The impact of media consumption of attributes of disordered eating in adult women

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The Impact of Media Consumption on Attributes of Disordered Eating in Adult Women

by

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Abstract

The vast majority of research on eating disorders and disordered eating focuses on young women and girls, despite data suggesting that disordered eating habits and attitudes are rampant among women of all ages, and that the incidence of disordered eating as well as eating disorders is increasing steadily in every age cohort. The most promising approach to terminating this trend is to prevent eating disturbances before they start. However, results regarding prevention that focused on younger women may not apply to older women, as eating pathology may vary with age. It is therefore important to learn more about these problems as they exist in adult women. This study focused on a particular area of disordered eating research from which adult women have been almost wholly excluded: the effects of media consumption. A survey was used to examine the association of television and magazine exposure with eating disorder symptomatology, drive for thinness, body dissatisfaction, and maturity fears in women ages 30-60. Analyses revealed a significant relationship between body dissatisfaction and time spent watching television as well as between body dissatisfaction and consumption of television shows that depict and promote thinness. This research thus extends the current work by demonstrating a link between the media and attributes of disordered eating in the previously un-tested population of adult women.
The Impact of Media Consumption on Attributes of Disordered Eating in Adult Women

Women’s Health

As women made enormous strides against inequality and oppression in the 1960’s and 1970’s, it became clear that years of being stereotyped and discriminated against had resulted in the exclusion of the group from mainstream discourse on many important health issues (Alexander and LaRosa, 1994). Males received the vast majority of attention in health research, except in areas like fertility and reproduction, which reflected the dominant roles women were commonly expected to inhabit (Weitz, 1998; Kolander, Ballard and Chandler, 1999). Along with the overall societal increase in the perception of females as complex, versatile human beings has come a push for balanced representation in the field of health as well. Accordingly, medical, psychological, and social research have expanded to include women and to investigate health issues with an eye toward the ways in which they may arise and manifest themselves differently in females and males (Alexander and LaRosa, 1994; Kolander, Ballard and Chandler, 1999).

Eating Disorders

One such issue which has received considerable attention in recent years is eating disorders. These diseases include several distinct illnesses which are characterized by unusual and unhealthy eating habits and attitudes which infiltrate and consume the lives of sufferers and their loved ones. In addition to emotional problems, social exclusion,
and chronic health problems, people with eating disorders face the risk of death if they do not get well (Hesse-Biber, 1996; Kolander, Ballard and Chandler, 1999).

This family of diseases affects primarily women, and incidence has been rising steadily since the 1930's (Hoek and van Hoeken, 2003). The National Eating Disorders Association (NEDA) (2002) estimates that about 10 million women and 1 million men suffer from either Bulimia Nervosa or Anorexia Nervosa, with about 25 million people suffering from Binge-Eating Disorder in the United States. It is very difficult, however, to gauge the precise prevalence and incidence rates for eating disorders, mainly because prevalence rates are low in the general population and many sufferers hide or deny the illness (Hsu and Zimmer, 1988). Incidence can be especially hard to establish, since it is not always possible to determine the exact time of disease onset (Polivy and Herman, 2002). Additionally, assessment of these figures is troublesome because evaluators tend to use vastly different methods and many samples that are used are not generalizable to the population at large. In an attempt to account for these difficulties, Hoek and van Hoeken (2003) estimated the prevalence and incidence of eating disorders in the United States and Western Europe by examining 15 separate epidemiologic studies from the areas. They concluded that Bulimia Nervosa affects approximately 1% of women. The incidence was assessed as 12 cases per 100,000 population per year. This disease is characterized by periods of consuming large quantities of food and subsequently engaging in some purging behavior (e.g. vomiting, exercising, fasting) in attempts to dispel the calories that were consumed (Alexander and LaRosa, 1994). Anorexia Nervosa is the 2nd most common eating disorder and is characterized by distortions about
the appearance of one’s body and extreme attempts to become thinner by restricting calories, often in conjunction with excessive exercising (Hesse-Biber, 1996; Kolander, Ballard and Chandler, 1999). Hoek and van Hoeken (2003) estimated the prevalence of anorexia at .3%, with an incidence of 8 cases per 100,000 population per year. Binge-Eating Disorder (BED) is characterized by bulimia-like binges without subsequent purging efforts and is listed in the Diagnostic and Statistic Manual of Mental Disorders IV (DSM-IV) as a disease requiring more research, for possible inclusion in the DSM-V. Those that have studied the prevalence of this disorder list it as even higher than that of bulimia: Hoek and van Hoeken estimate it as “at least 1%.” Other eating disorders, including Compulsive Overeating Disorder, Eating Disorders Not Otherwise Specified (EDNOS) are rising in prevalence and incidence as well (Zerbe, 2003). It should be noted that all 15 studies that were the basis of Hoek and van Hoeken’s (2003) estimates are from populations of women described as “schoolgirls” to “college women.” Estimates for older populations of women (and for men) are few and far between, as they are normally only calculated in populations of women in their teens and early 20s (Hoek and van Hoeken, 2003; Eating Disorders Review, 2004). Furthermore, it is highly likely that prevalence and incidence rates of all eating disorders are much greater than reported, due to the methodological problems mentioned above (Polivy and Herman, 2002; Hoek and van Hoeken, 2003).

