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Changes in eating and exercise behaviors during the COVID-19 pandemic in a community sample: A retrospective report

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ARTICLE INFO

Keywords:
COVID-19
Pandemic
Eating disorders
Exercise
Exercise motives

ABSTRACT

Objective: The COVID-19 pandemic has generated extreme physical, psychological, and social consequences across the world, many of which have the potential to exacerbate disordered eating and exercise behaviors. The purpose of this study was to retrospectively assess changes in eating pathology and exercise behaviors as a result of the COVID-19 pandemic in a community sample.

Method: Participants (n = 159,Mage = 27.59 years, 90.6% female) were individuals in the United States surveyed during COVID-19. Participants completed measures quantifying eating pathology, exercise behaviors, and motives for exercise both prior to and during the pandemic.

Results: All results compare variables prior to and during COVID-19. Overall, individuals with a prior eating disorder (ED) diagnosis did not report significantly different changes in eating or exercise pathology compared to the non-ED group. Participants had significantly fewer episodes of overeating (p < .05, d = −0.23) and eating with loss of control (p < .05, d = −0.23), but not objective binge episodes. Respondents also indicated an overall decrease in time spent on strength/weight activity (p < .05, d = −0.34) and increase in cardiovascular activity (p < .05, d = 0.19), as well as significant changes in motives for exercise.

Discussion: Our results suggest that in a sample of primarily young adult females, with and without a prior ED, exercise behaviors and motives, but not eating pathology, shifted significantly in the first few months of the COVID-19 pandemic. Further longitudinal studies examining the maintenance and potential risk of these changes are warranted, particularly in individuals at high risk, as the pandemic continues.

1. Introduction

The advent and continued presence of the novel coronavirus, COVID-19, has led to significant shifts in lifestyles across the globe. COVID-19 is an infectious respiratory disease that became a global pandemic in March 2020. In the United States (US), protocols to prevent the spread of COVID-19 were implemented, including “stay-at-home” orders and “social distancing protocols.” The closure of schools and businesses, decreased in-person social interaction, and widespread health-related anxiety could lead to a myriad of negative health outcomes, including increases in pathological eating and exercise behaviors (CDC, 2020a); efforts to contain the pandemic continue to markedly impact daily life.

Initial research on effects of the pandemic suggest eating pathology has increased during the pandemic both in individuals with diagnosed EDs and the general population (Phillipou et al., 2020; Termorshuizen et al., 2020). Notably, neither study included validated eating pathology measures. The present study quantifies the impacts of the pandemic on eating using psychometrically valid measures to identify potentially harmful changes in eating and exercise behaviors in a community sample. Previous ED history may be an important predictor of increased ED behaviors during this time (Phillipou et al., 2020). Additionally, subclinical maladaptive eating may lead to significant psychological and medical consequences (Kärkkäinen et al., 2018; Wade et al., 2012). Thus, we also explore pre-existing ED diagnosis as a risk factor for increased symptom change (Cooper et al., 2020).

COVID-19 may also be leading to substantial changes in exercise behaviors and motives. While fitness center closures have caused individuals’ prior fitness routines to be disrupted, individuals may be motivated to begin or continue engaging in exercise for a myriad of reasons (Mutz & Gerke, 2020). Emerging anecdotal reports have shown increased exercise equipment sales and advertisements for products and mobile applications facilitating at-home exercise (Nicassio, 2020). We...
hypothesize that the pandemic has led to greater time availability and decreased access to activities other than exercise. We further hypothesize that individuals previously engaging in weight/strength exercise requiring gym access may be switching to cardiovascular exercise, as it can be completed outside where there is lower risk of COVID-19 infection (CDC, 2020b).

The pandemic and its ensuing lifestyle changes may additionally impact exercise motivations. Motives for exercise, the primary underlying reasons leading to engagement in physical activity, can be intrinsic (e.g. for health) or extrinsic (e.g. societal pressure) (Teixeira et al., 2012). COVID-19 has prompted changes in both external circumstances and mental states, two primary causes of shifts in exercise motives (Sheehan et al., 2018). Increased exposure to social media messages urging individuals to use time during the pandemic to ‘get in shape’ may lead individuals to be more extrinsically motivated by appearance (Gizauskas, 2020), while the heightened anxiety associated with COVID-19 could prompt an increase in intrinsic stress-management motivated exercise (Brooks, 2020). Extrinsic motivations for exercise, including appearance and weight-based motivations, are linked to maladaptive exercise behaviors and increased ED symptomology (Malby & Day, 2001; Vartanian et al., 2012). It is vital to understand the impact of COVID-19 on eating and exercise behaviors as the pandemic continues in order to appropriately target interventions.

