

THE PANDEMIC SAVED MY LIFE: HOW THE PANDEMIC AFFECTED TREATMENT  
FOR EATING DISORDERS

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Submitted to Texas State University  
in partial fulfillment  
of the requirements for  
graduation in the Honors College  
May 2023

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## **ABSTRACT**

The COVID pandemic affected the treatment of eating disorders, including education, going online for information about eating disorders, and determining who received and how treatment would be administered. The scope of this research is moderate, focusing primarily on data surrounding eating disorder treatment centers and their findings after the pandemic began. It is difficult to determine what is believed about my topic, considering how new the pandemic is to the world (historically). Nonetheless, it can be said that the pandemic made it easier for those in school and treatment to continue their educational career through the transfer to online. There is not a wide understanding of what goes into eating disorder treatment, so it makes it harder to answer the question: was the pandemic good for people with an eating disorder or bad? My approach to this topic is neutral and informative, focusing on analyzing the data collected from different treatment centers throughout the country. Evidence includes feedback from clients, data (specifically observations and improvements seen) from treatment centers, etc. From my findings after researching, it is clear the pandemic had several contrasting effects, and for some it was lifesaving (this was my case). However, it also had deadly effects, not just due to the COVID-19 virus itself, but also due to forced isolation. In a world post-COVID, how can we adopt the innovative measures taken during the pandemic to significantly improve treatment, and encourage more people suffering from an eating disorder to seek treatment?

## **I. INTRODUCTION**

How can a deadly pandemic that killed 1.8 million people in less than a year, constituting the third leading cause of death in America in 2020, be something positive, even lifesaving, for some? The COVID-19 pandemic had a devastating effect on the world, without a doubt. Three years later we are still dealing with long-term side effects and grieving those lost. But when it comes to mental health, the pandemic also brought new positive ways to go about getting treatment, especially among treatment for eating disorders.

## **II. THE PANDEMIC AND EATING DISORDER TREATMENT**

The first wave of the pandemic changed the dynamics of everyday life for everyone in the United States (not just that, but the world as well.) A large majority of schools and universities started by enacting a two-week long spring break, or general break, that turned into the rest of the semester being converted to virtual classes. Lockdowns impacted every detail of life before COVID, not just education; restaurants shut down, everyone wore masks, people stayed inside their homes, traveling ceased, people stopped working, etc. It seemed like the entire world went on pause, in a way. In that first month of lockdown, many people were confused about the state of the world and how to proceed. Shifting their lives suddenly came as a huge shock.

So why are the changes caused by the pandemic important to treatment for eating disorders? When it comes to mental health issues, seeking treatment or support can be quite hard. There is a wide spectrum of mental health disorders, with an even wider spectrum of associated behaviors. Among the most common behaviors associated with symptoms is isolation. It can be

extremely hard for those struggling to find the courage to seek treatment, and they may feel shame or embarrassment. People struggling may fear what others will think, or if people around them will notice their absence; it is also just generally normal for those struggling with mental health to isolate themselves, as a behavior of that struggle. With treatment for an eating disorder, there are various levels of care: outpatient, inpatient residential, independent, etc. depending on a person's needs. They each take up a chunk of time during the day and week, some levels much more than others. Imagine someone secretly struggling with an eating disorder; this person feels shame, embarrassment, and guilt, among many complex emotions. They want to get treatment, but they are in school, or they work full-time. They do not want to just disappear from their life, because they are worried about what their peers will think. They do not want to change their life suddenly to work on this thing they are struggling with. Fear of change or the unknown is common in an eating disorder, and that fear is something the disorder uses. If there is no treatment option that lets this person continue their life somehow, in a way that does not make their absence so apparent to others, they will give up and not seek treatment. Now factor in the effect of the pandemic, and the lockdown following the first few waves. Most treatment centers or programs that do not require residential inpatients become online, over Zoom. School transfers to Zoom and assignments are online. Many jobs shut down, and many people in the United States are encouraged to file for unemployment. Almost nothing is in person.

For a person struggling with shame and embarrassment about their eating disorder, starting therapy or treatment in person can be too much of a hurdle to overcome; facing other people in real life can be terrifying, and thinking of your absence being noticed by peers after

leaving your day-to-day life can be embarrassing. But suddenly, the pandemic granted people an opportunity to stay home and in school or at work, all while getting the treatment they need and deserve. Classes moving to virtual, and the influx of people that applied for unemployment after their jobs were shut down, allowed people either working full time or being a student full time to continue getting paid or continue their education while being on lockdown. Notably, it could have been quite hard for a person to pay for treatment before the pandemic if it required they severely limit their hours or take a leave of absence altogether (provided they are not given paid leave.) During the pandemic, however, a person could still be getting paid while away from their job and not struggle to pay their daily expenses while getting treatment. The pandemic made it possible for those struggling to privately get the treatment they deserve, in a way that was comfortable for them.

