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Weight-Related Selves and Their Relationship With Body Mass Index Among Young Individuals in Curaçao

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Abstract

Based on the assumptions of self-discrepancy theory, the present study examined the degree of overweight, weight-related body images, and the relation between these images and body mass index (BMI) among two samples of young people from Curaçao (secondary school students, $n = 176$; undergraduate students, $n = 205$). In addition to BMI, participants reported their current, ideal, and most feared body sizes, the thinnest and largest body sizes still acceptable to them, and the body size they considered the healthiest by means of the Contour Drawing Rating Scale. We expected females to show a larger discrepancy between current and ideal body size than males (Hypothesis 1) and that this discrepancy (as an indicator of body dissatisfaction) would be related more strongly to BMI among females than among males (Hypothesis 2). Results yielded support for Hypothesis 1 among secondary school students only. Only in the undergraduate sample, BMI and body dissatisfaction were related, but equally so for males and

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females. Possible explanations are discussed as well as implications for weight management interventions.

Keywords

body image, BMI, body dissatisfaction, obesity, Curaçao

In the past decennia, the number of individuals who are overweight or obese has grown dramatically. To date, more than 1.6 billion adults worldwide are overweight, of which 650 million are considered obese (World Health Organization [WHO], 2017). Overweight and obesity are usually defined by means of the body mass index (BMI), an index that reflects a person's weight relative to their height (e.g., Harris, Bradlyn, Coffman, Gunel, & Cottrell, 2008). Individuals are classified as overweight when their BMI is greater than or equal to 25 and as obese when their BMI is greater than or equal to 30. Overweight and obesity may increase the risk of many health problems, such as high blood pressure, heart disease, osteoarthritis, stroke, certain cancers, and diabetes (e.g., Kemper, Post, Twisk, & Van Mechelen, 1999; Sherry & Dietz, 2004). The present study aims to get a better understanding of some of the psychological variables that are related to (the development of) overweight and obesity on the island of Curaçao, a small Caribbean island with about 140,000 inhabitants. Curaçao is a former Dutch colony and, although it achieved autonomous status in 1954, is still a constituent part of the Kingdom of the Netherlands. Although its inhabitants come from diverse ethnic backgrounds, the cultural background of Curaçao's inhabitants is overwhelmingly Afro-Caribbean (UNICEF, 2013). Historically, Curaçao is shaped by the mechanisms of colonialism and slavery, and, although formally Curaçao left its colonial background behind, today still individual's place in society is determined strongly by one's ethnic heritage and skin color (e.g., Allen, 2010; Heijes, 2011). Today, Curaçao has three official languages: Dutch, Papiamentu (the traditional Creole language with elements of African, Portuguese, Spanish, English, and Dutch), and English. For almost all inhabitants Papiamentu is the preferred language. The Dutch language is used at all levels of education, whereas English is hardly spoken as a primary language (United Nations Development Program, 2011).

Recent studies on obesity show that about two third of the adults in Curaçao are overweight or obese. Although exact numbers are lacking, it is estimated that about 25% to 30% of Curaçaoan youth is overweight or obese as well (UNICEF, 2013; Verstraeten, 2015). Better understanding the psychological variables that accompany (the development of) overweight and obesity may help develop effective interventions that may prevent or reduce

overweight and obesity, and, as a consequence, reduce the health risks due to overweight and obesity. Especially important in this regard is to better understand the psychological variables that are related to BMI among young individuals. In the present article, we define young individuals as *adolescents* (aged 10-24 years, see Sawyer, Azzopardi, Wickremarathne, & Patton, 2018; this is an extension of the earlier WHO's definition of ages 10-19 years; WHO, 1986), and *young adults* (here, we adopt the definition proposed by Levinson, 1986, who defines this as the age range between 17 and 45 years).

In general, in adolescence and young adulthood, body image and eating-related habits are still relatively malleable (Greene-Finestone, Campbell, Evers, & Gutmans, 2008; Laghi, Liga, Baumgartner, & Baiocco, 2012), and interventions aimed at changing an unhealthy lifestyle are therefore best implemented when individuals are still relatively young. Interventions aimed at young people may also prevent unhealthy eating habits from developing into adult overweight and obesity. For these reasons, the present research examined two samples of young individuals (secondary school and undergraduate students) in Curaçao. More specifically, the present research examined what different weight-related selves these young people hold and how these selves are related to their BMI.

Weight-Related Selves

According to self-discrepancy theory (Higgins, 1987), individuals possess different images of the self that guide their cognitions, emotions, and behaviors. More specifically, this theory distinguishes between the "current," "ideal," and "ought" self. Whereas the *current self* refers to beliefs individuals hold about themselves in the present, the *ideal self* is defined by their hopes and aspirations, whereas the *ought self* refers to how individuals believe they should be. Particularly, well studied in relation to weight have been the current and ideal self, and the discrepancy individuals may experience between these two selves (e.g., Grossbard, Neighbors, & Larimer, 2011; Jacobi & Cash, 1994; Novella, Gosselin, & Danowski, 2015; Woodman & Steer, 2011). The paradigm that is often used in this type of research presents participants with figure drawings representing 6 to 10 same-sex individuals who are identical except for their weight, ranging from underweight to overweight (e.g., Body Rating Scale; Stunkard, Sorensen, & Schulsinger, 1983; Contour Drawing Rating Scale [CDRS]; Thompson & Gray, 1995). In using this paradigm, participants are asked to indicate what figure best represents their current and ideal body sizes. In general, these studies have shown that men's ideal body size is similar or somewhat larger than their current body size, women have an ideal body size that is thinner than their current body

size (e.g., Dion et al., 2015; Fallon & Rozin, 1985; Grossbard et al., 2011; Laus, Costa, & Almeida, 2015). This finding likely reflects the Western cultural ideals of thinness for women, but to a lesser extent that of muscularity and a triangular shaped upper body for men (Murnen & Karazsia, 2017).

The discrepancy between current and ideal body sizes can be seen as an indicator of body dissatisfaction: the larger this discrepancy, the more individuals are dissatisfied with their body (e.g., Paul et al., 2015). Several studies, for instance, found positive relations between these current-ideal discrepancies in body size and body concerns, and symptoms of eating disorders (e.g., Benninghoven, Raykowski, Solzbacher, Kunzendorf, & Janschek, 2007; Hildebrandt & Walker, 2006; Lantz, Gaspar, DiTore, Piers & Schaumberg, 2018; Novella et al., 2015; Woodman & Steer, 2011). It is important to note that the discrepancy between current and ideal body sizes is not per se damaging in nature. A discrepancy between current and ideal body sizes may also motivate individuals to take control of their weight by eating more healthy or engaging in exercise or sports (Lantz et al., 2018; Michels & Amenyah, 2017).