1.1. Aims and hypotheses

The a priori aims and hypotheses of this study were as follows:

1.1.1. Aim 1

Assess changes in reported symptoms of disordered eating prior to and during the pandemic in individuals with a prior ED and in the total sample.

Hypothesis 1. Individuals with a prior ED will have significantly greater increases in ED symptoms than those without a prior ED; in the total sample, there will be a significant increase in all ED symptoms from prior to during the pandemic.

1.1.2. Aim 2

Assess changes in rates of and motives for exercise behavior as a result of the pandemic in individuals with a prior ED and in the total sample.

Hypothesis 2. Individuals with a prior ED will have significantly greater increases in cardiovascular and weight/strength activity than those without a prior ED; in the total sample, weekly cardiovascular and weight/strength activity will be higher during compared to prior to the pandemic.

Hypothesis 3. Significantly more participants will endorse exercise motives related to coping with pandemic changes (e.g., stress management and getting fresh air) and significantly less participants will endorse social exercise motives (e.g. socialization and competition), during the pandemic than prior to the pandemic; there are no a priori hypotheses regarding differences in motivations between groups given the wide range of exercise motivations in an ED population (Schlegl et al., 2018).

2. Methods

This study was approved by the Institutional Review Board at the University at Albany, State University of New York. Participants reviewed an informed consent form indicating the nature and purpose of the research and provided consent to participate prior to completion of questionnaires.

2.1. Participants and procedures

Participants were recruited through social media postings on the Principal Investigators’ Instagram, Facebook, and Twitter accounts, and a Reddit ED support group between April 9, 2020 and May 27, 2020. The reach of social media recruitment posts, including posts in a Reddit ED support group, which identified the survey topic as disordered eating and exercise behaviors, likely contributed to the sample demographics, including a relatively high proportion of female respondents with a prior or current ED diagnosis. Inclusion criteria included ages 18 and older and fluency in written English. Non-US participant responses were excluded prior to running analyses, due to geographic differences in COVID-19 onset and protocols.

2.2. Measures

Participants completed the following questions and measures via the secure server Qualtrics.

2.2.1. Demographics

Participants self-reported age, race, gender, location of residence, weight, and height. Participants indicated which restrictions were in place in their state. Retrospective report of weight was used to assess body mass index (BMI) prior to the pandemic. Longitudinal studies have shown evidence of high correlations between retrospective recall of weight and actual previous weight (Dahl & Reynolds, 2013; Perry et al., 1995).

2.2.2. Previous eating disorder diagnosis

Participants self-reported whether or not they had previously had an ED diagnosis (“have you previously been diagnosed with an eating disorder?”) and provided the diagnosis, if applicable.

2.2.3. Eating Disorder Examination Questionnaire (EDE-Q)

Frequency and severity of disordered eating behavior was assessed using the 28-item EDE-Q (Fairburn & Cooper, 1993). Participants completed the EDE-Q twice, once retrospectively about the four weeks prior to the onset of the pandemic in their area, and again for the past four weeks during the pandemic. Calendars were provided to aid in retrospective report. Items are rated on a seven-point Likert scale and averaged to create a Global EDE-Q score (Cronbach’s α prior = 0.93 [95% CI: 0.90, 0.94]; Cronbach’s α during = 0.95 [95% CI: 0.94, 0.96]). Higher scores indicate greater severity of eating pathology. Although the EDE-Q shows good validity in community samples (Mond et al., 2004), research has not supported the original four-factor structure of the EDE-Q (Allen et al., 2011; Rand-Giovannetti et al., 2020). Therefore, only the Global score and single-item questions ascertaining the frequency of loss of control eating, overeating, objective binge eating [overeating with loss of control], purging, and laxative use over the past 28 days were used in analyses. Research suggests good validity of single-item measures of compensatory behaviors, but mixed support regarding validity of items assessing binge eating behaviors, and validity of items assessing compulsive exercise remains largely unknown (Berg et al., 2011; Berg et al., 2012). The current study will refer to constructs as they were worded in the question (e.g., “overeating” and “loss of control”), however, these are merely subjective reports of these constructs given the self-report nature of the questionnaire.