According to clinicians that were interviewed, when asked what developments from the pandemic were beneficial to treatment, one of the most common answers was Telehealth. Danielle Polland, a licensed master social worker that worked in the outpatient levels of care (which are PHP/IOP,) stated that in some ways it was helpful and in other ways, it was not, but she thought it was amazing when it comes to accessibility. There were a lot of people who needed care during the pandemic who just maybe did not feel comfortable going in person, and now it is more about access; people who do not have therapists around them can see someone in their state virtually, and that is huge. But [she] also has had patients who despised virtual care; for them, it just really did not feel like a connection, it did not feel helpful... It was really a personal choice, but [she] think(s) having it at least accessible to people who might benefit from it is huge (Polland, 3.) Alexa Shank, a licensed professional counselor, stated that when she was working at the higher level of care at PHP/IOP, it was a lot more difficult at least initially when

[they] transitioned to a virtual format to get people to continue to engage, continue to build rapport, and that that was a really big obstacle in just delivering good treatment. But as the pandemic went on, and as people got more used to being on the virtual platform and kind of being forced to get more comfortable with it, she noted that it started to become easier, and people started to kind of become accustomed to having to build relationships online, and how that was sort of just weird in general, and an unnatural kind of thing (Shank, 3). She went on to contribute to the beneficial developments in treatment during the pandemic, stating that a lot of treatment centers and providers, like the treatment center that [she] worked for, tried to kind of supplement care by offering more availability for support groups and meal support. So, they would open these free times where people could just come and either get support emotionally or do meal support; [which] was not something that was being done before the pandemic. Since people were struggling more initially with having to be at home and having to be virtual, that was the emphasis for it... but it ended up benefiting people a lot more than [they] realized it would (Shank, 4).

Registered dietician Tori White stated that she has a virtual and in-person hybrid practice set up and that the majority of [her] clients prefer virtual over in-person. Adapting other resources to be digital was another change, [like] paper or other types of material. Whenever covering a handout, now [she] can ask if this is something to be emailed, or is it something where [she] can screen share? Is it something [she] can write on a whiteboard, which is [a method that she and] the client can do where [they] jot things down at the office? (White, 2). Additionally, she stated she had a client who seems to have benefited highly from being able to meet from their home; whether it's because of stress and anxiety and not having to commute across town, or whether they feel safer in their space, and a little bit more willing to engage in

conversation they might otherwise have more difficulty in, [she] certainly saw in large part in [her] caseload that in especially adult clients, there seemed to be a level of increased engagement and sense of being engaged in our conversations (White, 4). Virtual care and video calls becoming normalized during the pandemic gave clients a new sense of security and support, as it could accommodate changes in their lives, whether expected or unexpected: such as traveling or moving. Tori White argues the option of virtual care as a standard or regular practice for clients, as well as the ability to switch to that modality if needed due to transportation issues, illness, and so on is a positive development from the pandemic that increased accessibility. For [her] clients who might graduate high school and move to another city in their state, or another state that [she is] licensed in/able to practice in, the continuity of care is certainly a benefit to continuing to work virtually. And generally, for any client moving states that continuity of care is certainly a benefit (White, 8).

According to Carli Packard, who worked in group practice during the beginning of the pandemic, providing only virtual sessions was a huge transition. In [her] master's program it was not even discussed as a method of doing therapy. It was incredibly stressful to figure out up front and many clients stopped therapy due to so many unknowns happening at the same time. The biggest change was offering virtual sessions and getting used to them [herself], now [she] love(s) virtual sessions (Packard, 2). She raved about virtual therapy, arguing it is amazing and has completely changed the industry forever. More people can access the care they need because everyone was forced to figure out how to make at least half of their treatment virtual (Packard, 2).

### **III. PERSONAL REFLECTION**

I saw firsthand what COVID did to eating disorder treatment. During my first year of college, I developed a severe and life-threatening eating disorder. After the “two-week spring break” had commenced, I moved home, and my mom did everything she could to help me while she sought out resources to better support me. She found a therapist that recommended a PHP center in Austin, where my parents lived. The day before Austin, Texas went into official lockdown, I went to my first day of outpatient treatment at that center. Everyone did the best they could to stay 6 feet apart, wearing masks and wiping down equipment after use. Unfortunately, it became clear I would need a higher level of treatment. On the day that Austin, Texas went into lockdown, I was admitted to a residential treatment facility outside of Houston, Texas. The first few weeks were interesting there, as policies would constantly shift. The tables we would eat our meals at soon became spaced apart (as well as the chairs), we were given masks to wear, and cleaning was done with much more thoroughness and care than it was pre-pandemic. We had our days planned and were given time each morning to do schoolwork. Before being admitted to the residential facility, the only way I accepted treatment was because the pandemic allowed me to continue classes virtually. And that I did. Even while I was fighting for my life and pushing through mental battles multiple times a day every single day during those first few weeks, I still could complete school assignments and watch recorded lectures. It gave me a sense of productivity and accomplishment. I soon found myself looking forward to doing schoolwork each weekday since it was a distraction.

To hear my mother talk about how my disorder was before going to treatment, she would tell you that I would have been in the ICU had the pandemic lockdown not happened. Or even possibly dead. She knew how much my education mattered to me, and how I was not going to step away from it for any reason. She said I would have fainted on campus one day, that I would hit



my head on some of the stairs and have had to go to the hospital. She said I would have stayed in the hospital for most of my immediate recovery; I would have been given a feeding tube which would have traumatized me, not just physically but mentally. I quote my mom mainly because she remembers this time of my life better than I can. I was in a state of psychosis; not only that but being severely malnourished from my eating disorder harmed my brain function, which in turn made my ability to recall events from that time of my life even worse (I have also since blocked numerous memories from that time.) For my mother, however, it was brutally memorable.