General Etiology

Theories abound regarding the origins of eating disorders. The specific combinations of factors and routes of causation that are presented in the many proposed
Many, however, espouse an overarching biopsychosocial model of the disorders, considering them to be the result of biological, psychological, and social factors (Alexander and LaRosa. 1994; Kolander; Ballard and Chandler. 1999; Polivy and Herman. 2002). The diseases have commonly been associated, for example, with certain individual traits like anxiety, loneliness, and low self-esteem as well as social factors like family dynamics and idealization of thinness (Alexander and LaRosa. 1994; Chessick. 1983; Levine. 2000; Polivy and Herman. 2002; Zerbe. 2003).

Common Pathological Attributes

While different eating disorders may have different origins, different diagnostic criteria, and are associated with different behaviors and presenting characteristics, there are several shared attributes that eating disorder sufferers are exceedingly likely to exhibit. One of the most common and most noticeable characteristics is a disturbance in one’s body image. This concept is commonly defined as an individual’s mental representation of himself or herself (Myers and Biocca. 1992; Garner. 1997). Body image can greatly affect behavior, emotions, and self-esteem of the individual. Disturbances in body image usually take the form of body size overestimation (sometimes referred to as “body percept”) or body dissatisfaction (sometimes called “body concept”) (Shaw. 1995). A drive for thinness has also been associated with eating disorder symptomatology. This mind-set can include or develop into obsessive preoccupation with weight (Gupta. 1995).
It must be stated that these attributes are not purported to cause eating disorders. Gathering data to support such a notion is a virtually impossible task because ethical considerations prevent the execution of true experimental studies of eating disorders (Harrison and Cantor, 1997). The intention here is to point to the highly common co-occurrence of these attributes with eating disorders.

**Disordered Eating**

Indeed, there is much cause for concern in view of the fact that growing numbers of people are struggling with eating disorders. Perhaps even more worrisome is the reality that some of the major factors present in the pathology of eating disorder patients are remarkably common throughout the United States among women who do not meet the full diagnostic requirements of an eating disorder. The term “disordered eating” can be used in reference to such women who struggle with one or more of these issues, but not to the extent that is necessary to be medically diagnosed with one of the recognized eating disorders.