2.2.4. Exercise behaviors

To examine changes in exercise behavior due to COVID-19, participants were asked to report the average number of minutes they spent engaged in cardiovascular and strength/weight exercise twice, both for an “average week” prior to COVID-19 and an “average week” since the COVID-19 pandemic began affecting their area. Changes in compulsive exercise frequency were also assessed via the EDE-Q (“over the past 28 days, how many times have you exercised in a ‘driven’ or ‘compulsive’
way as a means of controlling your weight, shape or amount of fat, or to burn off calories?

2.2.5. Exercise motives

Participants were asked to report all motivations for exercise prior to the time COVID-19 began to impact their area, and currently, during the COVID-19 pandemic. Responses were recorded in a dichotomous manner (“yes” or “no,” endorsing or not endorsing a motivation, respectively). Prior research has quantified motives for exercise in a comparable manner (Fuller-Tyszkiewicz et al., 2018). Motivation options were drawn from commonly assessed motives on questionnaires including the Exercise Dependence Scale (Kim & Cho, 2020), and motives hypothesized as relevant given the unprecedented COVID-19 pandemic.

2.3. Statistical analyses and power

A total of 251 participants started the study. Participants located outside of the US (n = 5), under the age of 18 (n = 9), who discontinued the study prior to beginning the exercise and eating behavior questionnaires (n = 21), or for whom COVID-19 began impacting their area < 4 weeks prior to the survey (thus their EDE-Q “during” data captured time prior to COVID-19) (n = 57), were excluded from the analyses, resulting in a final sample of n = 159. Data was missing at random (Little’s Missing Completely at Random test p > 0.05) for all key measures except EDE-Q prior. Missing data was handled via pairwise deletion (Newman, 2014).

Welch’s t-tests (Aim 1/Aim 2) and Chi-square tests (Aim 3) were used to examine differences between individuals with and without a prior ED diagnosis prior to running analyses. If there were no significant differences between groups on a measure, analyses were conducted using the entire sample. If there were significant differences between groups, analyses separated by group were run to control for influence of a prior ED diagnosis prior. Importantly, group differences were underpowered, with sample sizes of n = 26 and n = 132 respectively; full power to detect medium effects, assuming power of 0.80 and α = 0.05, would require samples of n = 40 and n = 200.

A paired t-test was used to assess change in global EDE-Q scores and paired Wilcoxon signed rank tests were used to assess change in single-items on the EDE-Q, as these variables were non-normally distributed (Hypothesis 1). Paired-samples t-tests were used to compare cardiovascular and weight/strength activity (Hypothesis 2) and two-tailed McNemar’s Chi-square analyses were used to compare changes in motivation for exercise prior to and during the pandemic; differences in motives endorsed during the pandemic between individuals with and without a prior ED diagnosis were assessed (Hypothesis 3) (Adedokun & Burgess, 2012; Hoffman, 1976).

This study was adequately powered, with minimum samples of n = 34, n = 35 and n = 96 needed to detect medium effects in two-tailed paired-samples t-tests/Wilcoxon signed rank tests (Hypotheses 1 and 2) and McNemar Chi-square analyses, respectively, assuming power of 0.80 and α = 0.05 (Hypothesis 3).

3. Results

Participants were 90.60% women (n = 144) with a mean age of 27.59 years (SD = 11.68, range = 18–74); 90.60% of participants identified as White; 74.80% of participants identified as heterosexual. Thirty participants (16.40%) endorsed a previous ED diagnosis. All participants endorsed having some COVID-19 restrictions in their area at the time of survey completion. Full sample characteristics can be found in Table 1, information regarding COVID-19 restrictions in place can be found in Table 2, and descriptive statistics of all primary variables can be found in Table 3.