The main effect on my time in residential though was that because of the pandemic and lockdowns, I was not hospitalized. I got the chance to go to an amazing residential facility and receive the level of care I needed because I decided to go; in large part because I could continue my education simultaneously, but also because what little fight I had left in me at the time was screaming for help. I have amazing parents, who when I needed an IV of fluids and the facility was not sure how to proceed since that normally means a trip to a medical clinic, and that was not possible due to lockdown regulations, personally sought a mobile IV unit to come to the treatment facility to reduce the risk of COVID exposure. I recognize how immensely privileged I am to get to say that; it is necessary to point out that not everyone can afford that level of care for that length of time: which was around 4 months. Most other clients I saw come and go had an average stay of around two months, for reference. But the point is that had the pandemic not happened, had lockdowns and massive shifts not happened in the world, my life could have been drastically different because of the state of treatment. Even non-existent. But that is just *my* life. My experience absolutely does not reflect the experience of every other person in the United States that was struggling with an eating disorder during the pandemic; or every other person in the world for that matter.

#### IV. SO WHAT DID THE PANDEMIC DO?

Many studies have shown the pandemic significantly *increased* the number of people struggling with an eating disorder. Understandably so: the global prevalence of anxiety and depression increased by 25% in the first year (World Health Organization, 1). Anxiety and depression both are highly correlated to eating disorders, which are often dangerous coping mechanisms developed in response. The effect of this was massive: the number of hospitalizations for eating disorders increased drastically. A study published on the American Academy of Pediatrics website showed that eating disorder emergency visit volume increased by 12.9 per month within the first year of the pandemic; before COVID, the rate was 1.5 visits per month. According to Sawyer Cobb, a registered dietician working in an Eating Recovery Center (commonly known as ERC), they had waitlists that [she] did not know if ERC had ever experienced before. Waitlists were up to 6-8 weeks (about 2 months) long, and during the middle of lockdown – not just at the very start (Cobb, 3). Adolescents were hit hard as well: an article by the New York Times quoted psychologist Erin Accurso, the clinical director of the eating disorders program at the University of California, San Francisco, stating that the inpatient unit [had] exploded in the past year, taking in more than twice as many adolescent patients as it did before COVID. Erin Accurso stated further on the topic that providers were not taking new clients [at that time] or had wait lists up to six months long (Accurso, 13). The higher hospitalization rates were detrimental to treatment since COVID-19 cases were high simultaneously: thus, COVID-19 hospitalizations were high and were taking up space in hospitals across the country. In turn, this meant even less hospital space available for eating disorder patients that needed hospitalization.

Anxiety and depression are not the only harmful roots in the disease of an eating disorder. One of the biggest is shame. Shame is intertwined within the nature of a majority of eating disorders (important to note, though, that there are numerous complex eating disorders not rooted in shame or insecurity.) The shame of one's body, one's presence, and one's being perceived are all common. An eating disorder can usually have a voice of its own; one of the most common tactics used in treatment is practicing separating the person's own thoughts and inner voice from the disordered thoughts. It is in the nature of this disease to isolate a person and make them believe the harm they are doing to their body is "good." The disorder tells them that going against what it tells them to do will make them "lose," or that it makes them weak. The disorder makes the person feel guilty for even wanting help. Coupled with the isolation during the pandemic, it made seeking treatment an incredibly challenging thing for people suffering from a severe eating disorder to do. According to LCSW Danielle Polland, there was a big thrust in people coming for higher levels of care, and the people who were coming in were at a more residential level than PHP/IOP level (Polland, 6). She argues that it was because the people who needed PHP two months prior did not come into treatment for care; and between just not starting treatment sooner [along with] the stresses of the pandemic, their eating disorder got much more intense. So, by the time they did come into treatment, they needed a much higher level of care than they were seeking (Polland, 7). It was also stated by dietician Tori White that with adolescents ... it made things a bit more difficult, because there was a lot of privacy and because this new generation does not enjoy or prefer a video call type modality. And it can be harder for them to engage than it would be in person (White, 4). When asked what was detrimental to treatment during this time, she noted that very big practical and food-related tasks, like grocery shopping, eating food from restaurants, and accessing and preparing food became even more

stressful than it already was for clients [she] worked with because of the threat in the question: “how is this going to impact my risk of getting covid or sharing covid?” (White, 5). Additionally, the limitation of just virtual sessions during the pandemic was detrimental for some. Tori White stated she had a small handful of clients who would have benefitted from in-person sessions, had that been an option at the time, or had that felt feasible at the time. In terms of building rapport and things like that, [she thought] that [in-person sessions] would have been helpful... and that video modality for them may have been more on the detrimental side, and just not the right fit for them (White, 5).