In addition to the discrepancy between the current and the ideal self, also discrepancies between the current self and other weight-related selves, may motivate individuals to engage in a healthier lifestyle (e.g., Woodman & Steer, 2011). For instance, Carver, Lawrence, and Scheier (1999) introduced the feared self; that is, the self that one does not wish to become or is afraid of becoming (Oliver & Flint, 2014; Woodman & Hemmings, 2008). Like the discrepancy between current and ideal self, the discrepancy between feared and current self may motivate individuals to change their lifestyle (e.g., Woodman & Steer, 2011). Moreover, research by Dalley and Buunk (2011; see also Dalley & Buunk, 2009) showed that the discrepancy between current and feared self motivates women more strongly to engage in dieting than the discrepancy between current and ideal self.

Weigh-Related Selves and BMI

Weight-related selves are, in different ways, closely linked to BMI. Among women, it is usually found that as BMI increases, the discrepancy between the current and ideal self becomes larger, and females become more dissatisfied with their body (e.g., Dion et al., 2015, Swami et al., 2010). In men, the relation between BMI and weight-related selves is somewhat more nuanced (Murnen & Karazsia, 2017). In general, higher BMI and a larger body size are more desirable to the extent that they reflect muscularity and strength, but undesirable to the extent that they reflect high amounts of fat, especially around the stomach (Buunk & Dijkstra, 2005). Nonetheless, once overweight

and/or obese, men also suffer from discrepancies between ideal and current body sizes and body dissatisfaction more than normal-weight men do (Pokrajac-Bulian, Tončić, & Anić, 2015; Watkins, Christie, & Chally, 2008).

It must be noted that, although relatively strongly related, individuals' BMI and their current self in terms of weight are not the same. Individuals may hold distorted images of their weight and appearance (e.g., Fuentes, Longo, & Haggard, 2013; Gustat, Carton, Shahien, & Andersen, 2017). Individuals may both underestimate or overestimate their body size. With regard to BMI, a recurrent finding is that overweight or obese adults and children often underestimate their own size as well as the size of other overweight or obese people (Montoya, Boursaw, Tigges, & Lobo, 2016; Paul et al., 2015). Such distortions may have severe consequences for the motivation to adopt a healthier lifestyle: Because they believe they have a relatively normal body size, overweight and obese individuals may not feel a very strong need to lose weight.

In addition to being related to perceptions of current body size, BMI has also been found to be positively related to individuals' ideal body size: As individuals have a higher BMI, they often adopt a larger ideal body size (Petti & Cowell, 2011). For instance, in a sample of 253 primarily Hispanic women, Paul et al. (2015) found that only 1% of women with a healthy weight chose the body size of an overweight figure as their ideal, whereas about 21% of obese women chose such a figure as their ideal.

Cultural Differences in Weight-Related Selves

Originally, studies on weight-related selves were conducted in Western cultures, such as the Netherlands (Dalley & Buunk, 2009), France (e.g., Dion et al., 2015), and the United States (e.g., Fallon & Rozin, 1985). In the past decade, the topic of weight-related selves has been studied in other cultures as well, such as Brazil (e.g., Laus et al., 2015) and Nigeria (e.g., Okoro et al., 2014). These studies showed that the main assumption of self-discrepancy theory was valid in other cultures as well; that is, people hold different weight-related selves. Individuals from non-Western cultures, however, do differ in the way these different weight-related selves are related to each other. Illustrative is the study by Okoro et al. (2014) among more than 500 adult men and women from Yoruba ethnic origin in Nigeria. When asked about their ideal body size, both men and women usually reported an ideal body size highly similar to their current size. Moreover, in those cases that current and ideal body sizes differed, both sexes usually indicated a preference for a larger body size than their current one. Likewise, in a sample of 159 Brazilian undergraduates, Laus et al. (2015) found that both males and

females chose ideal body sizes (for both themselves and the opposite sex) that were heavier than individuals from Western cultures usually did.

More in general, studies have found that individuals in less socioeconomically developed societies often have positively evaluated overweight and, when overweight or obese, often have thought their weight was normal (for a summary, see Swami et al., 2010). A possible explanation is that, in socioeconomically less developed societies, overweight and obesity are perceived as a sign of prosperity and health. In addition, individuals in socioeconomically less developed societies may be exposed less to Western ideals of beauty. For instance, in a study in 26 countries across 10 world regions including almost 7,500 participants, Swami et al. (2010) found that, at least for women, the discrepancy between current and ideal body sizes (body dissatisfaction) was positively related to exposure to Western media images of beauty. As women were exposed more to these images, they were more inclined to think that they should be slender.

To date, still relatively little is known about weight-related selves in communities in the Caribbean area, more specifically in Curaçao. Although young individuals on the island are increasingly exposed to Western media images, people in the island still seem to hold relatively tolerant attitudes toward overweight and obesity. Especially intriguing, is the relationship between the weight-related selves of young Curaçaoan individuals and their BMI. A recent study among 300 female undergraduates, Dijkstra, Barelds, and Van Brummen-Girigori (2017) showed that, despite their higher BMI, Curaçaoan females were more satisfied with their appearance than their counterparts from the Netherlands. A possible explanation for the tolerant attitude toward overweight and obesity is the relatively high level of poverty on the island: 25% of households live below the poverty line (Central Bureau of Statistics Curaçao, 2018). As a consequence, people may still perceive overweight as a sign of prosperity and health.

The Present Study

The present study examined the relation between different weight-related selves and BMI among young individuals in Curaçao. First, it was established what proportion of young people could be classified as overweight and/or obese. In line with self-discrepancy theory, the present research then examined the current and ideal selves, and discrepancies between these selves. Finally, relations between these selves and BMI were examined. In line with previous studies based on self-discrepancy theory (e.g., Dion et al., 2015; Fallon & Rozin, 1985; Grossbard et al., 2011; Laus et al., 2015), it was expected that women would show a larger discrepancy between current and

ideal self than men (Hypothesis 1) and that, among women, discrepancy (and thus body dissatisfaction) would be related to BMI more strongly than among men (Hypothesis 2). The present study examined these issues separately in a sample of secondary school students (Study 1) and a sample of undergraduate students (Study 2). Differences between these samples, for instance, in age and educational level, may show different patterns of findings that may be of interest for both theory and practice.

