANKS FOR YOUR PARTICIPATION!

APPENDIX 3:

APPROVED CONSENT FORMS

(IN BULGARIAN AND ENGLISH)

ИНФОРМИРАНО СЪГЛАСИЕ ЗА УЧАСТИЕ В ИЗСЛЕДВАНЕТО: АНКЕТА

ХРАНА И ХРАНЕНО НА СЪВРЕМЕННИТЕ БЪЛГАРИ

Каним Ви да участвате в изследване за храната и хранителните навици на съвременните българи. Главният изследовател в България е Роза Ангелова, докторски кандидат в отдел "Науки за храненето" на университета Корнел. За да участвате, трябва да сте на възраст между 18 и 85 години.

Преди да се съгласите да участвате в изследването, моля прочетете внимателно този формуляр и задайте въпросите си (ако имате таква).

Какво представлява изследването: Бихме искали да научим за храната и хранителните Ви навици. По-специално, бихме искали да разберем дали начинът Ви на хранене се е променил с времето, и ако той наистина се е променил, как бихте си обяснили промените.

Какво ще Ви помолим да направите: Молим за Вашето участие, понеже сте изявили интерес при установен контакт с Роза Ангелова. Ако се съгласите на участие, ще Ви помолим да попълните кратка анкета. Допълнително, можете да изберете да участвате в до две последователни, задълбочени интервюта, в които ще обсъдим:

- Хранителните Ви навици и промените в начина Ви на хранене, откогато сте били по-млади;
- Вашите представи за добра физическа форма; и
- Вашия интерес към и употреба на масови медии.

Анкетата ще отнеме около 30 мин. за попълване. Ако изберете да бъдете интервюирани, моля запишете Вашата информация за връзка върху анкетната книжка. Първото задълбочено интервю ще отнеме около 60 мин., последвано от кратко второ интервю от около 30 мин. в рамките на 3 месеца след първото интервю. С Ваше разрешение, бихме желали също да направим дигитален запис на интервютата.

Рискове и ползи: Съществува риск от това някои от въпросите за хранителните Ви навици и нагласи да Ви се сторят неудобни. Не сте задължени да отговаряте на тези въпроси. Изследването не ви предлага никакви директни и непосредствени ползи.

Компенсация: Компенсация за попълване на кратката анкета няма. Ако обаче изберете да бъдете интервюирани подробно, ще получите общо 20 лв., след като приключите с второто от двете последователни интервюта.

Участието Ви е доброволно: Участието в това изследване е напълно доброволно. Може да прескочите всички въпроси, на които не искате да отговаряте. Ако решите да вземете участие, можете да се откажете във всеки момент.

Отговорите Ви са поверителни: Данните от това изследване ще се държат в тайна. Във всеки случай на публикуване на данните от изследването, ние няма да разкрием каквато и да било информация, чрез която бихте могли да бъдете идентифицирани. Всички анкети и интервюта ще бъдат събирани анонимно. Данните от изследването ще бъдат съхранявани в заключен архив; само изследователите ще имат достъп до тези данни. Ако направим дигитален запис на интервюта, файлът ще бъде унищожен веднага след като данните бъдат набрани, което очакваме да бъде извършено в рамките на шест месеца от осъществяването на самия запис.

Ако имате въпроси: Оглавяващи това изследване са Роза Ангелова и проф. д-р Вирджиния Утермолен. Моля задайте сега всички Ваши въпроси. В случай на въпроси, възникнали впоследствие, можете да осъществите контакт с Роза Ангелова на raa29@cornell.edu или на тел. (02) 8668635, (0895) 119656. Можете да се свържете с проф. д-р Вирджиния Утермолен на wu10@cornell.edu или на тел. (001 607) 2555719. Ако имате въпроси и притеснения относно правата Ви като участник в настоящото изследване, бихте могли да се свържете с Етичната комисия в университета Корнел (Cornell University Institutional Review Board – IRB) на тел. (001 607) 2555138 или да посетите и-нет страницата им на <http://www.irb.cornell.edu>. Можете също анонимно да отправите въпросите или оплакванията си чрез Етикспойнт (<http://www.ethicspoint.com>) или като се обадите на (011 866) 293–3077. Етикспойнт е независима организация, която служи като посредник между университета и оплаквания се, като по този начин анонимността на оплаквания се е гарантирана. Ако желаете да се свържете с хора, които не говорят български, помощен превод ще бъде осигурен по поискване.

По поискване копие от настоящия формуляр ще Ви бъде предоставено на разположение да пазите сред документите си.

Изявление за съгласие:

Прочетох по-горната информация и получих отговор на всички въпроси, които зададох. Съгласен(на) съм да взема участие в това изследване.

Вашето Име: _____ **Подпис:** _____ **Дата:** _____
(с печатни букви)

Отнася се само за изследователя:

Име на Изследователя: _____ **Подпис:** _____ **Дата:** _____
(с печатни букви)

Настоящият формуляр на информирано съгласие ще бъде съхраняван от изследователя за не по-малко от три години след края на изследването и получи одобрение от местната етична комисия (IRB) на 04.29.2009.

ИНФОРМИРАНО СЪГЛАСИЕ ЗА УЧАСТИЕ В ИЗСЛЕДВАНЕТО: ИНТЕРВЮТА

ХРАНА И ХРАНИТЕЛНИ НАВИЦИ НА СЪВРЕМЕННИТЕ БЪЛГАРИ

Каним Ви да участвате в изследване за храната и хранителните навици на съвременните българи. Главният изследовател в България е Роза Ангелова, докторски кандидат в отдел "Науки за храненето" на университета Корнел. За да участвате, трябва да сте на възраст между 18 и 85 години.

Преди да се съгласите да участвате, моля прочетете внимателно този формуляр и задайте въпросите си (ако имате такива).

Какво представлява изследването: Бихме искали да научим за храната и хранителните Ви навици. По-специално, бихме искали да разберем дали начинът Ви на хранене се е променил с времето, и ако той наистина се е променил, как бихте си обяснили промените.

Какво ще Ви помолим да направите: Молим за Вашето участие, понеже сте изявили интерес като сте дали своята информация за връзка на Роза Ангелова. Ако се съгласите на участие, ще Ви помолим да дадете до две последователни, задълбочени интервюта, в които ще обсъдим:

- Хранителните Ви навици и промените в начина Ви на хранене, от когато сте били по-млади;
- Вашите представи за добра физическа форма; и
- Вашия интерес към и употреба на масови медии.

Първото задълбочено интервю ще отнеме около 60 мин. С Ваше разрешение, бихме искали да се свържем с Вас за кратко второ интервю от около 30 мин. в рамките на 3 месеца след първото интервю. Молим, също така, за Вашето разрешение да направим дигитален запис на интервюта.

Рискове и ползи: Съществува риск от това някои от въпросите за хранителните Ви навици и нагласи да Ви се сторят неудобни. Не сте задължени да отговаряте на тези въпроси. Изследването не ви предлага никакви директни и непосредствени ползи.

Компенсация: Ще получите общо 20 лв., след като приключите с второто от двете последователни интервюта. Ако по някаква причина дадете само едно интервю, ще получите 10 лв.

Участието Ви е доброволно: Участието в това изследване е напълно доброволно. Може да прескочите всички въпроси, на които не искате да отговаряте. Ако решите да вземете участие, можете да се откажете във всеки момент.

Отговорите Ви са поверителни: Данните от това изследване ще се държат в тайна. Във всеки случай на публикуване на данните от изследването, ние няма да разкрием каквато и да било информация, чрез която бихте могли да бъдете идентифицирани. Всички интервюта ще бъдат събирани анонимно. Данните от изследването ще бъдат съхранявани в заключен архив; само изследователите ще имат достъп до тези данни. Ако направим дигитален запис на интервюто, файлът ще бъде унищожен веднага след като данните бъдат набрани, което очакваме да бъде извършено в рамките на шест месеца от осъществяването на самия запис.