### Table 1

| Sociodemographic characteristics of participants. |
|--------------------------------------------------|
| Baseline characteristics | n | % |
| Gender | | |
| Men | 14 | 8.8 |
| Women | 144 | 90.6 |
| Sexual orientation | | |
| Heterosexual | 119 | 74.8 |
| Homosexual | 4 | 2.5 |
| Bisexual | 23 | 14.5 |
| Location | | |
| Urban | 73 | 45.9 |
| Suburban | 65 | 40.9 |
| Rural | 20 | 12.6 |
| Education | | |
| High school graduate | 8 | 5.0 |
| Less than 2 years of college | 14 | 8.8 |
| Technical or vocational program | 1 | 0.6 |
| Associate degree | 11 | 6.9 |
| College graduate | 99 | 62.3 |
| Master's degree | 23 | 14.5 |
| Doctoral degree | 3 | 1.9 |
| Race/ethnicity | | |
| White | 144 | 90.6 |
| Hispanic/Latino | 8 | 5.0 |
| Asian | 10 | 6.3 |
| American Indian or Alaska Native | 1 | 0.6 |
| Native Hawaiian or Pacific Islander | 1 | 0.6 |
| Native American | 2 | 1.3 |
| Self-reported Eating Disorder Diagnosis | 26 | 16.4 |
| Anorexia Nervosa (AN) | 22 | 13.7 |
| Bulimia Nervosa (BN) | 8 | 4.9 |
| Binge ED | 4 | 2.6 |
| Other | 3 | 1.8 |

Note: Some participants reported more than one ED diagnosis (e.g. 6 participants reported both an AN and BN diagnosis).

### Table 2

Pandemic restrictions reported by sample at time of survey completion.

| Pandemic restrictions | n | % |
|-----------------------|---|---|
| Job became work from home | 114 | 71.70 |
| Stay-at-home order | 135 | 84.90 |
| Non-essential businesses closed | 139 | 87.42 |
| Gyms closed | 137 | 86.16 |
| Voluntary business closures | 57 | 35.85 |
| No restrictions in place | 0 | 0.00 |
| State has begun reopening process | 0 | 0.00 |

3.1.1. Hypothesis 1

There was no significant difference in change in EDE-Q Global scores between those with and without a previous ED diagnosis (t(21) = 1.54, p = .14). Although there was no statistically significant difference in change scores, individuals with a previous ED diagnosis reported an increase of 0.21 (d = 0.26), while individuals without a previous ED diagnosis endorsed a decrease of 0.09 (d = −0.14) on their EDE-Q Global score. Changes in overeating, loss of control eating, binge eating, self-induced vomiting and laxative use from prior to during the pandemic did not differ significantly between those with and those without a prior ED diagnosis (all p > .05).

In the total sample, there were no significant changes in EDE-Q Global scores (t(74) = 0.27, p = .79, d = −0.03) from prior to during the pandemic. There were significantly fewer episodes of “eating more than usual” (Z = −2.00, p < .05, d = −0.23) and “loss of control eating” (Z = −2.00, p < .05, d = −0.23) during compared to prior to the pandemic. There were no significant changes in episodes of “overeating with loss of control,” i.e., objective binge eating, (Z = −0.31, p = .67, d = −0.04), “self-induced vomiting” (Z = −0.43, p = .67, d = −0.05), or
“laxative use” \((Z = -1.13, p = .26, d = -0.14)\). Self-reported BMI significantly decreased from prior to during the pandemic \((Z = -2.43, p < .05, d = -0.26)\). 

3.1.2. Hypothesis 2

There were no differences in change in cardiovascular activity, weight/strength activity, or compulsive exercise between those with and without a prior ED diagnosis (all \(p > .05\)).

In the total sample, results from a paired samples \(t\)-test showed a significant increase in time spent engaged in cardiovascular activity \((t(114) = -2.05, p < .05, d = 0.19)\) and a significant decrease in time spent engaged in weight/strength training \((t(99) = 3.53, p < .001, d = -0.35)\) during an average week during compared to prior to the pandemic. There were no significant changes in “compulsive exercise” \((Z = -0.59, p = .56, d = -0.07)\).

There were significant differences in endorsement of “weight” as an exercise motive between individuals with and without an ED diagnosis during the pandemic \((X^2(1, N = 124) = 9.21, p < .01)\) with a greater percentage of individuals with a previous ED diagnosis endorsing “weight” as a motive. No other motives significantly differed between individuals with and without an ED diagnosis during the pandemic (all \(p > .05\)).

In the total sample, “increased health/fitness” was the most frequently reported exercise motive prior to (74.2%, \(n = 118\)) and during the pandemic (61.0%, \(n = 97\)). McNemar’s test showed no change in endorsement of the motives “appearance,” “weight,” “increased health/fitness,” and “alleviate stress/anxiety” from prior to during COVID-19. Table 4 displays frequencies of endorsed exercise motivations that significantly differed from prior to during the pandemic.