According to Danielle Polland, treatment methods and tactics were changed in the terms of care: examples such as physically separating, wearing masks, and having dividers between clients during meals and snacks she believes impacted care. Some [clients] had comfort in the idea that they were doing what they could; for others, it might have taken away that personal comforting aspect of seeing the person directly next to you going through something similar (Polland, 7). She further explained that isolation was a big part of the challenge presented to treatment. There were things that [they] could not do in treatment that [they] used to do; for example, [they] used to do exposures in the community: social anxiety exposures, grocery shopping exposures, and even clothing shopping exposures. [They] also used to do activities that were not cooking classes, but were more hands-on with the food, which they could not do during the pandemic. Although not sure if it were detrimental in terms of treatment, she stated it did take away from some of the things that could have been helpful in treatment (Polland, 8). With the huge increase in adolescents who got treatment for eating disorders and who ended up in the hospital for eating disorders, Polland argues that it says something about how the pandemic either exacerbated high rates of eating disorders, or exacerbated isolation, loneliness, and

emotional dis-regulation. And all of that added up to impact people with eating disorders (Polland, 8).

According to Carli Packard, who was earlier stated, client care suffered on all fronts and at all levels during the beginning of the pandemic. She argues that during that time, support systems became the most important thing in a client's life. If a client was quarantining at home with someone who was particularly triggering, it was nearly impossible to make progress, [and] management became the main goal (Packard, 3). When asked what impacted client success, she stated that resources, finances, remote failures, and isolation/quarantine were all negative factors. She also informed that there was a new fear around food being legitimately unsafe and needing to be wiped down or washed that created much more anxiety around food even outside of [a client's] eating disorder. Overall, therapists and clients were in survival mode [during that time], doing the best they could with what they had. The pandemic impacted everyone, [and] people who needed accountability around eating due to an eating disorder particularly suffered. [She is not] sure there was much anyone could have done differently in those moments (Packard, 5).

## **V. MEDIA EFFECT ON EATING DISORDERS; AND THE PANDEMIC EFFECT ON MEDIA USE**

In the world we live in today, digital media is everything. Most people in the United States use the internet every day: more than eight in ten U.S. adults go online at least daily (Pew Research Center, 1). With how common media is consumed, unfortunately, media literacy is not as common. Media literacy is defined as the ability to critically analyze stories presented in the

mass media and to determine their accuracy or credibility (Oxford Languages). But how can it be, with how drastically technology advances every year? Not to mention how many younger people are present on social media?

New features and possibilities with social media and the internet in general have exploded in the past ~10 years. Filters, deep fakes, and more opportunities to stretch what is true into something fake have all popped up in the past 8 years. Misinformation is not new, but because of how easily modern technology (such as artificial intelligence, or AI) has made false information look much more believable, it has spread rapidly across the internet to a worrisome degree. It has become harder and harder to discern what information is real, and what information is fake. Staying on the Internet and social media for extended periods has resulted in media and digital literacy continuing to gain importance (Dolanbay H., 1). In response to the issue, media literacy has been adapted and pushed onto people by educators and universities recently; but unfortunately, it was not promoted enough to prevent damage during the pandemic.

Media literacy has been around since the 20th century, stemming from journalism and written works such as newspapers. Elements spread into the film industry, and then finally onto the internet after it was made available to the public in the 1990s. Then came the rise of social media – starting in 1997 with the first social media platform, named Six Degrees. Followed by the launch of LinkedIn in 2002, and the founding of Myspace in 2003, social media began to take off. Facebook went live the next year, followed by Reddit, YouTube, Twitter, Facebook Newsfeed, Spotify, Pinterest, Instagram, Snapchat, and more; all within less than a decade. The rise of these social media platforms meant a drastic rise in content and information from anyone being spread across the globe; hence, the rise in the need for media literacy. Then TikTok was

launched globally in 2018. Rising dramatically in popularity, TikTok was the most used social media app in 2020, according to an article by Forbes. TikTok had over 82 million downloads as of that year. On top of that, the platform allowed 1.4 million children (about half the population of Nevada) under the age of 13 to use the app in 2020, “despite its own rules requiring users to be above this age to create a TikTok account” (CNBC article.) The New York Times reported internal company data from July 2020 showing that 18 million users (more than one-third of overall users from that time) were 14 years old or younger. An even larger number of users were minors, under the age of 18. As impressionable as children are, media literacy is a challenging thing for a child to practice. Many adults do not even practice it; according to a survey by Media Literacy Now, a nonprofit group that advocates for teaching media literacy skills in schools, nearly half of adults ages 19 to 81 did not learn media literacy skills in high school. The average age of respondents was 41.

When children under the age of 18 (and honestly, people under the age of 21) are not being taught how to discern what is real and what is fake online, they easily believe false information and in turn, can cause a lot of damage: whether to themselves or others. Even for children with media literate parents, who warn them that there are swarms of false information being spread everywhere online, adolescents frequently tend to ignore their parents’ advice as they try to assert their independence. This is typical behavior in many adolescents as they start to build their own identities. Then the pandemic hits, and everyone is stuck inside their homes with nothing better to do than to scroll through social media apps. Including children.