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По поискване копие от настоящия формуляр ще Ви бъде предоставено на разположение да пазите сред документите си.

Изявление за съгласие:

Прочетох по-горната информация и получих отговор на всички въпроси, които зададох. Съгласен(на) съм да взема участие в това изследване.

Вашето Име: _____ **Подпис:** _____ **Дата:** _____
(с печатни букви)

В допълнение на съгласието си да участвам, съм също съгласен(на) интервюто(тата) да бъде(ат) записано(и) по дигитален път.

Вашето Име: _____ **Подпис:** _____ **Дата:** _____
(с печатни букви)

Отнася се само за изследователя:

Име на Изследователя: _____ **Подпис:** _____ **Дата:** _____
(с печатни букви)

Настоящият формуляр на информирано съгласие ще бъде съхраняван от изследователя за не по-малко от три години след края на проучването и получи одобрение от местната етична комисия (IRB) на 04.29.2009.

STUDY INFORMED CONSENT FORM: QUESTIONNAIRE

FOOD AND EATING OF MODERN BULGARIANS

You are invited to take part in a study of the food and eating habits of contemporary Bulgarians. The primary researcher in Bulgaria is ROSA ANGELOVA, a doctoral candidate at Cornell University's Division of Nutritional Sciences. You must be between the ages of 18 and 85 to take part in this study.

Please read this form carefully and ask any questions before agreeing to participate in the study.

What the study is about: We would like to learn about your food and eating habits. Specifically, we would like to hear if your eating has changed over time, and if it indeed has, how you would explain the changes.

What we will ask you to do: We are asking you to participate, because you showed interest when approached by Rosa Angelova. If you agree to participate, we will ask you to complete a brief questionnaire. Additionally, you can choose to participate in up to two consecutive in-depth interviews, in which we will discuss:

- * Your eating habits and any changes in your eating, since you were younger;
- * Your fitness beliefs; and
- * Your interest in and use of mass media.

The questionnaire will take up to 30 min to complete. If you choose to be interviewed in depth, please write down your contact information on the questionnaire booklet. The first in-depth interview will take about 60 min., followed up by a brief second interview of about 30 min within 3 months after the first interview. With your permission, we would also like to digitally record the interviews.

Risks and benefits: There is the risk that you may find some of the questions about your eating habits and attitudes to be sensitive. You do not have to answer these questions. The study does not offer you any direct and immediate benefits.

Compensation: There is no compensation for filling out the brief questionnaire. However, if you choose to be interviewed in depth, you will receive a total of 20 lv. after you complete the second of the two consecutive interviews.

Your participation is voluntary: Participation in this study is completely voluntary. You may skip all questions that you do not want to answer. If you decide to take part, you can withdraw at any moment.

Your answers are confidential: The data from this study will be kept private. In any case of public reporting of study data we will not reveal any information that will make it possible to identify you. All questionnaires and interviews will be collected anonymously. Research data will be kept in a locked file; only the researchers will have access to these data. If we make a digital record of the interviews, we will destroy the file after data has been transcribed, which we anticipate will be within six months of recording.

If you have questions: Heading this study are Rosa Angelova and Prof. Dr. Virginia Utermohlen. Please ask all your questions now. In case of later questions, you may contact Rosa Angelova at raa29@cornell.edu or (02) 8668635, (0895) 11-96-56. You can reach Prof. Dr. Virginia Utermohlen at vu10@cornell.edu or (001 607) 2555719. If you have questions or concerns regarding your rights as a participant in this study, you may contact the Cornell University Institutional Review Board (IRB) at (001 607) 255-5138 or visit their website at <http://www.irb.cornell.edu>. You may also report your concerns or complaints anonymously through **Ethicspoint** (<http://www.ethicspoint.com>) or by calling toll free at (001 866) 293-3077. Ethicspoint is an independent organization that serves as a liaison between the University and the person bringing the complaint so that anonymity can be ensured. If you wish to contact people who do not speak Bulgarian, assistance with translation will be provided upon request.

Upon request you will be given a copy of this form to keep for your records.

Statement of Consent:

I read the above information, and received answers to all questions I asked. I consent to take part in this study.

Your Printed Name _____ Signature _____ Date _____

For researcher's use only:

Researcher's Printed Name _____ Signature _____ Date _____

This consent form will be kept by the researcher for at least three years beyond the end of the study and was approved by the IRB on 4.29.2009.

STUDY INFORMED CONSENT FORM: INTERVIEWS

FOOD AND EATING OF MODERN BULGARIANS

You are invited to take part in a study of the food and eating habits of contemporary Bulgarians. The primary researcher in Bulgaria is ROSA ANGELOVA, a doctoral candidate at Cornell University's Division of Nutritional Sciences. You must be between the ages of 18 and 85 to take part in this study.

Please read this form carefully and ask any questions before agreeing to participate in the study.

What the study is about: We would like to learn about your food and eating habits. Specifically, we would like to hear if your eating has changed over time, and if it indeed has, how you would explain the changes.

What we will ask you to do: We are asking you to participate, because you showed interest by providing your contact information to Rosa Angelova. If you agree to participate, we will ask you to complete up to two consecutive in-depth interviews, in which we will discuss:

- * Your eating habits and any changes in your eating, since you were younger;
- * Your fitness beliefs; and
- * Your interest in and use of mass media.

The first in-depth interview will take about 60 min. With your permission, we would like to contact you for a brief second interview of about 30 min within 3 months after the first interview. We also ask your permission to digitally record the interviews.

Risks and benefits: There is the risk that you may find some of the questions about your eating habits and attitudes to be sensitive. You do not have to answer these questions. The study does not offer you any direct and immediate benefits.

Compensation: You will receive a total of 20 lv. after you complete the second of the two consecutive interviews. If you for any reason you complete only one interview, you will receive 10 lv.

Your participation is voluntary: Participation in this study is completely voluntary. You may skip all questions that you do not want to answer. If you decide to take part, you can withdraw at any moment.

Your answers are confidential: The data from this study will be kept private. In any case of public reporting of study data we will not reveal any information that will make it possible to identify you. All interviews will be collected anonymously. Research data will be kept in a locked file; only the researchers will have access to these data. If we make a digital record of the interviews, we will destroy the file after data has been transcribed, which we anticipate will be within six months of recording.

If you have questions: Heading this study are Rosa Angelova and Prof. Dr. Virginia Utermohlen. Please ask all your questions now. In case of later questions, you may contact Rosa Angelova at raa29@cornell.edu or (02) 8668635, (0895) 11-96-56. You can reach Prof. Dr. Virginia Utermohlen at vu10@cornell.edu or (001 607) 2555719. If you have questions or concerns regarding your rights as a participant in this study, you may contact the Cornell University Institutional Review Board (IRB) at (001 607) 255-5138 or visit their website at <http://www.irb.cornell.edu>. You may also report your concerns or complaints anonymously through **Ethicspoint** (<http://www.ethicspoint.com>) or by calling toll free at (001 866) 293-3077. Ethicspoint is an independent organization that serves as a liaison between the University and the person bringing the complaint so that anonymity can be ensured. If you wish to contact people who do not speak Bulgarian, assistance with translation will be provided upon request.

Upon request you will be given a copy of this form to keep for your records.

Statement of Consent:

I read the above information, and received answers to all questions I asked. I consent to take part in this study.

Your Printed Name _____ Signature _____ Date _____

In addition to agreeing to participate, I also consent to having the interview(s) recorded digitally.

Your Printed Name _____ Signature _____ Date _____

For researcher's use only:

Researcher's Printed Name _____ Signature _____ Date _____

This consent form will be kept by the researcher for at least three years beyond the end of the study and was approved by the IRB on 4.29.2009.