Research indicates that disordered eating habits and attitudes are widespread among women. “When the average young woman looks in the mirror,” note Myers and Biocca (1992), “she sees a fat person” (pp.109). In a survey of 3,452 women from around the world, Garner (1997) found striking evidence in support of this statement. Eighty-nine percent of the women expressed a desire to lose weight. In response to the question, “How many years of your life would you trade to achieve your weight goals?” 39% of women chose either “more than three years” or “more than five years”. An issue
of *Eating Disorders Review* (2004) declared that the percentage of women who feel dissatisfied with their body can be anywhere from 55-95%.

**Disordered Eating in Adult Women**

*Lack of Research*

Even a modest exploration of the literature on the subject of eating disorders makes it obvious that the overwhelming majority of the research focuses on adolescents and young women, to the exclusion of adult women (i.e. women over 30) (Allaz et al. 1998; Zerbe, 2003). As mentioned above, prevalence and incidence rates are usually not even calculated for women past their 20’s, let alone for women in later decades of life (Hoek and van Hoeken, 2003; Zerbe and Domnitei, 2004b). In the same vein, most of the measures designed to screen for eating disorders were validated using populations of exclusively young women (Gupta, 1995; Hoek and van Hoeken, 2003). Even some studies that allegedly study older women consider “older” to be only 18 years of age or more. For instance, in a study of the ages of onset of bulimic and anorectic patients, Woodside and Garfinkel (1992) considered later onset, as that which occurred at any age over 25. In another study, Shaw (1995) compared body dissatisfaction and eating psychopathology in “adolescent and adult females.” The mean age for the “adult” group was only 27.3.

Reasons for the deficiency of information on eating disorders and disordered eating in adult women may exist for several reasons. One explanation might be that because the majority of eating disorders are identified in younger females, there are no significant motives for thoroughly investigating issues regarding eating disorders in older
women (Garner and Garfinkel, 1982; Hoek and van Hoeken, 2003). Another reason may be that since in young women, the onset of puberty is commonly associated with eating disturbances, older women (who are well past that process) are thought to be immune to the triggers of eating disorders.

Results from those studies that have been conducted among women over age 30 suggest that reasons like these are highly unwarranted because eating disorders are present in adults of all ages (Cosford and Arnold, 1992; Hsu and Zimmer, 1988; Woodside and Garfinkel, 1992). The vast majority of these studies are qualitative and descriptive, offering individualized case studies which include details of the disorder's progression and presentation. For example, Hall and Driscoll (1993) detail the symptoms of a 64-year-old woman and a 61-year-old woman who were believed to have been struggling with eating disorders for over 10 years.

There is also evidence of eating disorders in those deemed "elderly" (often defined as those over age 70) (Hsu and Zimmer, 1988; Cosford and Arnold, 1992). Riemann, McNally, and Meier (1993) for instance, discuss the anorexic and bulimic behaviors of a 72-year-old man within the context of his life story. Beck et al. (1996) note the presentation and illness characteristics of anorexia in a 77-year-old woman as well as an 80-year-old woman. Certainly, study of this group is important and should continue to be pursued in the future. However, it is extremely difficult to distinguish the symptoms of eating disorders from the symptoms of other illnesses that are relatively common in the elderly (e.g. depression, loss of appetite). For this reason the present
study will focus solely on women of ages 30-60, who will be henceforth be termed “adult women.”

Research dealing with disordered eating among adult women is much more common than that which deals directly with adult women and eating disorders. Nevertheless, a deficiency persists (Lewis and Cachelin, 2001; Halliwell and Dittmar, 2003). Like the findings from eating disorder studies in older women, results regarding disordered eating and adult women are very clear: Women experience feelings of dissatisfaction about their body throughout the lifespan. For example, A study by Bennett and Stevens (1996) compared disordered eating attitudes in one group of women aged 50-84 to another aged 17-29 and found almost identical amounts of weight anxiety in each group. Another study investigated the body figure preferences of women between the ages of 18 and 59, and results revealed that women across the sample rated their ideal body figure as significantly smaller than their current figure. Furthermore, there was no significant difference among age groups with respect to body dissatisfaction (Stevens & Tiggemann, 2003). Allaz et al. (1998) used a Swedish sample of 30-74 year-olds, and found that 71% of women desired to lose weight, despite the fact that 73% were at a medically “normal” weight for their height. In a comparison of eating attitudes and weight concerns between mothers, daughters, fathers, and sons, Rozin and Fallon (1988) found evidence of similar levels of body dissatisfaction in mothers, daughters, and fathers. However, the fathers exhibited significantly less discomfort in regards to their bodies and significantly fewer weight-related concerns than the females. The researchers
concluded that "the major factor in concern about weight is sex rather than generation..." (p. 344).