Lockdowns prompted everyone, children and adults alike, to sit on their phones or computers all day. Again, no one had anything better to do. Overall social media engagement

increased by 61% during the first wave of the pandemic, according to Penn Medicine. So that increased the amount of content being produced/posted online, including diet culture content. Tips for calorie counting, at-home workouts, and rhetoric describing those who do not work out as “lazy” and “unmotivated” were everywhere, even more so than before the pandemic. And with the way algorithms work, the more you look at certain kinds of content, the more that content will then be delivered to your feed for your eyes to see. TikTok and social media apps alike became a cesspool of diet culture content, pushed onto children and adults struggling with eating disorders or disordered eating; most importantly children that were highly impressionable since their brains were still in the process of developing. This was incredibly harmful and debilitating. Not to mention fatal.

## **VI. THE GRAVITY OF EATING DISORDERS**

It is not new to the world that eating disorders are deadly. One study found that people with anorexia are 56 times more likely to commit suicide than people without an eating disorder (Eating Disorders Coalition, 2016), and according to the National Association of Anorexia Nervosa and Associated Disorders, eating disorders are the second deadliest mental illness, second only to opioid overdose. But something that is drastically overlooked is the falsehood of eating disorder stereotypes. Eating disorder stereotypes permeate many distinct parts of media and culture, usually portraying an image of white teen girls that are extremely underweight; but that is only a small portion of people with eating disorders. Many people assume that eating disorders just affect women, but that is false. True that women have a higher percent chance than men of having anorexia (the most widely known eating disorder) at least once in their lifetime,



but the percentage of men vs women that are affected is much higher than you may think. Few people realize just how many men are also affected by them: According to the National Eating Disorders Association (NEDA), national surveys estimate that 20 million women (about the population of New York) and 10 million men (about half the population of New York) in America will have an eating disorder at some point in their lives. Although the chance is higher for women, men still have a higher chance of developing an eating disorder than many people may think; and it is not common for men to be portrayed as having eating disorders in the media. On top of this, less than 6% of those with an eating disorder are medically diagnosed as “underweight”. Stereotypes make it hard to notice when people who do not fit into this percentile of people are struggling, just because they do not physically “look the part.” Fat-shaming is common in society, but at the root of it is fatphobia: an abnormal and irrational fear of being fat or of being around fat people (Monte Nido, 1). This in turn contributes to the high rate of eating disorders, present not just in those that are underweight, but in those that are *not* and are fat-shamed because of it. Black, indigenous, and people of color are also massively affected; according to NEDA, black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior (Goeree, Sovinsky, & Iorio, 2011), and researchers also reported a trend toward a higher prevalence of binge eating disorder in all minority groups (Swanson, 2011). Higher rates of disordered eating are dangerous: but most importantly, people of color with self-acknowledged eating and weight concerns were significantly less likely than white participants to have been asked by a doctor about eating disorder symptoms, despite similar rates of eating disorder symptoms across ethnic groups. (Becker, 2003). Given the rise in eating disorders overall during the pandemic, the number of minorities affected by an eating disorder also rose significantly; and unfortunately, this meant a rise in untreated cases. A study published in the

Nature Public Health Emergency Collection found higher rates of binge eating in black women during the first wave of COVID, but among participants, it was additionally found that they averaged to be around 30-40 years of age; something else that is overlooked. While adolescents/teens make up many those with eating disorders, anyone of any age can be affected by it. Globally, 13% of women older than 50 experience disordered eating behaviors. (*International Journal of Eating Disorders*, 2012). At 19 years old, which is even within the common age range for having an eating disorder, I was asked by a doctor when seeking help: “Aren’t you a little old to have an eating disorder?” The truth is anyone from any demographic on the planet can suffer from an eating disorder. Someone from almost all demographics on the planet statistically suffers from an eating disorder. Eating disorders are promoted by pop culture. Not only that but disordered eating is largely promoted and practiced in college settings. I experienced this firsthand: although I had a history of body insecurity, dieting, and mental health issues on my back, coming to college my first year and being hit with the normalized eating habits of college students contributed to me developing an eating disorder. It is normalized for college students to skip meals to study or to complete assignments, along with many other unhealthy habits such as lack of sleep, drug use, etcetera. Between 10 and 20% of women and 4 to 10% of men in college suffer from an eating disorder, and rates are on the rise (Child Mind Institute, 1). Beauty standards, advertising, and general normalized behavior integrated into not just society, but also the medical world, all promote harmful “health” standards that feed into diet culture.

The term “diet culture” refers to a set of beliefs that values thinness, appearance, and shape above health & well-being (Daryanani, 1.) This concept promotes restriction, obsession [with] food and exercise, avoiding and stigmatizing fatness, and anxiety about the social,