APPENDIX 4:
SEMI-STRUCTURED INTERVIEW SCHEDULE
(IN BULGARIAN AND ENGLISH)

ХРАНА И ХРАНИТЕЛНИ НАВИЦИ НА СЪВРЕМЕННИТЕ БЪЛГАРИ (ИНТЕРВЮ)

ДИСЕРТАЦИОННО ИЗСЛЕДВАНЕ

НА

РОЗА АНГЕЛОВА • ДОКТОРСКИ КАНДИДАТ • УНИВЕРСИТЕТ КОРНЕЛ

УЧАСТНИКЪТ ТРЯБВА ДА ПРОЧЕТЕ И РАЗПИШЕ ФОРМУЛЯРА ЗА ИНФОРМИРАНО СЪГЛАСИЕ

- ▶ Запознайте се с участника
- ▶ Представете целта на интервюто и начина, по който информацията от него ще бъде използвана
- ▶ Обещайте анонимност
- ▶ Попитайте за разрешение да направите дигитален запис на интервюто
- ▶ Попитайте за въпроси преди да започнете (с интервюто)

Здравейте! Казвам се Роза Ангелова и съм докторски кандидат по хранене в университета Корнел в САЩ. Това интервю е част от работата по докторската ми дисертация. Целта ми е да науча повече за хранителните Ви навици, вярвания и нагласи, както и за мнението Ви за определени видове медии.

Уверявам Ви, че по никакъв начин няма да давам оценка или съдя личните Ви вярвания, мнения, нагласи, постъпки или навици, споделени по време на интервюто. Считам Вашите отговори за уникални и еднакво важни за изследването ми. Интервюто е напълно **поверително** и **анонимно**.

Преди да започнем бих желала да Ви помоля за разрешение да направя дигитален запис на интервюто. Това би ми помогнало да се съсредоточа над това, за което говорите. Бих желала да Ви окуража да зададете каквито и да било въпроси сега.

Анкета (~30 мин) >>> Да се попълни **преди** или **по време** на интервю № 1- първата среща лице в лице

- ▶ Демографски Данни (~5 мин)
- ▶ Анкета (~25 мин):
 - ▶ Медийно Изложение (~5 мин)
 - ▶ Скали за Оценка на Фигурата (~5 мин)
 - ▶ Обществени Нагласи за Външността (само за жени) (~5 мин)
 - ▶ Хранителни Нагласи (~10 мин)

Интервю № 1 (до 1 ч 30 мин общо) >>> Пълна версия е с анкетата, попълнена **по време** на първата среща
В днешното интервю ще Ви питам (и ще Ви дам да попълните анкетата с) няколко вида въпроси:

- ▶ Интервю (~60 мин)
 - ▶ Темни, обхващащи: приятелства; физическа активност; медийната, обществената и културната среда; привлекателност; религия, вяра и разбирания за постенето; правила и навици на хранене; здравословно хранене; история на телесното тегло; представи за собственото тяло; удоволствия и пориви.
- ▶ Допълнения към Интервюто
 - ▶ Допълнение Едно: Здравословно Хранене/Промяна на Фигурата:
 - ▶ Лист А: Източници на информация
 - ▶ Лист Б: Ползи
 - ▶ Лист В: Бариери
 - ▶ Допълнение Две: Снимки на Знаменитости (жени/мъже)

Интервю № 2 >>> Интервю, специфично за всеки отделен участник (~30 мин)

Днес ще обсъдим някои въпроси и теми, които възникнаха по време на първия ни разговор.

ПРИЯТЕЛСТВА

Разкажете ми за приятелите си. Какви са отношенията Ви с тях?

Проба 1: Понякога чувствате ли ги [отношенията] повърхностни? Чувствате ли се разбран(а)...и че се грижат за Вас?

Проба 2: До колко сте "отворени" (социални): доста, горе-долу или по-скоро бихте прекарвали времето си сам(а)?

ФИЗИЧЕСКА АКТИВНОСТ

Разкажете ми за начините, по които се поддържате *физически активни*.

Какво значение има за Вас това да сте физически активни?

Проба 1: Когато си мислите за физическо активност/натоварване, какво (първо) Ви идва на ум?

Проба 2: Каква емоция? Мисъл?

МЕДИЙНА, ОБЩЕСТВЕНА И КУЛТУРНА СРЕДА

Какво Ви харесва да гледате по И-нет или телевизията.... какъв вид програми? Дайте примери.

Проба 1: Западни: сериали, филми, реалити шоута....ТВ/кабелни канали или програми за музика или мода/красота?

Проба 2: Българския вариант на по-горните?

Колко внимание обръщате на реклами или съвети за красота (напр. грим, коса) или отслабване (хапчета, уреди, кремове)?

Проба 1: Никакво? Малко? Някакво? Много? На кои обръщате внимание (ако изобщо обръщате)?

Проба 2: Реклами в списанията.... статии? ТВ реклами.... съвети? Реклами в И-нет.... статии?

Назовете някои от любимите Ви списания за красота или мода, или мъжки списания (може да са в И-нет).

Проба 1: Български (отпечатани на Български)?

Проба 2: Западни (отпечатани на друг западно-европейски език)?

Назовете някои от любимите Ви модни каталози (може да са в И-нет).

ВАЖНО: Прегледай отговорите на участника за фигурните скали и задай следващия въпрос, ако е подходящо.

Какви промени (ако ги има) бихте направили, че избраният от Вас силует да прилича повече на Вашия тип тяло?

ВАЖНО: За следващите 2 въпроса ползвай фигурните скали, ако е подходящо. Също така, ако времето позволява, покажи на интервюирания снимките в *Допълнение Две*.

Как си представяте едно идеално (перфектно) женско тяло.... мъжко тяло?

Проба 1: Дайте пример за знаменитост (Българска или западна), която Ви се струва (почти) перфектна.

Проба 2: Опишете разликите и приликите, откогато сте били тийнейджър (по-млади).

Какъв мислите (общо взето) е идеалът за женска/мъжка фигура (форма, размер или тегло) на Българите днес?

Проба 1: Идеалът на жените за женско/мъжко тяло? Идеалът на мъжете за женско/мъжко тяло?

Проба 2: Дайте пример за знаменитост (Българска или западна), която олицетворява този идеал.

Проба 3: Как мислите този идеал се е изменил, откогато сте били тийнейджър (по-млади)?

Мислите ли, че Българите имат предрасъдъци срещу хора, които са дебели? Ако да, в какво отношение?

Проба 1: Какви са личните Ви чувства относно крайно дебелите хора? Защо мислите са дебели (нямат воля, мързеливи са и пр.)?

Проба 2: Отношението Ви към дебелите хора променило ли се е в последните години? Откогато сте били тийнейджър (по-млади)?

ПРИВЛЕКАТЕЛНОСТ

Разкажете ми за позната жена, която изглежда добре. А за мъж?

Проба 1: Защо мислите тя/той изглежда добре?

Проба 2: Променили ли са се представите Ви за красота, откакто сте били тийнейджър (по-млади)? Ако да, как? Някакви идеи защо?

ПРИВЛЕКАТЕЛНОСТ (ПРОДЪЛЖЕНИЕ)

Любимите Ви кино/ТВ актриси/певици/други знаменити жени са по-скоро: ____ *ВЖНО: Загради едно*

1-Зашеметяващи	2- Привлекателни	3- Обиновени	4- Грозни	5- Много грозни
1- Дебели	2-С пълна фигура	3- Обикновени	4- Тънки	5- Много тънки

Проба: Дайте един пример (може да бъде от България или Запада, или и двете).

Любимите Ви кино/ТВ Актьори/певци/други знаменити мъже са по-скоро: ____ *ВАЖНО: Загради едно*

1-Зашеметяващи	2- Привлекателни	3- Обиновени	4- Грозни	5- Много грозни
1- Неатлетични (немускуести)	2- <u>Относително</u> Неатлетични (немускуести)	3- Обиновени	4- Атлетични (мускуести)	5- <u>Много</u> Атлетични (мускуести)

Проба: Дайте един пример (може да бъде от България или Запада, или и двете).