For exploratory purposes, the present research also examined four other weight-related selves, of which previous studies (Madanat, Hawks, & Angeles, 2011; Paul et al., 2015; Siervo, Grey, Nyan, & Prentice, 2006) have suggested that they may be of interest: the body size individuals fear the most of becoming (feared self), the body size individuals perceive to be the most healthy, and both the thinnest and largest body sizes individuals perceive to be still acceptable for themselves. To date, these selves are hardly examined; let alone their discrepancies with the current self and their relations with BMI. Insight in these additional selves and their relations with BMI may further enhance understanding the relatively high prevalence of overweight and obesity in Curaçao and may help find avenues for interventions that may help young people gain and maintain a healthy weight.

Study I

Method

Participants and procedure. Participants were recruited by one of this article's authors and her research assistants at public areas such as Brion Plein and cafeterias in the capital city of Willemstad, where students from different secondary schools visit after a school day. Students were asked to voluntarily participate in a study on physical appearance and well-being. Those who agreed, filled out a paper-and-pencil questionnaire that was offered in both Dutch and Papiamentu. It was ensured that students filled out the questionnaire independently and without interference from others. Participants were given a granola bar as a reward for their participation. A total of 88 males and 88 females filled out the questionnaire. Mean age was 18.28 ($SD = 2.33$, range: 14-24) for males and 17.60 ($SD = 2.37$, range: 14-23) for females. A total of 37% of students came from families where the father was either unemployed or worked in a job that required low levels of education (e.g., handyman). In contrast, about 21% of students came from families where the father was employed in a job for which higher education (bachelor or master's) was required (e.g., doctor). The rest of the students (42%) came from families where the father was employed in a job for which a middle level of

education (e.g., administration assistant) was required or for which the level was unspecified.

Instruments. Individuals filled out a paper-and-pencil questionnaire that, in addition to demographics (i.e., sex, age, weight, length, school, grade, place of birth, parental level of education and profession, and parental absence; the latter variables were included as part of an ongoing project on parental absence in Curaçao, but were not used in the present study), assessed the below variables.

Weight-related selves. Weight-related selves were assessed by means of the CDRS (Thompson & Gray, 1995). This rating scale is made up of nine line drawings of silhouettes for both males and females, ranging from very thin to very large. The first and second line drawings represent underweight body sizes, whereas the eighth and ninth line drawings reflect overweight body sizes (Thompson & Gray, 1995). Participants were presented only with figures of their own sex and asked to choose those figures that represented their current body size, their ideal body size, the largest body size that they would find still acceptable for themselves, the thinnest body size that they would be still find acceptable for themselves, the body size they think is healthiest, and the body size they most strongly fear to become (feared self).

Previous studies have found support for the test-retest reliability of the CDRS scores, with reported values of, for example, .78 for the original CDRS (current size, 1-week interval; Thompson & Gray, 1995), and values ranging from .65 to .87 for the current size, ideal size and current-ideal discrepancy for periods up to 14 weeks (and higher values for shorter time intervals; Wertheim, Paxton, & Tilgner, 2004). In support of the construct validity of the CDRS, current body size has been found to correlate .59 with self-reported BMI, .71 with reported weight (Thompson & Gray, 1995), and .69 with measured BMI (Wertheim et al., 2004).

Body dissatisfaction. In line with previous studies (e.g., Paul et al., 2015; Wertheim et al., 2004), the difference between ideal and current self in terms of the CDRS was calculated as a measure of body dissatisfaction. For this purpose, the score for the ideal self was subtracted from the score for the current self. The higher this score, the thinner individuals would like to be. The current-ideal discrepancy has been found to correlate .62 with body dissatisfaction and .57 with restrained eating (Wertheim et al., 2004).

Degree of overweight. The questionnaire included two measures of possible overweight or obesity. First, as part of the demographic questions,

participants were asked to report their current weight and height. These ratings were used to calculate participants' BMI. If a person's BMI is equal to or higher than 25, he or she can be classified as overweight; if a person's BMI is equal to or higher than 30 he or she can be classified as obese (e.g., Harris et al., 2008). In addition, the line drawing individuals choose as their current self may indicate the degree of overweight. More specifically, participants can be classified as overweight and/or obese when they chose the eighth or ninth line drawing from the CDRS (Thompson & Gray, 1995). Whereas a BMI ≥ 25 constitutes a relatively objective indication of overweight or obesity, choosing the eighth or ninth line drawing from the CDRS as the current self reflects participants' perception of overweight or obesity (Thompson & Gray, 1995).

Results and Discussion

Preliminary analyses. Prior to the main analyses, descriptive statistics were computed to check the data for input errors, missing data, normality, and outliers. Some randomly missing data were found for the weight-related selves, varying from zero up to five participants (see Table 1). For BMI, there were more missing data: 27 participants (out of 176) did not report their height and/or their weight. The exact number of participants involved per analysis is listed in Table 1. With the exception of the variable *feared self*, there were no notable deviations from normality, which is comparable to previous studies using the CDRS and BMI (e.g., Wertheim et al., 2004). For *feared self*, however, a bimodal distribution was found, with scores all at the extreme ends of the scale (participants all feared most to be either very overweight or very underweight). The mean score on this variable (see Table 1) served as a mid-point demarcating the upper and lower distributions of scores. A mean score below zero indicated the majority chose an underweight figure, and a mean above zero that the majority chose an overweight figure as the feared self. In additional exploratory analyses, it was explicitly examined how often either very small or very large body sizes were selected by the participants as the feared self, and chi-square analyses were computed. Based on the number of analyses, the *p* value in this study was set to .01. Effect sizes were also calculated for comparisons between means (Cohen's *d*). In line with Cohen (1992), we interpreted *d* values of 0.20 as small, 0.50 as moderate, and 0.80 as large.

Degree of overweight. First, the mean BMI scores were calculated, separately for males and females. An independent samples *t* test was consequently conducted to examine potential differences between males and females regarding their BMI. Among males, the average BMI was significantly higher

Table 1. Means and Standard Deviations of Weight-Related Selves and Discrepancies with the Current Self for Males and Females for Study I.