physical, and romantic consequences of failing to perform these behaviors (Within Health, 1.) Additionally, the concept places importance on restricting calories, normalizing negative self-talk, and labeling certain foods as “good” and “bad” (Daryanani, 1). Individuals subjected to “diet culture” messages have been conditioned to believe that not only does thinness and dieting equate to health, but that the pursuit of health makes one person morally superior to another (Daryanani, 1). While diet culture is most often promoted in pop culture, it is unfortunately subtly intertwined with the medical world as well. When visiting doctors’ offices, common practices include taking a patient's weight and either reading it to them or letting them see the number on the scale. Height and weight are normally then taken and converted to find the patient’s body mass index: commonly referred to as BMI. Although weight is taken in eating disorder treatment as well, weight is not an important health indicator in many cases. The BMI was invented almost 200 years ago by Adolphe Quetelet, who played a key role in the origins of eugenics – the systemic sterilization of disabled people, autistic people, immigrants, poor people, and people of color (Elemental,1). Quetelet, an academic that studied sociology, mathematics, astronomy, and statistics, was best known for his sociological work aimed at identifying the characteristics of *l’homme moyen* — the average man — who, to Quetelet, represented a social ideal (Elemental, 1). User Your Fat Friend in Elemental states Quetelet believed that the mathematical mean of a population was its ideal, and his desire to prove it resulted in the invention of the BMI, a way of quantifying *l’homme moyen*’s weight. Initially called Quetelet’s Index, Quetelet derived the formula based solely on the size and measurements of French and Scottish participants. That is, the Index was devised exclusively by and for white Western Europeans. By the turn of the next century, Quetelet’s *l’homme moyen* would be used as a measurement of fitness to parent, and as a scientific justification for eugenics (Elemental, 1.) But

aside from the racist origin, the BMI is inaccurate and misleading. Factors such as age, sex, ethnicity, and muscle mass can influence the relationship between BMI and body fat (CDC, or Center for Disease and Control, 1.) Also, BMI does not distinguish between excess fat, muscle, or bone mass, nor does it provide any indication of the distribution of fat among individuals (CDC, 1.) Although racist roots are not abnormal to the world today, it nevertheless makes it odd that the BMI is still commonly used in the medical field; especially given its inaccuracy. It contributes to diet culture, though: which is likely at least part of the reason it is still commonly used. The normalization of diet culture and its roots in society today contribute entirely to the excessive and heartbreaking rates of eating disorders in not just the United States, but the world. Additionally, diet culture is a multi-billion-dollar industry, worth \$64.7 billion (Tori Dunlap, 1). The entire industry profits from people disliking the way they look. Many factors play into why the industry has made so much profit, but reasons include fear-mongering spreading false information, and stereotypes. One falsehood that is not talked about enough is the utter lack of sustainability in any type of diet. Diets simply are not meant to be used for prolonged periods of time because we as humans naturally have cravings for foods we cut out. Some diets are more drastic than others, but the bottom line is when a person cuts out an entire food group, or multiple, their body only craves those food groups more: making it harder and harder to deny themselves that food. And when they eventually give in to their cravings, the behavior of binge eating often occurs, because they have cut out the food group for so long that their body craves more than that of a person who does not deny their cravings. The person then feels guilt or shame for cheating on their diet, so they start back at square one, or they try a new diet: and the cycle continues. These fad diets have no long-term sustainability and cause controlling relationships with food; which are exactly how eating disorders are developed. Why do people

continue to diet if they only end up cheating and gaining most of the weight they lost? That is because of the fear-mongering that diet culture promotes in society. And diet culture is everywhere: commercials, beauty standards, advertisements, etc. The industry profits directly from shame and insecurity around people's bodies and their health.

## **VII. FINANCIAL IMPLICATIONS**

There is little data on the prevalence of eating disorders in lower-class communities, however, some studies indicate that people from lower socioeconomic backgrounds are less likely than those from higher socioeconomic backgrounds to seek treatment for eating disorders. This might be due to a lack of access to healthcare and the stigma and shame some communities have toward people who struggle with mental health disorders. The inability to afford transportation to treatment facilities or time off work to attend appointments are also some barriers that people from lower-class communities may have when trying to receive treatment for eating disorders. In addition, for people without insurance or with limited resources, the expense of treatment can be a considerable barrier and an enormous financial burden. During my time in a residential facility, I saw many people come and go. Unfortunately, a lot of people were forced to leave before they were ready due to their health insurance running out. About 1 in 10 people in the United States do not even have health insurance (health.gov, 1). And the cost of treatment is high in the United States; programs can cost anywhere from \$30,000 - \$40,000 per month for inpatient eating disorder treatment. For outpatient day treatment programs, the cost without insurance can be around \$7,000-\$10,000 for a 6-week period; 3-7 days a week, for 3-5 hours each day (Wei, 1.) Healthcare in the United States is a widely known issue, and unfortunately,

the pandemic did not help much for people's incomes. Although applying for unemployment allowed some cushioning; the fact was a lot of people still lost their jobs and had to grapple with less income for the year the pandemic began. The median income of lower-income households decreased by 3.0% between 2019 and 2020, while the median income of middle-income households fell by 2.1%. In contrast, the median income of upper-income households between 2019 and 2020 was about the same (Pew Research Center, 2). This was an issue for those seeking treatment who were not financially privileged.