Какъв тип послания получавате от медиите по отношение на **привлекателност и красота**?

Проба 1: Семейство? Приятели? Певци(ици)? Кино/ТВ звезди?

Проба 2: Тези послания различават ли се по някакъв начин, откогато сте били тийнейджър (по-млади)?

РЯЛИГИЯ, ВЯРА И ПРЕДАВИ ЗА ПОСТЕНЕТО

ВАЖНО: Провери, дали информацията за вяра (религиозни предяви) е записана в Демографски Данни

Как религиозните ви предяви (или вярата Ви) влияят на начина Ви на хранене?

Проба: Избягвате ли определени храни? Следват ли определени ритуали, свързани с храна?

Какво означава постенето за Вас.....какво е определението Ви за постене?

Постили ли сте някога? Ако не, познавате ли хора, които постят? Кого?

Проба 1: Какво направихте? Какви правила спазвахте? Теглото Ви промени ли се?

Проба 2: Къде потърсихте съвет (научихте) как да постите? *ВАЖНО: Допълнение Едно, лист А*

Проба 3: Постите ли редовно? [Ако е подходящо: Кога първоначално почнахте да постите?]

Какво би Ви (или другите хора би ги) мотивирало да постите(ят)?

Проба 1: Религиозни вярвания (защото практикувате стриктно)? Духовни причини?

Проба 2: Загуба на тегло? Пречистване и чистота на тялото? За де дадете почивка на тялото си (на храносмилателния си тракт)?

Проба 3: За да проверите волята си? Защото сте любопитни? Защото всички други постят?

Опишете някои въздействия, които постенето би могло да има върху фигурата/теглото/външността Ви.

Проба: Можете ли да се сетите за някакви вреди? А за ползи? *ВАЖНО: Допълнение Едно, лист Б*

Опишете някои въздействия, които постенети би могло да има върху здравето Ви.

Проба: Можете ли да се сетите за някакви вреди? А за ползи? *ВАЖНО: Допълнение Едно, лист Б*

ПРАВИЛА И НАВИЦИ НА ХРАНЕНЕ

Разкажете ми как протича един Ваш обикновен ден: от като станете сутрин, до като си легнете вечер.

Как бихте описали начина си на хранене (в момента)?

Проба 1: Опишете каквито и да било правила (или изисквания), които сте си поставили относно храна или хранене.

Проба 2: Какви са разликите и приликите, откогато сте били тийнейджър (по-млади)?

Проба 3: Има ли някакви храни, които не можете да ядете? Защо?

Проба 4: Има ли определен начин, по който никога не бихте могли да се храните (напр. вегетарианство, постене, броење на ккал, и пр.)?

ПРАВИЛА И НАВИЦИ НА ХРАНЕНЕ (ПРОДЪЛЖЕНИЕ)

Ако можеше да промените каквото и да било по отношение на начина си на хранене (в момента), какво бихте променили?

Опишете каквито и да било трудности (“битки”, усилия, стрес), които сте имали относно храна и хранене.

Проба 1: Финансови трудности? Свързани със здравето? Свързани с размер/форма/тегло на тялото?

Проба 2: Трудности в детството и тийнейджърските Ви години (когато сте били по-млади)? Сега?

ЗДРАВΟΣЛОВНО ХРАНЕНЕ

Какво е Вашето определение за здравословно хранене?

Проба 1: Какви хранителни навици? Видове храни? Специални програми или режими?

Проба 2: До колко различна е представата Ви за здравословно хранене сега в сравнение с когато сте били тийнейджър (по-млади)?

Можете ли да помислите за определени храни и хранителни навици, които считате за вредни за здравето?

Проба: Бихте ли обяснили защо, моля?

Как бихте оценили храненето си в момента от гледна точка на здраве?

Ако можеше да промените каквото и да било относно сегашния си начин на хранене, за да стане по-здравословен, какво бихте променили?

Как бихте описали един здрав човек на Ваша възраст?

Проба: Жена? Мъж?

ВАЖНО: За следващите 3 въпроса ползвайте Допълнение Едно, както подобава

Къде търсите информация за здравословно хранене? *ВАЖНО: Покажи лист А*

Какви мислите е/са ползата(ите) от здравословното хранене? *ВАЖНО: Покажи лист Б*

Какви (ако ги има) биха били основните пречки (лично за Вас) да се храните здравословно? *ВАЖНО: Покажи лист В*

Какъв тип послания получавате от медиите относно **здравословното хранене**?

Проба: Семейство? Приятели? Певци(ици)? Кино/телевизионни звезди?

ИСТОРИЯ НА ТЕЛЕСНОТО ТЕГЛО

ВАЖНО: Провери, дали информацията за телесно тегло е записана в Демографски Данни

Опишете каквито и да било забележими промени (или вариации) в теглото Ви от като сте расли, до сега.

Проба 1: Какво дете бяхте...тийнейджър (на външен вид)?

Проба 2: Какъв е най-дългият период, през който теглото Ви е било стабилно?

Проба 3: Какви фактори или житейски събития мислите, че са повлияли върху промените в теглото Ви?

Опитвали ли сте се някога да сваляте/качвате тегло? Ако не, как жените/мъжете, които познавате свалят/качват тегло?

Проба 1: Какво направихте (ползвахте диети, постене, хапчета или билки, уреди или други упражнения)?

Проба 2: Какво стана? Получи ли се? Теглото Ви промени ли се?

Проба 3: Какво Ви мотивира да свалите/качите тегло?

Проба 4: Някой каза ли Ви, че имате нужда да свалите/качите тегло?

Проба 5: Опишете каквито и да било разлики и прилики, откакто бяхте тийнейджър (по-млади).

ВАЖНО: За следващия въпрос ползвайте Допълнение Едно, както подобава

Проба 5: Къде потърсихте съвет как да промените теглото си? *ВАЖНО: Покажи лист А*

Какво правите, за да поддържате теглото си (с др. думи, да избегнете качване или загуба на тегло)?

Проба: Опишете разликите и приликите, откакто бяхте тийнейджър (по-млади).

Какъв тип послания получавате от медиите относно **тегло и спазване на диети**?

Проба: Семейство? Приятели? Певци(ици)? Кино/телевизионни звезди?

ПРЕДСТАВИ ЗА СОБСТВЕНОТО ТЯЛО

Как бихте се описали на външен вид и като фигура (в момента)?

Проба 1: Кои са най-привлекателните Ви черти? Най-малко привлекателните черти?

Проба 2: Колко важна за Вас е фигурата Ви?

Доволни ли сте от фигурата си в момента?

Проба 1: Какво бихте променили по тялото си, за да го харесвате повече? *(за черти позволяващи промяна)*

Проба 2: Ако можеше да промените каквото и да било по тялото си, какво бихте променили? *(включително непроменими черти)*

Разкажете ми за начините, по които сте се 'чувствали' във връзка с външността/фигурата си?

Проба 1: Кога сте се чувствали най-добре? Най-зле? Опишете как се чувствахте.

Проба 2: Какви са разликите и приликите, откогато бяхте тийнейджър (по-млади)?

Как бихте се почувствали, ако надобелеете много? А ако отслабнете много?

Вие или другите правили ли сте (за)бележки по отношение на [коментирали ли сте] размер, форма или тегло на тялото? Дайте пример.

Проба: Какво казвате? Какво казват другите? Сега...преди? На/за кого? Защо?

Опишете някои (за)бележки правени от другите относно размера/формата/теглото на тялото Ви, докато растяхте.

Проба 1: Майка/баща? Приятел/приятелка *(в смисъл на гадже)*? Роднини? Приятели?