Two-sided McNemar’s Chi-square tests showed a statistically significant increase in the proportion of participants who endorsed “pressure to get in shape” \((X^2(1, N = 124) = 29.64, p < .001)\), “boredom” \((X^2(1, N = 124) = 36.27, p < .001)\), and “to get outside/get fresh air” \((X^2(1, N = 125) = 17.63, p < .001)\) as motivations for exercise from prior to during COVID-19. McNemar’s Chi-square tests showed a statistically significant decrease in the proportion of participants who endorsed “social engagement” \((X^2(1, N = 122) = 21.19, p < .001)\) and “competition” \((p < .001)\) as motivations for exercise from prior to during COVID-19.

### Table 3

Descriptive statistics of primary variables.

| Variable                        | Prior M (SD) | Prior range     | During M (SD) | During range |
|---------------------------------|--------------|-----------------|---------------|--------------|
| BMI                             | 23.67 (4.95) | 16.44-39.15     | 23.27 (4.45)  | 16.44-39.15  |
| EDE-Q Global                    | 2.13 (1.62)  | 0.5-4.52        | 2.11 (1.83)   | 0-5.75       |
| EDE-Q Overeating                | 3.74 (5.89)  | 0.28            | 2.92 (6.10)   | 0-28         |
| EDE-Q LOC                       | 2.17 (4.35)  | 0.22            | 1.55 (4.28)   | 0-28         |
| EDE-Q Objective                 | 1.79 (3.31)  | 0-15            | 1.64 (4.21)   | 0-28         |
| Binge Episodes                  | 0.24 (1.24)  | 0-22            | 0.40 (2.07)   | 0-8          |
| Vomiting                        | 0.21 (2.63)  | 0-10            | 0.32 (1.39)   | 0-17         |
| EDE-Q Laxative Use              | 0.25 (6.25)  | 0-360           | 0.45 (57.62)  | 0-300        |
| EDE-Q Compulsive Exercise       | 5.21 (6.21)  | 0-28            | 5.53 (9.07)   | 0-28         |
| Cardiovascular                  | 158.3 (172.26) | 0-700          | 171.2 (196.85) | 0-1000       |
| Minutes                         | 250.4 (85.69) | 0-230          | 45.51 (57.62) | 0-300        |

Note: BMI = body mass index, EDE-Q = Eating Disorder Examination Questionnaire.

### Table 4

McNemar’s Test Frequencies.

| Motivation for Exercise          | n  | %   |
|----------------------------------|----|-----|
| “Pressure to get in shape”       | 25 | 20.16|
| “To get outside/get fresh air”   | 65 | 52.42|
| “Boredom”                        | 89 | 71.77|
| “Social engagement”              | 17 | 13.71|
| “Competition”                    | 39 | 31.97|
|                                  | 10 | 8.06 |
|                                  | 32 | 25.80|
|                                  | 16 | 13.11|

### 4. Discussion

This study examined how the COVID-19 pandemic has been impacting eating and exercise behaviors in a community sample. Research suggests the pandemic has exacerbated ED symptoms in those with and without preexisting ED diagnoses (Phillipou et al., 2020; Termorshuizen et al., 2020). Contrary to these findings and our a priori hypotheses, results suggest few increases in pathological eating and exercise behaviors. These findings may be partially due to the characteristics of our sample, which included primarily females without prior EDs.

There were no statistically significant differences in changes in eating pathology between those with and without a prior ED diagnosis. Unlike other studies, which have suggested ED diagnosis is a risk factor for increasing ED symptoms during COVID-19 (Phillipou et al., 2020; Termorshuizen et al., 2020), those with a prior ED diagnosis in our sample showed no increased risk for eating pathology or pathological exercise. Although the change was not statistically significant between groups, individuals with a prior ED diagnosis had an increase in global eating pathology whereas individuals without a prior ED diagnosis had a decrease. Continued research may be warranted to better understand this risk factor and ensure appropriate interventions.

In contrast to our hypotheses, certain ED behaviors decreased in the total sample during the pandemic, including overeating and feeling a loss of control while eating. Interestingly, when these behaviors were combined to assess objective binge episodes, there was no longer a statistically significant change. These results contrast findings from other studies which have shown increases in binge eating as a result of the pandemic in both individuals with and without an ED diagnosis (Castellini et al., 2020; Foulds et al., 2020). We hypothesize that the decrease in these behaviors is related to shifts in food environments due to COVID-19, such that individuals may not be engaging in normative overeating or loss of control (e.g., eating out at restaurants with large portions), which would not impact clinical, objective binge eating episodes in the same manner. Additionally, mixed findings may be due to difficulty of retrospectively assessing overeating and low validity of the EDE-Q assessment of binge eating behaviors (Grilo et al., 2001; Berg et al., 2012). Finally, self-induced vomiting and laxative use did not significantly change over the course of the pandemic. Of note, base rates of self-induced vomiting and laxative misuse in this sample were low, perhaps making significant shifts more unlikely.