Seeking and getting treatment is already hard enough for those that are financially lower-class. But also, lower-class persons have been disproportionately affected by the COVID-19 pandemic in many ways, including financial hardship, lack of access to healthcare, limited access to technology, and more. Due to the pandemic, lower-class people are more likely to have lost their jobs or had their hours and income decreased. Many people now find it challenging to pay for necessities like housing, food, and medical care. People from lower socioeconomic classes are also more likely to have pre-existing conditions, which increases their chance of developing a severe COVID-19 illness; what is more, it increases their chances of having debilitating health defects from having or developing an eating disorder. As more people engage in remote work and online study, lower-class individuals may not have the internet access or technology required to fully engage in these activities, either. Lower-class people are also more likely to work in vital sectors like healthcare, transportation, and food service, all of which require them to interact directly with customers. Their chance of contracting the virus rises as a result: and those with malnutrition from eating disorders can already be immuno-compromised, increasing the risk of damaging their health. Overall, the pandemic has disproportionately impacted members of lower social and economic classes, and further aggravated socioeconomic disparities.

According to a former client of outpatient eating disorder treatment, they also feel a personal responsibility to not need that level of care again, because [they] know it was a strain for [their] family, that they made that financial sacrifice for [them]. So [they] do feel a definite responsibility to not get back to that point. There have even been times [they've] been struggling a lot since [they] discharged from treatment, and [they] still [tell themselves to] just try to support [themselves], instead of going back to treatment again (Former Client, 1.) As a former client myself, I also have experienced (and still do experience) guilt from the financial aspect of my treatment journey. I come from an upper-middle-class household that could afford healthcare, which paid for me to stay in a residential facility twice as long as the average client (because I needed to.) Outside of residential treatment, though, they paid out of pocket for the cost of my seeing a therapist and dietician as often as I did. While I needed that care, and they were more than happy to support me, I know how high of a cost that was and it motivates me to stay recovered; but I feel guilt from time to time, even though having an eating disorder was not something I could control developing.

## **VIII. FORMER CLIENT PERSPECTIVES**

An issue that came up during the pandemic for clients was the transitions during treatment. According to a former residential client, when they were admitted to a residential treatment center, COVID-19 was not really a known thing yet and people were not fully quarantined yet (Former Client, 1). They went on to say that it was a shock to discharge from residential treatment; the day of, they went to a grocery store to see that they were only letting in a certain number of people at a time and that that was the first time they had seen people wearing

masks in public. They also highlighted that they were not allowed access to their phones until policies shifted, and even then, they were restricted on time of usage, which in turn restricted internet access and caused them to not realize just how terrible things got until after they discharged. They also stated that everyone in residential treatment was used to eating together as a group, and never eating out in public; so, after leaving, it was odd adjusting to eating by themselves and eating out in public since they never had that exposure (Former Client, 3). This person was discharged from the residential while the lockdown was still in full effect, so the shock is understandable. Many of those admitted to residential treatment during the beginning of the first lockdown did not get to see how people moved to isolation and had to quickly shift from being with a group of people every day to isolation after their discharge.

According to a former client that attended outpatient treatment from July 2020 to August 2020, they only got to be there in person for a week at the start, and the rest of it was entirely on Zoom: which was an odd experience, being at home in [their] house and having the meal times be over video on Zoom. So just from the week that it was not that way, [they] felt like the pandemic changed treatment a lot. They also thought that there was a lot more of a social aspect when it was in person because you're interacting with people at meal times more, and in between treatment sessions as well; whereas when it was all on Zoom, it was just like you're in the zoom room, everyone's talking only about the relevant things, and then you leave (Former Client, 3). They discussed the loneliness and isolation they felt from moving to virtual care, especially after having experienced in-person treatment. They recalled that [they] would just open [their] zoom, and suddenly there was a complete stranger looking back at them, which [they] felt was just a weirder introduction than how in person, someone walks in the room and [the staff] would introduce them. They would introduce new people [virtually], but it just felt like a more



estranged way of social interaction; which [made it] harder to [form] connections with people, including the therapists and the clinicians as well. They stated that there is something about being in person and seeing someone's full body and their mannerisms and knowing that [they had] their full attention and they are not looking at a screen or something, that just deepens that connection (Former Client, 4). Additionally, they stated that another method affected by the pandemic was being there and having the snacks provided for you; [they] could bring [their] own meals sometimes, and [the staff] would have to look them over, which is also harder to do on camera. They also stated they do not recall intentionally doing this, but it would be easier, with virtual treatment, to kind of fib or hide. Because you would just show your plate and the person would be like "Oh I guess that looks good!" And [they] were not being provided the same pool of snacks from their clinic for snack time, which they stated the snacks that they would give [them] at the program were more challenging for [them] than what [they] would have at home. So [they] felt that maybe it was a good thing ultimately, but it forced [them] when [treatment] moved online to kind of take more control of that [themselves]; which ended up working out because [they] wanted to recover, but if someone who entered the program was less sure or in a more precarious position, that could have opened the door to at least not progress as quickly, if not worse (Former Client, 4). They further argued that treatment in-person forces you to be more present, whereas there were times in the therapy sessions or in whatever group they would have that day, where [they] would start to get distracted because [they were] on [their] computer and could open [their] email or something similar. [They] could pretend to pay attention, which you cannot do when you are in a physical room. So, in that way, [they] just had to be a lot more conscious and self-directed in keeping myself attentive and motivated (Former Client, 4).