	Males, M (SD)	Females, M (SD)	n	t	p	d
CBS	5.31 (1.50)	5.15 (1.64)	176	0.67	.502	0.10
IBS	5.29 (1.01)	4.52 (0.99)	171	5.01	<.001	0.77
FBS	6.11 (3.76)	7.22 (3.25)	176	-2.08	.039	-0.31
LBSA	7.24 (1.49)	6.05 (1.20)	176	5.56	<.001	0.88
TBSA	2.98 (1.64)	3.72 (1.16)	174	-3.43	.001	-0.52
HBS	5.25 (0.86)	4.48 (1.12)	176	5.12	<.001	0.77
Discrepancy						
CBS-IBS	0.05 (1.61)	0.64 (1.39)	171	-2.54	.010	-0.38
CBS-FBS	-0.81 (4.39)	-2.07 (4.03)	176	1.99	.049	0.30
CBS-LBSA	-1.93 (1.76)	-0.90 (1.34)	176	-4.39	<.001	-0.66
CBS-TBSA	2.30 (1.96)	1.43 (1.15)	174	3.58	<.001	0.54
CBS-HBS	0.06 (1.59)	0.67 (1.86)	176	-2.36	.019	-0.36

Note: CBS = current body size; IBS = ideal body size; FBS = feared body size; LBSA = largest body size still acceptable; TBSA = thinnest body size still acceptable; HBS = body size that is seen as the healthiest (scores can range from 1 to 9).

than among females, $M_{women} = 21.81$, $SD_{women} = 3.81$, $M_{men} = 23.60$, $SD_{men} = 3.93$, $t(147) = 2.80$, $p = .006$, $d = 0.46$. On the basis of their BMI, 10.4% of females and 30.5% of males could be classified as overweight (BMI ≥ 25). A chi-square test was used to examine if males and females differed with regard to these percentages of overweight individuals. The number of overweight individuals was indeed found to differ significantly between males and females, $\chi^2 = 8.78$, $p = .006$, effect size $\phi = 0.24$. A total of 10.2% of females and 9.1% of males chose one of the overweight body sizes from the CDRS as similar to their current body size. A chi-square test revealed that these percentages did not differ significantly between males and females, $\chi^2 = 0.07$, $p = .500$, $\phi = 0.02$. In sum, whereas males on average had a higher BMI than females, and more males than females could be classified as overweight, there was no gender difference regarding the percentages of participants who chose an overweight body size from the CDRS as similar to their own body size.

Weight-related selves. Table 1 presents descriptive statistics (mean, standard deviation, N) of the weight-related selves, and the discrepancies between the current self and, respectively, the ideal self, feared self, the largest body size still acceptable, the thinnest body size still acceptable, and the healthiest

body size. We used independent samples *t* tests to compare the mean scores for males and females (see Table 1). Compared with males, females chose a *thinner* body size as their ideal, the healthiest and largest body size still acceptable ($t_s \geq 5.01, ps < .001$; see Table 1), and a *larger* body size as their thinnest body size still acceptable, $t(172) = -3.43, p = .001$. All effect sizes for these differences were moderate to large (effect sizes range from $|d| = 0.52$ to 0.88).

For all discrepancies, significant ($p < .01$) or marginally significant ($p < .05$) gender differences were found (see Table 1). In line with our first hypothesis, among females a larger current-ideal discrepancy (as an indicator of body dissatisfaction) was found than among males ($M_{males} = 0.05$ vs. $M_{females} = 0.64$). Whereas females, on average, chose an ideal body size that was thinner than their current body size (resulting in a positive discrepancy score), the current and ideal self of males hardly differed. Males and females also differed significantly in the discrepancies between their current body size and the largest and thinnest body sizes still acceptable (see Table 1).

The general impression was that males found extreme body sizes (both thin and large; discrepancy CBS-LBSA (current body size-thinnest body size still acceptable) and discrepancy CBS-TBSA) more acceptable for themselves than females. In other words, body sizes that females found acceptable for themselves varied within a smaller range than those among males: for females the range, on average, varied from -0.90 to 1.43 compared with their current body size, whereas for males, the range varied from -1.93 to 2.30 (see Table 1)

BMI and weight-related selves. Correlations between the present study's variables (the weight-related selves, body dissatisfaction, and BMI) are listed in Table 2, separately for males and females. As can be expected, BMI related positively and significantly to current body size among both males ($r = .29, p < .01$) and females ($r = .37, p < .01$). Only among women, BMI was positively and significantly related to the thinnest body size still acceptable ($r = .36, p < .01$). That is, as women reported a higher BMI, they also reported a larger acceptable thin body size. In contrast to Hypothesis 2, for both sexes, BMI was not significantly related to the degree of body dissatisfaction individuals experienced (r 's are $.23$ for females and $.19$ for males, respectively, ps nonsignificant). A test for independent correlations revealed that these correlations were not significantly different ($z = -0.25, p = .401$). Moreover, BMI was not related to the body size individuals feared most (r 's are $-.19$ for females and $.03$ for males, respectively, ps nonsignificant). These correlations were also not significantly different ($z = 1.32, p = .187$). One striking difference between the correlations for males and females in this sample

Table 2. Correlations Between Weight-Related Selves, Body Dissatisfaction, and BMI Among Students for Study I.

	1	2	3	4	5	6	7	8
1. CBS	1	.16	-.25	.30*	.22	.18	.79*	.29*
2. IBS	.53*	1	-.33*	.33*	.07	.30*	-.48*	.05
3. FBS	-.28*	-.27	1	-.13	-.13	.03	-.04	.03
4. LBSA	.59*	.44*	-.25	1	-.43*	.65*	-.06	.04
5. TBSA	.71*	.60*	-.33*	.42*	1	-.11	.20	.31*
6. HBS	.14	.30*	-.27	.09	.24	1	-.22	.12
7. Body dissatisfaction	.80*	-.09	-.14	.38*	.41*	-.05	1	.19
8. BMI	.37*	.26	-.19	.22	.36*	-.07	.23	1

Note: CBS = current body size; IBS = ideal body size; FBS = feared body size; LBSA = largest body size that is still acceptable; TBSA = thinnest body size that is still acceptable; HBS = body size that is seen as healthiest. *n* female and *n* male both vary from 77 to 88. Below the diagonal are the correlations for females, above the diagonal the correlations for males.