Проба 2: Как Ви караха да се чувствате тези (за)бележки, тогава и сега? Тези хора все още ли правят (за)бележки?

Разкажете ми за ситуация, в която сте се чувствали неудобно заради тялото си (размер, форма, тегло, и пр.).

Проба 1: Нервни или сте избягвали да бъдете видени в бански костюм или в тесни (прилепнали) дрехи?

Проба 2: Избягвали сте социални сбирки заради притеснения за формата/размера/теглото на тялото Ви?

До колко добрият външен вид и/или оформеното тяло са важни за успех в днешното общество (в България)?

Проба 1: Защо? За професионална или лична реализация?

Проба 2: За кого е по-голям надъг (пречка) да бъде дебел.....мъже.....жени...и двата пола?

Опишете каквото и да било влияние, което външният вид има върху храната и храненето Ви.

Удоволствия и Пориви

Как бихте се почувствали, ако можеше да имате пълен контрол над телесните си желания и нужди?

Проба: Притеснявате ли се от някои от телесните си пориви? Ще ли Ви се да имате повече контрол?

Колко силен е апетитът Ви за удоволствия в живота?

Проба: До колко стремежът Ви към удоволствия влияе върху житейските Ви решения?

Как бихте се почувствали, ако трябваше да се лишите от неща, които Ви доставят удоволствие?

Проба 1: Бихте ли се почувствали духовно по-силни (по-добри, превъзходни)?

Проба 2: Съгласни ли сте, че страданието прави хората по-добри? [Съгласни с "Търпи бабо за хубост""]

Проба 3: Чувствате ли, че удоволствията и отдихът са загуба на време?

Какво мислите за яденето с цел удоволствие (преяждане, прекаляване, в излишък)... трябва ли хората да се хранят, ЕДИНСТВЕНО за зареждане на тялото?

Проба: Чувствате ли, че преяждането е знак на слабост? Ако да, каква слабост (морална)? Защо?

БЛАГОДАРИЯ! *Обяви края на интервюто. Благодарни на интервюираните за времето и попитай, дали има нещо, което той/тя би довавил(а). Попитай по какъв начин интервюто му/и бе интересно и какво му/и се стори трудно. Също така попитай, дали би могла да се свържеш с него/нея в рамките на няколко седмици, за да продължиш днешния разговор или зададеш допълнителни въпроси (ако възникнат такива).*

ЛИСТ А: ИЗТОЧНИЦИ НА ИНФОРМАЦИЯ, КОИТО ПОЛЗВАТЕ, ЗА ДА НАУЧИТЕ ЗА: _____

Посочете ВСИЧКИ източници на информация, които НАИСТИНА ПОЛЗВАТЕ и нивото си на доверие към тях.

Източници на Информация	ДА	Пълно Доверие	Склонност към Доверие	Склонност към Недоверие	Пълно Недоверие
Реклами (напр. в списания, вестници, интернет, билбордове, по ТВ и пр.)					
ТВ новини или други ТВ програми					
Статии в списания или вестници					
Интернет (по мрежата)					
Информация върху опаковките на храните (ако е приложимо)					
Лекари или други здравни професионалисти					
Популярни Книги (не учебници)					
Информация от правителствени източници (напр. Министерство на Здравеопазването)					
Дипляни в клиники					
<u>Загради подходящите:</u> Семейство / Роднини / Приятели / Друго (уточни): _____					
Не ползвам никакви източници на информация с тези цели (за здравословно хранене или дейност)					
Друго (уточни): _____					

ЛИСТ Б: ПОТЕНЦИАЛНИ ПОЛЗИ ЗА ВАС, АКО: _____

Посочете ВСИЧКИ възможни ползи и ЕДНА полза, която считате за лично най-значима.

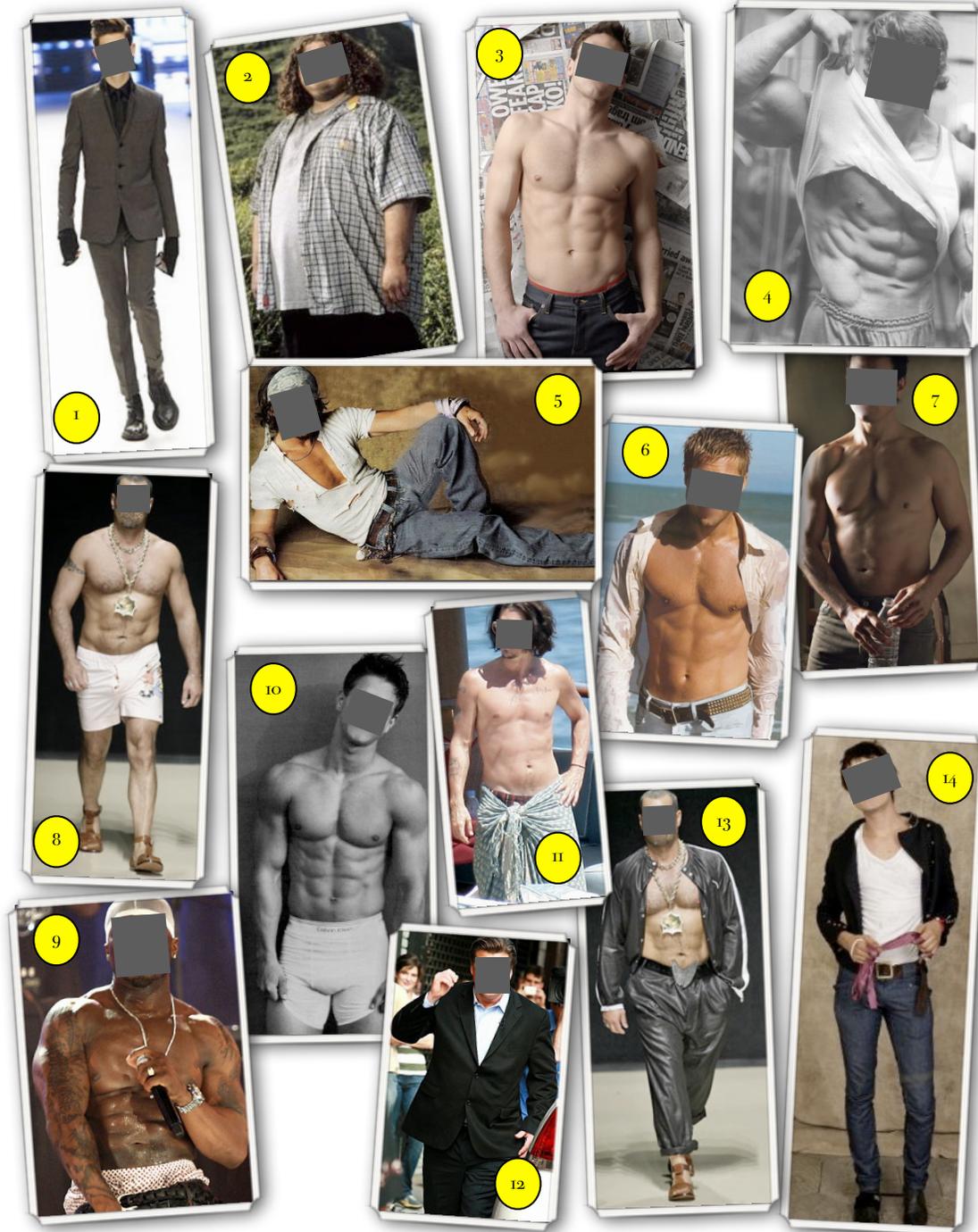
Ползи (_____ ЩЕ МИ ПОМОГНЕ ДА...)	ДА	ЕДНАТА НАЙ-ВАЖНА
Контролирам теллото си		
Изглеждам привлекателно		
Предотвратя болести (напр. сърдечни болести, рак и пр.)		
Съм във форма		
Живея по-дълго		
Имам успех в спорт или други физически тренировки (иако е приложимо)		
Имам достатъчно много енергия		
Имам по-добро качество на живот		
Остана здрав(а)		
Няма никакви ползи от _____ (здравословното хранене или дейност)		
Друго (уточни):		

ЛИСТ В: ПОТЕНЦИАЛНИ БАРИЕРИ, ЗА ДА СЕ: _____

Посочете ВСИЧКИ, които се отнасят за Вас (ако има такива).