Although the downsides of virtual care during the pandemic were emphasized by this same former client, they noted that when they had to leave for part of [their] treatment to go visit [their] grandparents in California, they were able to continue their care: whereas if [treatment] were in-person only, [they] would have just missed a week or whatever length of time [they were] gone from treatment. But because it was virtual, [they] could keep going and attending the program sessions and did not have to take a break from that because [they] could take it wherever [they were]. So, in that sense, [the pandemic] made treatment more accessible (Former Client, 6).

According to another former client who was in adolescent residential treatment, and was there for around two months during the pandemic, the anxiety just overall just increased and elevated, because the clients were all kind of trapped in one environment, and [they] didn't know what was going on outside; [they] weren't allowed to look at the news or anything because [they] weren't allowed to have [their] phones, so [they] didn't know what was going on and [they] felt like it escalated everyone's anxiety (Former Client, 2). The former client also highlighted how the protocols were changed significantly; [they felt] that how everything became so rigid with cleaning and maintaining distance, [that] that structure just created more stress, because [they] just felt on edge. So that just made things worse (Former Client, 3). Once this former client was discharged from the residential facility, they stepped down to PHP outpatient care, which was virtual. On the topic of the transition they faced, they stated that it was worse for [them] personally, and [they] did not enjoy that; and [they] do not believe anyone else did. Plus being in the Zoom meetings and then someone would ask a question and [they] would have to unmute yourself, and no one wanted to initiate any sort of discussions, [they felt] like overall the mood of everything was down (Former Client, 4).

## **IX. GOING FORWARD**

The COVID-19 pandemic has brought significant challenges for those who suffer from eating disorders and the professionals who provide them with care, including restrictions on access to care and modifications to daily routines that may have a negative impact on eating disorder symptoms. So, after everything that happened to treatment during the pandemic, what are things that we can use in a positive way? As previously stated, Telehealth and virtual therapy/care are huge. It allows a sense of privacy for those who prefer it and is very convenient for most people. It also allows patients a wider span of therapist and dietician options, extending past state lines which is huge. Patients can access care more fitting and specific to their needs, without geographic restrictions. On the other hand, those that prefer traditional therapy practices can do therapy in person now. Something else is how social media's impact is being changed: for example, Facebook has time and time again been called out for its content surrounding eating habits and negative body image being pushed onto impressionable people; a study found that the more time adolescent girls spend in front of Facebook, the more their chances of developing various eating disorders (Science Daily, 1). Now, several states are enacting legislation because of the pandemic spike; California lawmakers have proposed a bill prohibiting social media platforms from having algorithms that expose children to diet products or can lead to the development of an eating disorder, and platforms that violate this legislation could be fined \$250,000. Colorado lawmakers have put a bill into effect that creates a new state office that is charged with closing gaps in treatments, offering research grants to further research, and working to educate students, teachers, and parents. Similar bills in Texas and New York seek to educate students on mental illnesses and eating disorders.

More people may also now seek treatment for eating disorders due to the pandemic's increased knowledge of mental health issues and their value. Additionally, some treatment facilities and service providers have changed their services to be more adaptable and accessible, providing online therapy sessions, virtual support groups, and other resources to aid people in continuing their recovery throughout this trying time. Many treatment centers also offer sliding-scale fees or financial assistance for those that struggle financially, and there are online resources and support groups that can be accessed from anywhere.

After many months and waves of lockdowns, treatment centers started to incorporate different methods seen from different moments in time. Zooming was normalized for more virtual options, which aided in accessibility. Once COVID testing kits became widely available to the public, more treatment options were available and anxieties decreased; people in outpatient programs could return to in-person treatment, and people across states could access treatment virtually. Those in treatment centers could be taken to a hospital if needed and would be allowed to return to the residential center after the necessary care was given, provided they tested negative for COVID; something that was not widely allowed during the first few months of the pandemic. Both the good and harmful effects of the pandemic seen over time allowed for treatment options to be looked at and reviewed: both on effectiveness and safety. Being two-plus years out of lockdown and many pandemic regulations having been lifted to the point we are “back to normal” means being able to incorporate multiple options seen before and during lockdown to maximize treatment options.

Some other positive effects the pandemic was able to bring to mental health treatment, including for eating disorders, was increased awareness surrounding mental health disorders; and

the need for access to mental health care. This has led to increased advocacy for mental health services to be not just more accessible to the public, but better overall. In turn, a future rise in financing and resources for these programs is possible. The pandemic also created many virtual support groups: people struggling could connect with other people going through comparable situations and receive support and encouragement from peers. Many also come at no cost. Additionally, many mental health apps have been released following the pandemic, and there has been a drastic increase in the use of such apps. Contributing to telehealth and other virtual outlets for support, people can access care from their phones or tablets and can provide support anywhere. Many employers have also implemented mental health initiatives in the workplace and provided sources for treatment and support to their employees. Although devastating and presenting many challenges, the pandemic presented new opportunities for innovation and increased access to care.

With eating disorder treatment, 60% of patients make a full recovery. However, as of February of this year, it is stated that only 1 in 10 people with an eating disorder will seek and receive treatment (Team SingleCare, 1). In a world post-COVID, how can we encourage more people suffering from an eating disorder to seek treatment? On a broader range, not just for eating disorders; how can we do our part to normalize seeking help?

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