**p* < .01.

concerned the correlation between the largest and thinnest body sizes still acceptable. For males, a significant *negative* relation was found ($r = -.43, p < .01$), whereas for females, a significant *positive* relation was found ($r = .42, p < .01$). A test for independent correlations revealed that these correlations were indeed significantly different ($z = -5.88, p < .001, d = 0.99$). This meant that for males in this sample, the larger their still acceptable large body size, the thinner their acceptable thin body size (indicating a large range of acceptable body sizes), whereas for females, it was found that the larger their still acceptable body size, the larger also their acceptable thin body size.

Additional analyses. For exploratory reasons, we examined the number of males and females that chose the underweight body sizes (the two thinnest of the nine line drawings) in comparison with the overweight body sizes (the two heaviest of the nine line drawings) as their current, ideal, feared, acceptable, and the healthiest body sizes. These numbers are listed in Table 3. The majority of both males (61%) and females (75%) chose an overweight body size as the body size they feared most. However, a high percentage of males (44%) reported an overweight body size still acceptable for themselves (compared with just 13% of females). An even larger percentage of males found an underweight body size still acceptable for themselves (50%; for females this was just 15%). Differences between males and females regarding the body sizes still acceptable were examined by chi-square tests and conducted

Table 3. Percentages of Females and Males Who Selected an Underweight or Overweight Body Size for Study 1.

	Females		Males	
	Underweight	Overweight	Underweight	Overweight
Current body size	3	10	3	9
Ideal body size	3	2	2	6
Feared body size	21	75	34	61
Body size still acceptable	15	13	50	44
Healthiest body size	2	2	2	2

Note: $N = 171$ to 176 (see Table 1). We explicitly examined both underweight and overweight body sizes here; thus, the variables thinnest body size still acceptable and the largest body size still acceptable were combined under body size still acceptable.

separately for underweight and overweight body sizes (percentages choosing an overweight or underweight body size were compared with percentages not choosing one these body sizes). It was found that males significantly more often chose an overweight ($\chi^2 = 21.90, p < .001, \phi = 0.35$), and an underweight body size ($\chi^2 = 24.73, p < .001, \phi = 0.38$) as still acceptable for themselves. This underlines that males in the present sample had a larger range of body sizes they still found acceptable.

Study 2

Method

Participants and procedure. Participants were all undergraduate students at the University of Curaçao Dr. Moises da Costa Gomez. Participants were randomly selected from a list of student names obtained from the university bureau of student services. Selected students were sent a letter asking them to voluntarily participate in a study on physical appearance and well-being. Students could respond by sending an e-mail to the second author of this article, after which they received an invitation to fill out a pen-and-paper questionnaire in an especially arranged classroom of the university. In return for their participation, students received credit points. The final sample consisted of 94 males and 111 females. Mean age was 25.17 ($SD = 4.95$, range: 17-43) for males and 23.34 ($SD = 4.38$, range: 16-36) for females. A total of 9% of students reported growing up in a home where the financial situation was relatively poor (i.e., scores 1 or 2 on a 7-point scale, ranging from 1 (*poor*) to 7 (*rich*; see Instruments), 45% in a home where the financial situation was

about average (i.e., scores 3 to 5), and 46% in a home where the financial situation was relatively good (i.e., scores 6 or 7).

Instruments. Study 2 used the same instruments to assess weight-related selves, body dissatisfaction, and degree of overweight. The demographics assessed were sex, age, weight, length, parental absence, and financial situation at home when growing up (compared with other families, and assessed on a 7-point scale ranging from 1 (*poor*) to 7 = (*rich*)).

Results and Discussion

Preliminary analyses. Prior to the main analyses, descriptive statistics were again computed to check the data for input errors, missing data, normality, and outliers. The largest number of missing values was found for the *largest* body size still acceptable (28 cases missing). This number of missing values was quite deviant from the other weight-related selves, for which one up to 10 missing values were found (see Table 4). For BMI, there were 12 missing values. There were no notable deviations from normality, as in Study 1, with the exception of *feared* self (see Study 1), and BMI. For *feared* self, the expected bimodal distribution was found, with scores all hovering at the extreme ends of the scale. As in Study 1, it was explicitly examined, by means of additional analyses, how frequent either very small or very large body sizes were selected by the participants as the feared self, and a chi-square was computed to examine if males and females differed regarding these two extremes. For BMI, the distribution had a slight right skew, mainly as the result of two extreme outliers. There were two hyper obese students (hyper obesity means a BMI > 60), with BMI values of 63.43 and 73.25, respectively. It was decided to remove these two participants from the comparisons between males and females, and the correlational analyses. Based on the number of analyses conducted, the *p* value in this study was again set to .01. Effect sizes were again calculated for comparisons between means (Cohen's *d*; see Study 1).

Degree of overweight. Females reported an average BMI of 27.13 (*SD* = 7.22) and males an average BMI of 26.54 (*SD* = 4.34). An independent samples *t* test revealed that this gender difference in BMI was not significant, $t(189) = -0.67$, $p = .504$, $d = -0.10$. Interestingly, both for females and males, the average BMI values were higher than 25 (indicative of overweight). On the basis of their BMI, 53.3% of females and 60.2% of males in this sample could be classified as overweight (BMI \geq 25), of which 28.6% females and 20.5% males could be regarded as obese (BMI \geq 30).

Table 4. Means and Standard Deviations of Weight-Related Selves and Discrepancies With the Current Self for Males and Females for Study 2.

	Males	Females	<i>n</i>	<i>t</i>	<i>p</i>	<i>d</i>
CBS	6.15 (1.47)	5.89 (1.91)	204	1.07	.287	0.15
IBS	5.67 (0.90)	5.08 (1.26)	200	3.71	<.001	0.54
FBS	4.88 (3.71)	5.50 (3.84)	202	-1.16	.247	-0.16
LBSA	6.89 (1.35)	6.78 (1.31)	177	0.54	.590	0.08
TBSA	4.74 (0.91)	4.10 (1.29)	195	3.88	<.001	0.57
HBS	5.42 (0.86)	4.87 (0.99)	200	4.12	<.001	0.59
Discrepancy						
CBS-IBS	0.52 (1.50)	0.84 (1.59)	200	-1.42	.156	-0.20
CBS-FBS	1.30 (4.14)	0.26 (4.72)	202	1.49	.138	0.21
CBS-LBSA	-0.91 (1.16)	-1.05 (1.08)	177	0.84	.404	0.13
CBS-TBSA	1.46 (1.22)	1.83 (1.22)	195	-2.13	.035	-0.31
CBS-HBS	0.76 (1.64)	1.02 (1.76)	200	-1.08	.284	-0.15

Note: CBS = current body size; IBS = ideal body size; FBS = feared body size; LBSA = largest body size still acceptable; TBSA = thinnest body size still acceptable; HBS = body size that is seen as the healthiest (scores can range from 1 to 9).