БАРИЕРИ	ДА
Нередовни часове на работа	
Храна, която изглежда неприятно (ако е приложимо)	
Липса на готварски умения (ако е приложимо)	
Зает/забързан начин на живот	
Чувството, че се набивате на очи сред другите (ако е приложимо)	
Ограничен избор, когато се храня навън (ако е приложимо)	
Вкусовите предпочитания на семейство и приятели (ако е приложимо)	
Прекалено голяма промяна от сегашния ми начин на хранене (живот)	
Здравословни (или диетични) опции не се предлагат в магазини или на пазара (ако е приложимо)	
Да се откажа от храни, които харесвам (ако е приложимо)	
Странни или необичайни храни (начин на живот)	
Висока цена на здравословните храни (зали)	
Здравословните храни се развалят по-бързо (ако е приложимо)	
Липса на достатъчно знания за здравословното хранене (действие)	
Недостатъчно храна да задоволи глада ми (ако е приложимо)	
Продължително приготвяне (напр. дълго готвене, други свързани дейности и пр.)	
Експертите непрекъснато си променят мнението	
Липса на воля	
Липса на желание да променя сегашните си хранителни навици (начин на живот)	
За мен няма бариери да се храня здравословно (действие)	
Друго (уточни):	





**FOOD AND EATING HABITS
OF
MODERN BULGARIANS
(INTERVIEW)**

A DISSERTATION STUDY

BY

ROSA ANGELOVA • PHD CANDIDATE • CORNELL UNIVERSITY

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THE PARTICIPANT SHOULD READ AND SIGN THE INFORMED CONSENT FORM

- ▶ Introduce yourself
- ▶ State the purpose of the interview and the way interview information will be used
- ▶ Assure confidentiality
- ▶ Ask permission to have interview recorded digitally
- ▶ Ask if there are any questions before starting (the interview)

Hello! My name is Rosa Angelova and I am a nutrition PhD Candidate at Cornell University in the USA. This interview is part of the work for my doctoral dissertation. My goal is to learn more about your eating habits, beliefs and attitudes, as well as your opinion regarding certain types of media.

I assure you that I will not evaluate or make any judgments about your personal beliefs, opinions, attitudes, practices, or habits shared with me during the interview. I consider your answers unique and equally important for my research. This interview is absolutely **confidential** and **anonymous**.

Before we start I would like to ask your permission to digitally record the interview. This would allow me to stay focused on what you have to say. I would also encourage you to ask any questions you may have now.

Questionnaire (~30 min) >>> To complete either before, or at the time of interview #1- first face-to-face meeting

- ▶ Demographic Data (~5 min)
- ▶ Questionnaire (~25 min):
 - ▶ Media Exposure (~5 min)
 - ▶ Figure Rating Scales (~5 min)
 - ▶ Social Attitudes Toward Appearance (women only) (~5 min)
 - ▶ Eating Attitudes (~10 min)

Interview #1 (up to 1h 30 min total) >>> Full version is with questionnaire filled out at the time of the first meeting

In today's interview, I will be asking (and have you fill out a questionnaire with) several kinds of questions:

- ▶ Interview (~60 min)
 - ▶ Topics covering: friendships; physical activity; media, social, and cultural environments; attractiveness; religion, faith, and fasting beliefs; eating rules and habits; healthy eating; weight history; body image; pleasure and impulses.
- ▶ Supplements to the Interview
 - ▶ Supplement One: Healthy Eating/Figure Change:
 - ▶ List A: Information sources
 - ▶ List B: Benefits
 - ▶ List C: Barriers
 - ▶ Supplement Two: Celebrity Photographs (women/men)

Interview #2 >>> Interview specific for each separate participant (~30 min)

Today we will discuss some questions and themes that came out during our first conversation.

Rosa Angelova • email: raa29@cornell.edu • BG work: (2)8668635 • BG cell: (0895)119656 **TURN PAGE OVER**

FRIENDSHIPS

Tell me about your friends. What are your relationships with them like?

Probe 1: Do you feel they [the relationships] are sometimes superficial? Do you feel understood....and cared for?

Probe 2: How “open” (sociable) are you: very much, so-so, or you would rather spend your time alone?

PHYSICAL ACTIVITY

Tell me about the ways you keep yourself *physically active*.

What does being physically active mean to you?

Probe 1: When you think about physical activity/exercise what comes to mind (first)?

Probe 2: What emotion? Thought?

MEDIA, SOCIAL, & CULTURAL ENVIRONMENTS

What do you like to watch online or on TV... what types of programs? Give examples.

Probe 1: Western: serials, movies, reality shows....TV/cable channels or music or fashion/beauty programs?

Probe 2: Bulgarian versions of the above?

How much attention do you pay to beauty (e.g., makeup, hair) or weight loss (pills, equipment, creams) ads or tips?

Probe 1: None? Little? Some? A lot? Which ones do you pay attention to (if at all)?

Probe 2: Magazine ads.... articles? TV ads.... tips? Online ads.... articles?

Name a few of your favorite beauty or fashion, or men’s magazines (could be online).

Probe 1: Bulgarian (printed in Bulgarian)?

Probe 2: Western (printed in another western European language)?

Name a few of your favorite fashion catalogues (could be online).

IMPORTANT: Review interviewee’s figure rating answers and ask the next question, if appropriate.

What changes (if any) would you incorporate to make your silhouette selection look closer to your own body type?

IMPORTANT: For the following 2 questions use the figure scales, if appropriate. Also, if time allows for it, show interviewee the pictures in Supplement Two.

How do you imagine an ideal (perfect) female body.... male body?

Probe 1: Give an example of a celebrity (Bulgarian or western) that you see as (close to) perfect.

Probe 2: Describe the differences and similarities since you were a teen (younger).

What do you think (overall) is Bulgarians’ ideal for (fe)male figure (shape, size, or weight) nowadays?

Probe 1: Women’s ideal for (fe)male body? Men’s ideal for (fe)male body?

Probe 2: Give an example of a celebrity (Bulgarian or western) that depicts this ideal.

Probe 3: How do you think this ideal has changed since you were a teen (younger)?

Do you think Bulgarians are prejudiced against people who are fat? If yes, in what ways?

Probe 1: How do you feel about extremely fat (obese) people? Why do you think they are fat (no will, laziness, etc.)?

Probe 2: Has your attitude towards fat people changed in recent years? Since your were a teen (younger)?

ATTRACTIVENESS

Tell me of a woman you know that looks good. How about a man?

Probe 1: Why do you think s/he looks good?

Probe 2: Has your concept of beauty changed since you were a teen (younger)? If yes, how? Any ideas why?

ATTRACTIVENESS (CONTINUED)

Your favorite movie/TV actresses/singers/other famous women tend to be: ____ *IMPORTANT: Circle one*

1- Stunning	2- Attractive	3- Average	4- Ugly	5- Very Ugly
1- Fat	2- Full-figured	3- Average	4- Thin	5- Very thin

Probe: Give me one example (can be either Bulgarian, or Western, or both).

Your favorite movie/TV actors/singers/other famous men tend to be: ____ *IMPORTANT: Circle one*

1- Stunning	2- Attractive	3- Average	4- Ugly	5- Very Ugly
1- NOT Athletic (not muscular)	2- <u>Somewhat</u> NOT Athletic (not muscular)	3- Average	4- Athletic (muscular)	5- <u>Very</u> Athletic (muscular)

Probe: Give me one example (can be either Bulgarian, or Western, or both).