A second aim of this study was to examine the impact of the pandemic on time spent and motives for engaging in exercise. Contrary to our hypotheses, there were no significant differences between those with and without a prior ED diagnosis on change in exercise behaviors. In the total sample compulsive exercise frequency did not change, and time spent engaging in weight/strength exercise decreased significantly. However, consistent with our hypothesis, time spent engaging in...
cardiovascular exercise increased. Although some fitness center work-outs may have been adapted for at-home practice, engaging in weight/ strength training may have been more difficult without access to necessary equipment. Alternatively, with more time spent at home, restrictions limiting other activities, and a significantly lower spread of COVID-19 outdoors, individuals may have shifted towards engaging in cardiovascular-based workouts (CDC, 2020b).

Additionally, coping-related motivations including exercising to manage “boredom” and “to get outside/get fresh air” significantly increased from prior to during the pandemic, supporting the use of exercise as a coping strategy during stay-at-home orders. In contrast, motivation to exercise to alleviate stress/anxiety did not increase. One reason may be that levels of endorsement for this motivation were very high initially, leaving little room for change in endorsement.

Results further suggest significantly decreased endorsement of social-related motives, such as “competition” and “social engagement” during the pandemic. As officials have recommended maintaining social distancing while being active, it is natural that there was a decrease in exercise motivations involving being around others (CDC, 2020c). Additionally, participants endorsed “pressure to get in shape” as a motive significantly more during the pandemic. Furthermore, individuals with, compared to those without, a prior ED diagnosis were significantly more likely to report “weight” as a motive during the pandemic. Findings support our hypothesis that social pressures around exercising have increased during the pandemic (Pearl, 2020); individuals with a prior ED may be at increased risk of internalizing these messages.

4.1. Strengths and limitations

This study was cross-sectional and used retrospective report to assess eating and exercise behaviors occurring prior to the pandemic. Retrospective self-report can be subject to biases and findings should be considered with caution (Howard et al., 1979). Additionally, ED diagnoses were self-reported, limiting reliability and validity. Secondly, data were not missing completely at random for the EDE-Q scores prior to the pandemic, suggesting that participants skipped specific questions that may be especially difficult to recall retrospectively. Although the EDE-Q has not previously been utilized to assess symptoms beyond the past 28 days, the EDE successfully assesses symptoms over the past three to six months with similar questions (Fairburn et al., 2008). Additionally, the EDE-Q prior had acceptable Cronbach’s alpha values, indicating good internal consistency despite retrospective reporting.

Furthermore, our sample was not diverse in race, ethnicity, or gender, likely due to convenience sampling, and therefore the generalizability of these findings is limited. Individuals with different life circumstances (i.e., children, financial constraints, time constraints) may have significantly different experiences. Finally, exercise motives were assessed via a list of dichotomous options rather than via validated measures to shorten the survey; however, this limits sensitivity and constricts analysis.

Despite these limitations, there were several strengths of the study. This report allowed us to examine change in exercise and eating behaviors prior to and during the pandemic, which is not possible without either a previous ongoing study or retrospective reports. Our sample was primarily comprised of young, female adults, who are at the highest risk of developing an ED (Galmiche et al., 2019). Although this limits the diversity of our sample, it allows us to speak to issues relevant to the group most at-risk (Taylor et al., 2006). Finally, we utilized well-validated measures of eating pathology, and evaluated exercise motivations similar to previous studies (Nurkkala et al., 2016).

The results of this study are important implications for interventions as the pandemic continues. Intervention efforts to decrease the risk of eating pathology should focus on individuals with a history of EDs, whose endorsed higher ED pathology at both timepoints, or whose appearance-related exercise motives have increased, as this is a risk factor for pathological exercise (Schlegl et al., 2018; Vinkers et al., 2012). Although our results do not suggest increases in eating pathology in the beginning of the pandemic, it remains important to gain further insight on these behaviors as the pandemic and its aftereffects continue. Finally, exercise may remain a useful coping tool for many individuals during the uncertainty of the pandemic, and it will be important to continue to encourage this positive shift in community samples.
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