A chi-square test revealed this difference in frequency of obesity between males and females to be nonsignificant, $\chi^2 = 1.69$, $p = .194$, $\phi = 0.09$. In addition, a total of 22.5% of females and 18.3% of males chose one of the overweight body sizes from the CDRS as similar to their current body size. A chi-square test revealed that this gender difference was not significant, $\chi^2 = 0.56$, $p = .455$, $\phi = 0.05$.

Weight-related selves. Table 4 presents descriptive statistics of the weight-related selves, BMI, and the discrepancies between the current body size and the other weight-related selves. In addition, results from independent samples *t* tests are included in Table 4. Compared with males, females chose a thinner body size as their ideal, the healthiest and thinnest body sizes still acceptable (*t*'s ≥ 3.71 , p 's $< .001$; see Table 4). Effect sizes for these differences were moderate (range *d* from 0.54 to 0.59). Regarding the body sizes that reflected the current self, feared self, and largest self still acceptable, males and females did not differ significantly. In addition, no significant gender differences were found regarding the discrepancies between their current body size and the other weight-related selves (see Table 4). This also meant that, in contrast to Hypothesis 1, males and females did not differ significantly in their current-ideal body size discrepancy: Both sexes

Table 5. Correlations Between Weight-Related Selves, Body Dissatisfaction, and BMI Among Students for Study 2.

	1	2	3	4	5	6	7	8
1. Current self	1	.32*	-.13	.64*	.54*	.13	.81*	.47*
2. Ideal self	.55*	1	-.04	.46*	.43*	.28	-.31*	.09
3. Feared self	-.26*	-.24	1	-.14	-.02	-.03	-.16	-.06
4. Largest acceptable self	.82*	.55*	-.16	1	.49*	.10	.35*	.34*
5. Thinnest acceptable self	.77*	.68*	-.22	.70*	1	.16	.28	.27
6. Healthiest	.40*	.62*	-.35*	.43*	.54*	1	-.04	-.13
7. Body dissatisfaction	.76*	-.12	-.11	.54*	.38*	-.02	1	.43*
8. BMI	.55*	.38*	-.14	.40*	.42*	-.18	.36*	1

Note: CBS = current body size; IBS = ideal body size; FBS = feared body size; LBSA = largest body size that is still acceptable; TBSA = thinnest body size that is still acceptable; HBS = body size that is seen as healthiest. *n* females from 94 to 104, *n* males from 71 to 93. Below the diagonal the correlations for females, above the diagonal the correlations for males.

**p* < .01.

(on average) desired to be thinner than they currently were, $M_{males} = 0.52$, $M_{females} = 0.84$, $t(198) = -1.42$, $p = .156$, $d = -0.20$.

BMI and weight-related selves. Correlations between the weight-related selves, BMI, and body dissatisfaction for Study 2 are listed in Table 5. As can be expected, BMI related positively and significantly to current body size among both males ($r = .47$, $p < .01$) and females ($r = .55$, $p < .01$). In both sexes, BMI also correlated positively and significantly with the largest body size that individuals perceived to be still acceptable to them (for males $r = .34$, $p < .01$; for females $r = .40$, $p < .01$). Only among women, BMI was positively and significantly related to ideal body size ($r = .38$, $p < .01$), and the thinnest body size still acceptable ($r = .42$, $p < .01$): as women reported a higher BMI, they also reported a larger ideal body size, and a larger thinner body size still acceptable to them. In line with Hypothesis 2, for both males and females, BMI was significantly related to the degree of body dissatisfaction individuals experienced (for males $r = .43$, $p < .01$; for females $r = .36$, $p < .01$). The difference between these two correlations was, however, not statistically significant (test for independent correlations, $z = 0.15$, $p = .881$, $d = 0.02$).

Additional analyses. Again, for exploratory reasons, the number of males and females who chose the underweight body sizes (the two thinnest of the nine line drawings), respectively, the overweight body sizes (the two thinnest

Table 6. Percentages of Females and Males That Selected an Underweight or Overweight Body Size for Study 2.

	Females		Males	
	Underweight	Overweight	Underweight	Overweight
Current body size	4	23	1	18
Ideal body size	2	1	0	1
Feared body size	42	54	46	44
Body size still acceptable	9	31	2	32
Healthiest body size	1	0	0	1

Note: $N = 195$ to 204 (see Table 4). Because we explicitly examined both underweight and overweight body sizes here, the variables *thinnest* body size still acceptable and the *largest* body size still acceptable were combined under *body size still acceptable*.

of the nine line drawings) as their current, ideal, feared, acceptable, and the healthiest body sizes, was examined (see Table 6). About half of both males (44%) and females (54%) chose an overweight body size as the body size they feared most. And about a third of both males (32%) and females (31%) found an overweight body size still acceptable for themselves.

Differences between males and females regarding the body sizes still acceptable were again examined by means of chi-square tests that were conducted separately for underweight and overweight body sizes (see Study 1). The differences between males and females were nonsignificant: overweight body size $\chi^2 = 0.01$, $p = .929$, $\phi = 0.01$, and underweight body size $\chi^2 = 4.04$, $p = .044$, $\phi = 0.14$.

General Discussion

The aim of the present research was to examine two important weight-related selves distinguished by self-discrepancy theory, which is the current and ideal weight-related selves, among young individuals in Curaçao, as well as discrepancies between these selves and relations with BMI. We hypothesized that women would show a larger discrepancy between current and ideal self than men (Hypothesis 1) and that, among women, this discrepancy (i.e., body dissatisfaction) would be related to BMI more strongly than among men (Hypothesis 2). For exploratory purposes, the present research also examined the body size individuals feared the most of becoming (the feared self), the body size individuals perceived to be the most healthy, and both the thinnest and largest body sizes individuals perceived to be still acceptable for themselves. The present research examined these issues separately in a sample of secondary school students (Study 1) and a sample of undergraduate students (Study 2).

In line with Hypothesis 1 and in line with previous studies (e.g., Dion et al., 2015; Fallon & Rozin, 1985), the present research showed that, among secondary school students (Study 1), females showed a larger current-ideal discrepancy than males. However, in contrast to Hypothesis 1, among undergraduates (Study 2), males and females did not differ in their current-ideal discrepancy: both sexes desired to be thinner than they currently were. This latter finding may be due to the fact that, among undergraduates, the prevalence of overweight and obesity appeared to be almost twice as high as among high school students. With increasing weight, men may feel more of a desire to be thinner and perceive a similar discrepancy between current and ideal body sizes as women do.