What kind of messages do you get from media about **attractiveness** and **beauty**?

Probe 1: Family? Friends? Singers? Movie/TV stars?

Probe 2: Are these message any different from when you were a teen (younger)?

RELIGION, FAITH, & FASTING BELIEFS

IMPORTANT: Make sure faith (religious beliefs) information is recorded in Demographic Data

How do your religious beliefs (or faith) influence the way you eat?

Probe: Do you avoid certain foods? Do you follow certain food related rituals?

What does fasting mean to you.....what is your definition of fasting?

Have you ever fasted? If no, do you know people who fast? Who?

Probe 1: What did you do? What rules did you follow? Did your weight change?

Probe 2: Where did you seek advice (learn) how to fast? *IMPORTANT: Supplement One, list A*

Probe 3: Do you fast regularly? [If appropriate: When did you first begin fasting?]

What would be your (or other peoples’) motivation to fast?

Probe 1: Religious beliefs (because I am observant)? Spiritual reasons?

Probe 2: Weight loss? Cleanse and purify your body? Give your body (GI tract) a rest?

Probe 3: To test your willpower? Because you are curious? Because everyone else fasts?

Describe any effects fasting may have on your figure/weight/appearance.

Probe: Can you think of any detriments? How about benefits? *IMPORTANT: Supplement One, list B*

Describe any effects fasting may have on your health.

Probe: Can you think of any detriments? How about benefits? *IMPORTANT: Supplement One, list B*

EATING RULES & HABITS

Tell me about your regular day’s activities from the time you get up in the morning till you go to bed at night.

How would you describe the way you eat (now)?

Probe 1: Describe any rules (or expectations) you have for yourself about food and eating.

Probe 2: What are the differences and similarities since you were a teen (younger)?

Probe 3: Are there any foods you cannot eat? Why?

Probe 4: Is there a particular way of eating you could never do (e.g, vegetarian, fast, count kcal, etc.)?

EATING RULES & HABITS (CONTINUED)

If you could change anything about the way you currently eat, what would it be?

Describe any struggles (“battles”, effort, stress) you have had around food and eating.

Probe 1: Financial struggles? Health-related? Body size/shape/weight related?

Probe 2: Struggles in your childhood and teens (when you were younger)? Now?

HEALTHY EATING

What is your definition of healthy eating?

Probe 1: What eating habits? Types of foods? Special programs or regimens?

Probe 2: How is your idea of healthy eating different from when you were a teen (younger)?

Can you think of particular foods and eating habits that you consider bad for health?

Probe: Can you please explain why?

How would you evaluate your current eating in terms of health?

If you could change anything about your current way of eating to make it healthier, what would it be?

How would you describe a healthy person your age?

Probe: A woman? A man?

IMPORTANT: For the next 3 questions use Supplement One, as appropriate

Where do you seek information about healthy eating? *IMPORTANT: Show list A*

What do you think are the benefit(s) of healthy eating? *IMPORTANT: Show list B*

What (if any) would be the major barriers for you (personally) to eat healthy? *IMPORTANT: Show list C*

What kind of messages do you get from media about **healthy eating**?

Probe: Family? Friends? Singers? Movie/TV stars?

WEIGHT HISTORY

IMPORTANT: Make sure weight information is recorded in Demographic Data

Describe any notable changes (or fluctuations) in your weight growing up until now.

Probe 1: What were you like as a child....a teen (appearance wise)?

Probe 2: What is the longest time period in which your weight has been stable?

Probe 3: What factors or life events do you think influenced the changes in your weight?

Have you ever tried to lose/gain weight? If no, how do the women/men you know lose/gain weight?

Probe 1: What did you do (used dieting, fasting, pills or botanicals, machines or other exercise)?

Probe 2: What happened? Did it work? Did your weight change?

Probe 3: What motivated you to lose/gain weight?

Probe 4: Did anyone tell you that you needed to lose/gain weight?

Probe 5: Describe any differences and similarities to when you were a teen (younger).

IMPORTANT: For the next question use Supplement One as appropriate

Probe 6: Where did you seek advice on how to change your weight? *IMPORTANT: Show list A*

What do you do to maintain your weight (i.e. to avoid weight gain or loss)?

Probe: Describe the differences and similarities to when you were a teen (younger).

What kind of messages do you get from media about **weight** and **dieting**?

Probe: Family? Friends? Singers? Movie/TV stars?

BODY IMAGE

How would you describe your physical appearance and figure (currently)?

Probe 1: What are your most attractive features? Least attractive features?

Probe 2: How important to you is your figure?

Are you satisfied with your current figure?

Probe 1: What would you change about your body to like it better? (*for features possible to change*)

Probe 2: If you could change anything about your body, what would it be? (*including non-alterable features*)

Tell me about the ways you have 'felt' about your appearance/figure?

Probe 1: When have you felt the best? The worst? Describe how you felt.

Probe 2: What are the differences and similarities to when you were a teen (younger)?

How would you feel if you gained a lot of weight? How about if you lost a lot of weight?

Have you or others made comments [judgments] about body size, shape, or weight? Give an example.

Probe: What do you say? What do others say? Now...before? To/regarding whom? Why?

Describe any comments made by others about your body size/shape/weight when you were growing up.

Probe 1: Mother/father? Boyfriend/girlfriend? Relatives? Friends?

Probe 2: How did these comments make you feel, then and now? Do these people still make comments?

Tell me about a situation in which you felt embarrassed of your body (size, shape, weight, etc).

Probe 1: Nervous or avoiding being seen in a bathing suit or in tight-fitting clothes?

Probe 2: Avoiding social outings due to body shape/size/weight concerns?

How important are good looks and/or a shapely body for success in today's society (in Bulgaria)?

Probe 1: Why? For professional or personal realization?

Probe 2: For whom is being fat more of a handicap (burden).....men....women...both?

Describe any influence appearance has on your food and eating.

PLEASURE & IMPULSES

How would you feel if you could have full control over your bodily desires and needs?

Probe: Are you worried about some of your bodily impulses? Do you wish you had more control?

How strong is your appetite for pleasure in life?

Probe: How does your drive for pleasure influence your life decisions?

How would you feel if you had to deprive yourself of things that bring you pleasure?

Probe 1: Would you feel spiritually stronger (better, superior)?

Probe 2: Do you agree that suffering makes people better? [Agree with "No pain, no gain"?]

Probe 3: Do you feel that pleasure and leisure are a waste of time?

What do you think about eating for pleasure (overindulgence, immoderation, in excess).... should people eat ONLY to fuel their body?

Probe: Do you feel that overindulgence is a sign of weakness? If yes, what kind of weakness (moral)? Why?

THANK YOU! *Announce the end of the interview. Thank interviewee for the time and ask if there is something s/he would like to add. Ask what s/he liked about the interview and what was hard. Also ask whether you could contact him/her within the next few weeks to follow up on today's conversation or ask additional questions (if such emerge).*

LIST A: INFORMATION SOURCES YOU USE TO LEARN ABOUT: _____

Indicate ALL information sources you that ACTUALLY USE and your level of trust in them.

INFORMATION SOURCES	YES	Trust Fully	Tend to Trust	Tend to Distrust	Distrust Fully
Advertisements <i>(e.g., magazines, newspapers, the internet, billboards, on TV, etc.)</i>					
TV news or other TV programs					
Articles in magazines or newspapers					
Internet <i>(online)</i>					
Information on food packages <i>(if applicable)</i>					
Doctors or other health professionals					
Popular Books <i>(not text-books)</i>					
Information from government sources <i>(e.g. Ministry of Health)</i>					
Leaflets in clinics					
<u>Circle the appropriate:</u> Family / Relatives / Friends / Other (explain): _____					
I do not use any information sources for these purposes <i>(healthy eating or activity)</i>					
Other (explain): _____					

LIST B: POTENTIAL BENEFITS FOR YOU IF YOU: _____

Indicate ALL possible benefits and the ONE benefit, which you consider most personally significant.