**Importance of Research on Adult Women**

It is crucial that these trends be stopped, regardless of the age of the women they affect. However, the paucity of research in the area focusing on adult women requires special attention. The proliferation of disordered eating in this age group can be especially dangerous for several reasons. For one thing, age itself may be a confounding problem. As people age, they naturally become more prone to all kinds of health problems, which eating disorders can set off or aggravate. Therefore, adults who engage in unhealthy eating or exercise habits may have a more difficult time recovering and are probably more susceptible to long-term negative health effects than their younger counterparts. In addition, low weight and nutritional deficiencies (which may result from dieting) become more hazardous as people get older (Lewis and Cachelin, 2001). As a result of the greater number of possible afflictions doctors in adults, it is more likely that older women with an eating problem will be misdiagnosed because doctors may assume disordered eating symptoms to be caused by something else (Woodside and Garfinkel, 1992; Beck, Casper, and Andersen, 1996). Similarly, many doctors and clinicians do not think to screen older women for eating disorders, which could prevent or delay the patients' successful recovery (Hsu and Zimmer, 1988; Zerbe, 2003).

Another concern is that mature women may be more likely than younger people to go to extreme lengths to achieve their desired appearance. They are more financially able to undergo risky cosmetic surgery, purchase expensive lotions and creams, and buy
various types of pills, all with the intention of feeling better about their appearance. Some women even start smoking or become addicted to drugs such as cocaine in attempts to lose weight (Hesse-Biber, 1996; Zerbe and Domnitei, 2004b).

As well as spending valuable time and effort in the pursuit of a certain appearance, the probability is fairly high that adults undertaking such activities or exhibiting any kind of disordered eating habits will inadvertently pass them on to their children, who learn from their parents’ behaviors (Chernin, 1985; Rozin and Fallon, 1988). This may reinforce societal standards that may have a hand in eating disturbances, which gives another generation greater risk for the same problems (Eating Disorders Review, 2004).

It should also be added that as the overall prevalence of eating disorders rises, the prevalence in middle-aged women will likely rise, too. This is due to the fact that the population in North America and other countries is quickly getting older as baby boomers reach middle age (Zerbe, 2003; Zerbe and Domnitei, 2004a). Moreover, women comprise the majority of the elderly population and will most likely continue to do so (Lewis and Cachelin, 2001). This makes the need for research in this area all the more pressing.

**Treatment and Prevention**

It is clear that treatment for disordered eating sufferers of all ages would be greatly beneficial to individuals and society. Indeed for women with eating disorders, some type of treatment is usually necessary for successful recovery (Cosford and Arnold, 1991). Such treatment (e.g. therapy, nutrition counseling) commonly targets emotional
and psychological characteristics of the affected individual. Furthermore, it almost always involves getting the patient to adopt a more positive body image (Chessick, 1983; Alexander and LaRosa, 1994; Hesse-Biber, 1996). However, a large number of patients never enter treatment, as it can be very expensive and time-consuming (Hoek and van Hoeken, 2003). Even among those who do seek treatment, long-term recovery is notoriously difficult to achieve. It is estimated that approximately 50% of those who undergo treatment continue to have disordered eating habits even among those who undergo follow-up treatments. Relapse is also common among people who may appear to be fully recovered (Cosford and Arnold, 1991). Consequently, experts in the field are affirming the notion that a focus on the prevention of eating disorders, in addition to treatment, is wise (Stice et al., 1994; Austin, 2000; Matthieu, 2004).