Hypotheses 2 could not be confirmed. In Study 1, among both males and females, BMI and body dissatisfaction (the discrepancy between current and ideal body size) were found to be unrelated. In Study 2, BMI and body dissatisfaction were related, but about equally for both males and females. These findings contrast from previous studies in other cultures, in which usually a positive relation is found between BMI and body dissatisfaction, especially among women (e.g., Dion et al., 2015; Swami et al., 2010). A possible explanation for the lack of a relation between BMI and body dissatisfaction (at the least in Study 1) is that, among young individuals from Curaçao, beauty is not strongly determined by slenderness. Instead, other physical features may be more important in determining physical attractiveness, such as body curves and large breasts in women or expensive clothing in men (see also Dijkstra, Barelds, et al., 2017).

The fact that body dissatisfaction and BMI are not clearly related may have both positive and negative implications. First, it may protect individuals with relatively high BMI from developing psychological symptoms, such as low self-esteem and symptoms of depression and eating disorder, which often accompany body dissatisfaction (e.g., Benninghoven et al., 2007; Woodman & Steer, 2011). However, the lack of a relation between body dissatisfaction and BMI also suggests that body dissatisfaction does not serve as a motivator to undertake action to improve weight. As a result, young individuals in Curaçao, who are overweight or obese, may not feel a strong need to lose weight, even though they would benefit strongly from it. This finding may help explain the relatively high prevalence of overweight and obesity among young people in Curaçao.

Degree of Overweight

In line with estimates of obesity and overweight among young people in Curaçao (UNICEF, 2013), the present research found that a relatively high

number of young individuals in Curaçao can be classified as overweight or obese. They either had a high BMI (based on the weight and length they reported) and/or selected an overweight or obese body size from the CDRS as their current self. Based on either of these measures the prevalence of overweight and obesity was found to be almost twice as high among undergraduate students (Study 2) compared with high school students (Study 1). A possible explanation for this rather large difference is that university students are, more than secondary school students, responsible for their own meals: They usually have to buy their own food and prepare it themselves. This new responsibility often weighs heavily on students and, as a consequence, students may resort to foods that are easy to consume but not very healthy, such as junk food (e.g., Navarro-Prado et al., 2017). Several studies have indeed shown that university students often show inadequate eating behaviors, distancing themselves from the healthy eating habits of their family (Azadbakht & Esmailzadeh, 2012; Senekal, Lasker, van Velden, Laubscher, & Temple, 2016).

In Curaçao, it may even be harder for university students to regulate their eating habits than for students elsewhere, since Curaçao can be considered a highly obesogenic environment, an environment that shows little incentives for healthy food choices, and in which unhealthy foods are widely available and easy to attain (Dijkstra, Van Brummen-Girigori, & Barelds, 2017). More specifically, Curaçaoan streets are characterized by the presence of many stands and shops where fried foods, such as French fries and pastachis, are sold. Although other countries may have a high availability of unhealthy foods as well, in Curaçao, incentives that stimulate individuals to make more healthy food choices—such as television programs on healthy cooking and advertisements with slender same-racial models—seem to be less dominant than in many other countries. In general, in obesogenic environments, it is hard to resist the temptation of unhealthy foods, which often leads to an increased intake of food (Brunstrom & Cheon, 2018). The combination of living in an obesogenic environment and struggling with the responsibility of preparing one's own meal may make it relatively hard for university students in Curaçao to maintain a healthy weight. Whatever the exact reason for the high prevalence of overweight and obesity among university students in Curaçao, our findings show that these university students are an important target group for weight management interventions.

Of interest is also that the two assessments of overweight/obesity that were used in the present research—BMI and overweight pictures of CDRS—showed quite discrepant findings. For instance, whereas on the basis of their BMI, 60.2% of undergraduate males could be classified as overweight (BMI \geq 25), only 18.3% of males chose one of the line drawings that reflected an overweight or obese body size in terms of the CDRS. The discrepancy

between these assessments suggests that either participants did not accurately report their weight and/or height, or that they, when presented with pictures of different body sizes, found it hard to recognize that their body size resembled pictures of overweight or obese body sizes. Regardless of which of the two explanations is valid, in line with previous studies (Gustat et al., 2017; Paul et al., 2015), both studies in the present article suggest that participants have a (somewhat) distorted perception of their actual body size.

Having a (somewhat) distorted perception of one's body size may make it harder to recognize when one should take action to change one's lifestyle in order to lose weight. Interventions aimed at encouraging individuals to lose weight and/or maintain a healthy weight, may, therefore, first help individuals gain a more accurate picture of their body size, for instance, by providing them with mirror feedback. Several studies have shown that, especially among obese, overweight, and underweight individuals and also among normal weight individuals, estimates of body size become more accurate after mirror exposure (e.g., Gardner, Gallegos, Martinez, & Espinoza, 1989; Griffen, Naumann, & Hildebrandt, 2018; Norris, 1984). In mirror exposure, individuals are asked to elaborately examine their body in underwear from head to foot in front of a body length mirror at a 0 to 5 meter distance (Norris, 1984). Mirror exposure usually leads to more realistic body size estimates, partly because individuals are confronted with those body parts they usually tend to avoid looking at (Griffen et al., 2018). Also, in addition to providing individuals with information about what a healthy weight is, individuals may be asked to weigh themselves and to calculate their BMI. This act may help them gain a more accurate picture of their body size, and their degree of overweight and help them recognize when change is necessary. Although many lifestyle interventions provide people with information about unhealthy weight and how to manage it, individuals will not apply this information to themselves when they underestimate their own body size or weight. Only when individuals recognize and acknowledge that they are overweight or obese, they may regard the information as self-relevant.