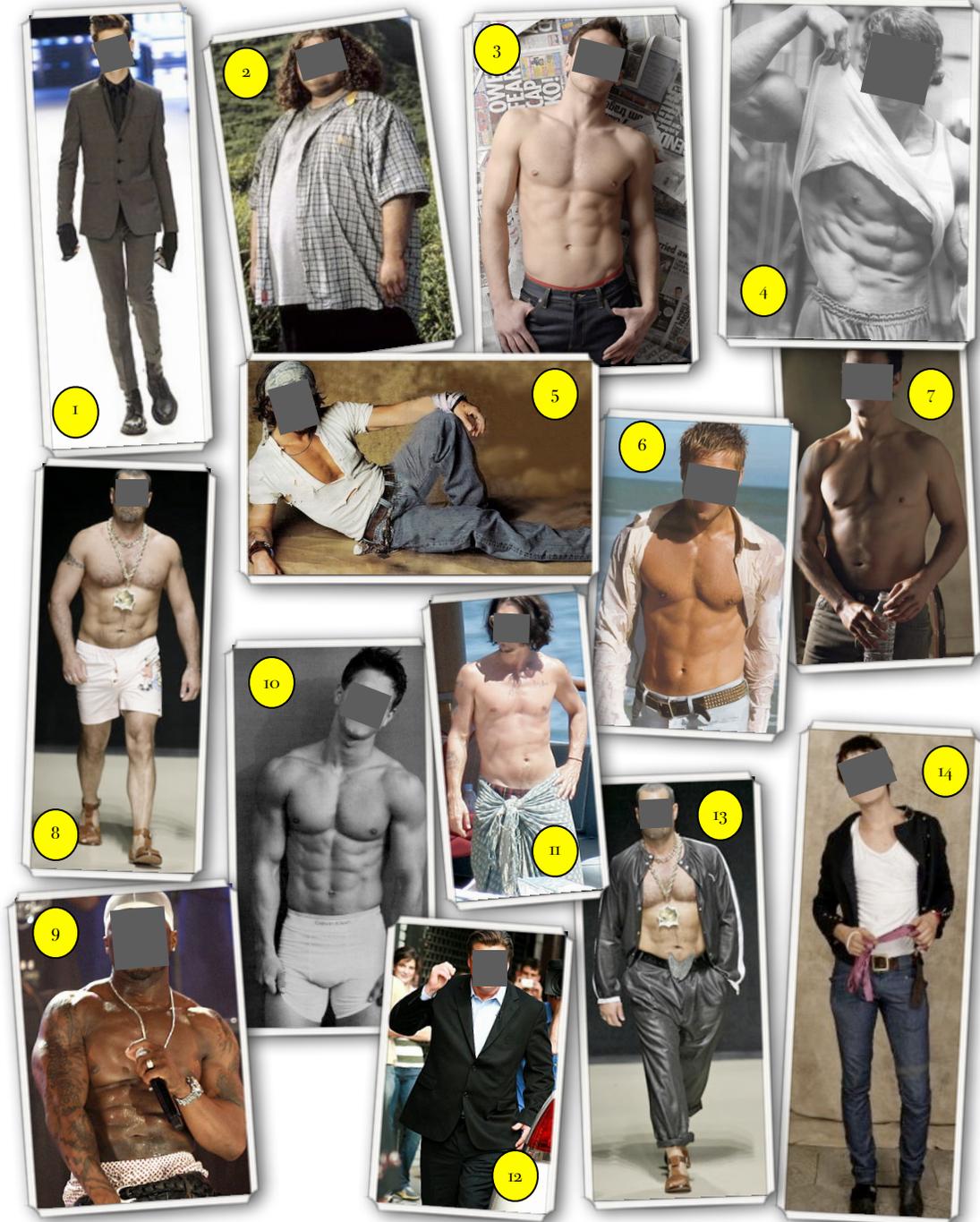
BENEFITS (_____ WILL HELP ME TO...)	YES	MOST IMPORTANT <u>ONE</u>
Control my weight		
Look attractive		
Prevent disease (e.g., heart disease, cancer, etc.)		
Be fit		
Live longer		
Do well at sports or other physical training (if applicable)		
Have plenty of energy		
Have a better quality of life		
Stay healthy		
There are no benefits to _____ (healthy eating or activity)		
Other (explain):		

LIST C: POTENTIAL BARRIERS FOR YOU TO: _____

Indicate ALL that apply (if any).

BARRIERS	YES
Irregular working hours	
Unappealing food (if applicable)	
Lack of cooking skills (if applicable)	
Busy lifestyle	
Feeling conspicuous among others (if applicable)	
Limited choice when I eat out (if applicable)	
Taste preferences of family and friends (if applicable)	
Too great a change from my current diet (lifestyle)	
Healthy (or diet) options not available in shop or market (if applicable)	
Giving up foods I like (if applicable)	
Strange or unusual foods (lifestyle)	
High price of healthy foods (facilities)	
Healthy foods are more perishable (if applicable)	
Not knowing enough about healthy eating (activity)	
Not enough food to satisfy hunger (if applicable)	
Lengthy preparation (e.g., timely cooking, other related actions, etc.)	
Experts keep changing their minds	
Lack of willpower	
Lack of desire to change my current eating habits (lifestyle)	
There are no barriers for me to eat healthy (activity)	
Other (explain):	





Rosa Angelova • email: raa29@cornell.edu • BG work: (2)8668635 • BG cell: (0895)119656 RETURN TO INTERVIEW

APPENDIX 5:

IRB APPROVAL LETTER



Cornell University
Office of
Research Integrity and Assurance

East Hill Office Building, Suite 320
395 Pine Tree Road
Ithaca, NY 14850
p. 607-255-5138
f. 607-255-0758
www.irb.cornell.edu

Institutional Review Board for Human Participants

NOTICE OF EXPEDITED CONTINUATION APPROVAL

To: Rosa Angelova
From: Jenny Gerner, IRB Chairperson
Protocol ID#: 0908000241
Project(s): Changes in ideal body image, fitness beliefs, and eating behavior among young adults in the course of transition from a post-communist to free-market society in Bulgaria: An exploratory study of dietary change and its relation to social change in Bulgaria
Date of Approval: April 29, 2009
Expiration Date: April 28, 2010

The above-referenced request for protocol continuation has been reviewed and given expedited approval by the Institutional Review Board for Human Participants (IRB) for the inclusion of human participants in research. **This approval shall remain in effect until April 28, 2010.**

This approval does not replace any departmental or other approvals that may be required.

Federal regulations require that all research be reviewed at least annually. We will send a courtesy "*Continuation Renewal Reminder*" approximately two months prior to the expiration date; however, as the Principal Investigator it is your responsibility to obtain review and continued approval *before* the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.

All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.

Unexpected events involving human participants must be promptly reported to the IRB. For guidance on recognizing, defining, and reporting unexpected events, please refer to the IRB website: <http://www.irb.cornell.edu/forms>.

Note: Forms should be downloaded from the IRB website for each use.

c: Virginia Utermohlen

APPENDIX 6:

INTERVIEW TRANSCRIPTION PROTOCOL

Transcript Element	Explanation
NAME (AGE)	Name and age (in parentheses) of speaker
Initials	Initials indicate speaker I=Interviewer
<i>Italic type</i>	Interviewer speaking
Bold type	Emphasis
...I: Text...	Interviewer interrupting, but not causing the original speaker to stop talking
...	Short pause
.....	Longer pause
...text begins with a non-capitalized letter	The speaker continues without interruption
[Material in square brackets]	Clarifying information
[] Empty square brackets	Some transcript omitted