*Age-Specific Origins*

In order for prevention efforts to be successful, it is necessary to direct attention towards the root(s) of these problems so that they can be stopped before they start. Several main themes are consistently indicated as factors underlying eating disorders in adult women. Some believe them to be the result of unresolved childhood psychological issues (Chessick, 1983). Or, they may experience a stressor which spurs the onset of the eating disorder as a coping strategy or as a way to gain control over their surroundings. In particular, research has linked eating abnormalities to a trauma or loss. A loss can refer to any of a number of occurrences, including the death of a loved one, an unrealized dream, or the loss of a youthful appearance), all which impact adults more than younger people (Chessick, 1983; Zerbe, 2003; Mathieu, 2004). Others believe that just as eating
disorders in young females often result from issues related to the onset of puberty and menarche, eating disorders in older females may also stem from natural bodily changes such as pregnancy or menopause, both which may lead to emotional and/or physical changes, one which is natural weight gain (Zerbe, 2003).

Several studies document women’s attitudes towards aging specifically in relation to body-image concerns. The basic procedures used have been almost identical: Quantitative measures were conducted to assess age-related apprehensions and body image, and the outcomes for each were compared. The findings have been virtually identical as well: Women experience anxiety about getting older, commonly for reasons related to a decreasingly-attractive appearance. This is often related to a drive for thinness and body dissatisfaction, which as previously mentioned, are frequently associated with disordered eating (Gupta and Schork, 1993; Gupta, 1994; Lewis and Cachelin, 2001).

This research also indicates that adult men are susceptible to body image troubles as well; however, information on this group is even more sparse than information about adult women. Although these concerns may appear similar to those experienced by women, some research has indicated that the body image concerns of men may be structurally different. Gupta and Schork (1993) assessed aging concerns and eating attitudes among men and women. They found that preoccupation with weight was significantly correlated with aging concerns for both men and women. However, women scored significantly higher than men on the aging concerns measure. In a qualitative study by Halliwell and Dittmar, (2003) a thematic analyses of interview responses
demonstrated that for men, the greatest worry about their aging bodies was the loss of physical capabilities. Very few male participants showed concern about appearance. On the other hand, all of the women interviewed exhibited concerns about decreasing of their physical appearance due to aging. This may be one reason why body image concerns are less prevalent in men. When men think about their bodies, they tend to place more importance than women on performance, and less importance on appearance.

Social Factors as Prevention Aids

The aforementioned biopsychosocial models of eating disorder etiology can account for how a plethora of underlying factors, including those just discussed, interact and affect one another (Hsu and Zimmer, 1988; Stice et al., 1994). One class of these contributors are social in nature and emphasize the ways in which different aspects of society and one’s social environment may influence eating disorder pathology. In terms of developing prevention strategies for disordered eating, focusing on this social dimension may be the most beneficial method of developing strategies to prevent eating disturbances, for three main reasons: (1) It is plausible that these social factors are the chief contributors to the significant increases in eating disorders and disordered eating throughout the last few decades (Thompson and Heinberg, 1999); (2) Societal factors often exert great influence on the psychological aspects of eating disorders (Polivy and Herman, 2002); and (3) As the social bases of eating disorders are primarily created by people, they may stand the best chance of being eradicated by people.

What are these malleable social factors? Several main themes are present in theories related to this question. Sociocultural cultural models usually emphasize the
highly specific and hard-to-come-by beauty ideals which have evolved in “modern”
societies (e.g. those that exist in the United States and Western Europe) along with the
social pressure people experience to conform to these standards (Cusumano and
Thompson, 1997; Thompson and Heinberg, 1999).