Other Weight-Related Selves: Exploratory Findings

In addition to the current and ideal selves, on the basis of self-discrepancy theory, also other weight-related selves may be distinguished. The present study examined four of these additional weight-related selves; that is, the body size individuals fear the most of becoming (feared self), the body size individuals perceive to be the healthiest, and both the thinnest and largest body sizes individuals perceive to be still acceptable for themselves. With regard to the feared self, the majority of secondary school students (Study 1)

chose an overweight body size as their feared self. Among undergraduates (Study 2), a different pattern emerged: About equal numbers of students chose the underweight and the overweight body sizes as the body size they feared the most. A possible explanation between the two samples lies in differences in social norms with regard to how one should look. Social norms reflect the rules that a group has for the acceptable behaviors, values and beliefs of its members, and strongly affect the behavior individuals tend to show (Aronson, Wilson, & Akert, 2005). In general, individuals who do not comply with social norms may expect social disapproval, and, not complying with the social norm is therefore often feared (Hareli, Moran-Amir, David, & Hess, 2013). It is highly likely that because of the high prevalence of overweight and obesity among university students, overweight and obesity are, at least to some extent, seen as the social norm rather than a deviance from it. In contrast, it is likely that in secondary schools, where the prevalence of overweight and obesity is much lower, overweight and obesity are much more seen as a deviance of the norm of how one should look. As a consequence, in secondary school students may perceive more fear of becoming overweight and obese than students in university. If this explanation is valid, university students may find themselves in an impasse regarding their weight: Because they perceive their overweight or obesity as relatively normal, they may feel little need to lose weight and adopt a healthier lifestyle. Worrying is also that lenient social norms regarding overweight and obesity are often accompanied by social norms that accept or encourage unhealthy eating. This may cause other students, who are not overweight or obese (yet), to adopt unhealthy eating habits as well (Higgs & Thomas, 2016). Research (Stok, de Ridder, de Vet, & de Wit, 2014) indeed shows that eating is a social behavior, and that, through processes of social learning and social comparison, people tend to eat as most others in their social environment do.

Another notable finding is that most participants chose, for the body size that they thought was healthiest, a line drawing that reflected a healthy BMI (20-25). This finding indicates that, in general, young individuals may not suffer from a lack of knowledge about what a healthy body size looks like. Nonetheless, many young individuals (over than 30% of both male and female undergraduate students) considered the overweight and obese body sizes as still acceptable to them. A possible explanation is that many young people consider the body size they see as the healthiest as not (easily) attainable. As a result, they may not be motivated to try to reach a healthy body size and instead settle for a less healthy one. If this premise is indeed the case, it seems wise for interventions aimed at individuals who are already overweight or obese not to focus on reaching a *healthy weight* per se, but on reaching a *more healthy weight*. This frame of reference may make the body size that

individuals (initially) aim for more attainable, at least from their perspective, which enhances the motivation to take action to lose weight. Once they reach this more healthy body size, they may feel motivated to further aim for the body size that is most healthy. An alternative explanation for the finding that so many young individuals perceive an overweight or obese body size as acceptable to them is that they underestimate or downplay the health risks of overweight and obesity. In general, for their own future, individuals often underestimate the likelihood of negative events, such as health problems, and overestimate the likelihood of positive events, a phenomenon called *unrealistic optimism* (Shah, 2012; Weinstein, 1983). Although seeing a positive future may increase feelings of hope, optimism, and satisfaction with life, such view also brings along risks, especially in the area of health and lifestyle. Unrealistic optimism with regard to one's health can undermine health-promotive practices by decreasing worry (e.g., Suls, 2011). If indeed, unrealistic optimism with regard to weight-related risks makes young individuals perceive overweight and obese body sizes as acceptable, it seems wise for interventions aimed at weight management to first reduce unrealistic optimism. The challenge for health educators is to present health-related information in such a way as to minimize unrealistic optimism, without too compromising individuals' general optimism about their future (which contributes to general feelings of well-being; e.g., Dijkstra & Buunk, 2018).

Scientific literature poses several suggestions as to how present information about health risks in order to reduce unrealistic optimism. Weinstein (1983), for instance, found that information about peers' actual risks of developing health problems largely eliminated optimistic biases for these health problems. In addition, Gold and de Sousa (2012) found that, for health problems about which individuals are likely to feel concern, framing health information positively rather than negatively (e.g., "having a healthy heart" rather than "becoming ill with heart disease") reduces unrealistic optimism. In addition, it seems of vital importance to include information about practical solutions for diminishing health risks. Providing information about health risks may only evoke feelings of anxiety and fear, making individuals reject the health message (Shen, 2017). By also providing practical advice about how to diminish health risks, individuals may be more likely to both acknowledge weight-related health risks and remain optimistic about their future (e.g., Zlomuzica, Preusser, Schneider, & Margraf, 2015).

Limitations, Future Research, and Conclusions

It must be noted that the present research suffered from several limitations. First, it is unknown how representative the samples are for young people in Curaçao. Our sample of undergraduate students consisted of a selective

representation of the age group of individuals in their twenties, excluding all those young people that followed a lower level education or were participating on the labor market. Second, the way participants were recruited seemed to be less than optimal. Participants as a consequence filled out the questionnaire under unstandardized circumstances (in Study 1), which may have lowered the reliability of the answers. Third, BMI was calculated on the basis of self-reported height and weight. However, young people may not always know their actual weight and height, because they are still growing. In general, people may also find it hard to acknowledge their actual weight or height, and, as a result, underreport or overreport it. As a result, calculating BMI on the basis of self-reported weight and height may not be an optimally reliable or valid procedure. It seems wise for future research to more objectively assess participants' weight and height and, as an additional measure for overweight, body fat percentage (e.g., Davillas & Benzeval, 2016). For instance, as part of a study, a research assistant or health professional should weigh and measure participants and assess body fat percentage, which could then be related to the weight-related selves and their discrepancies. Finally, the present study did not assess the motivation of participants to engage in a healthy lifestyle. As a result, we cannot be sure how the different weight-related selves and the discrepancies between these selves are related to the motivation to engage in a healthy lifestyle. Future studies may include this variable, and in so doing shed more light on what weight-related selves' interventions should exactly target to enhance young individuals' motivation to engage in a healthy lifestyle.

In addition, future studies may especially investigate the social and psychological factors that cause and maintain the high prevalence of overweight and obesity among undergraduate students in Curaçao. Insight in these factors may help develop effective weight management interventions programs that may specifically target this group, and, in so doing, help prevent these young individuals from developing overweight-related medical problems in the future. Despite these limitations, the present research adds to the understanding (or potentially of the development) of overweight and obesity among young people in Curaçao. It shows how young individuals in Curaçao perceive themselves in terms of the weight-related selves distinguished by self-discrepancy theory, and how these weight-related selves are related to BMI. In so doing, the present research provides interesting new avenues for interventions aimed at preventing and reducing overweight and obesity among young people on the island.


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