**Media Influence**

Many researchers have indicated that mass media may be the most powerful
purveyor of social pressure and dangerous messages regarding appearance and thinness
(Streigel-Moore, Silverstein, and Rodin, 1986; Groesz, Levine, and Murnen, 2002; Myers
and Biocca, 2002). Certainly these messages also come from other sources (e.g. peers,
partners, etc.) but the media is a ubiquitous and influential phenomenon which few other,
if any, providers of cultural messages can rival. Particularly, the media referred to here is
the type that is primarily visual in nature (mainly television and magazines).

As omnipresent technology makes it difficult to avoid media exposure (Allaz et
al., 1998; Tiggemann and Slater, 2003) portrayals of thin, young, and beautiful women
might represent one source of widespread body dissatisfaction (Gupta, 1994; Levine,
2000; Polivy and Herman, 2002). Indeed, media figures are thinner and younger than
ever (Stice et al., 1994). Additionally, prior to the proliferation of the myriad of media
sources which exists today, cultural messages regarding beauty ideals (e.g. portrayals in
paintings and sculptures) represented them as “otherworldly and unattainable” (Thompson
and Heinberg, 1999). Today’s media does not hesitate to disseminate content which
makes women believe that they can and should look like the “ideal” women they see on
television, in the movies, and in magazines. Very rarely are media consumers alerted to
various photographic techniques like airbrushing and the use of special cameras that can play a major role in editing the images they seek to emulate (Thompson and Heinberg, 1999). Audiences are, however, frequently informed about the diet plans and workout programs used by the stars in order to gain their appearance (Stice et al., 1994; Harrison and Cantor, 1997). Also omitted from these instructions are reminders that for most of the stars they see, being beautiful is their livelihood, a foremost requirement of their job—and they have personal trainers, private chefs, nutritionists, and other professionals at their beck and call to make sure they stay that way.

Sociocultural Theories of Media Influence

Several themes emerge which expound upon the specific routes by which media portrayals of thin women can have such powerful effects. Again, it must be mentioned that the specific structure of these models varies according to the person(s) employing them, but several patterns are present. The literature about media influence on body image usually emphasizes the highly specific and hard-to-come-by beauty ideals which have evolved in “modern” societies (e.g., those that exist in the United States and Western Europe) along with the social pressure people experience to conform to these standards (Cusumano and Thompson, 1997; Thompson and Heinberg, 1999).

Social learning theory. This theory offers two main explanations for how media portrayals of thinness can affect the behaviors and attitudes of audiences. One is simply that as the prevalence of thinness and dieting portrayed in the media increases, so does the likelihood that people will model dieting behavior in order to become thin. The second explanation is that audiences are highly influenced by the incentives which they
see or perceive others receiving as a result of dieting or being thin. In both situations, the media operates as an “identificatory role model” from which women acquire thinness as a goal and learn how to go about achieving it (Bandura, 1977; Harrison and Cantor, 1997).

*Social comparison theory.* This theory operates from the position that people have a drive for self-evaluation, and that this drive is acted upon through a process in which people compare themselves to others (Festinger, 1954). The media provides a wealth of images and standards to which people can compare themselves, and its omnipresence can make it difficult to refrain from doing so (Thompson and Heinberg, 1999; Tiggemann and Slater, 2003). In addition, because most current media images are so “perfect”, many people may experience feelings of inadequacy as a result of media exposure, which can strengthens body dissatisfaction and drive for thinness (Garner, Olmstead, and Polivy, 1983; Gupta, 1994; Hawkins et al., 2004).

*Socialization.* More generally, the media can be a strong factor in the process of socialization, explicitly or implicitly passing on specific norms and values to audiences. Socialization starts from youth and continues throughout the lifespan. Like other social factors, it is not only greatly affected by the media, but it is likely that socialization and media exposure work together to reinforce, maintain, and even create social stereotypes.

Socialization may be a prime factor in the previously cited work of Halliwell and Dittmar (2003) in which men and women showed great differences in their conceptualizations of their bodies and of aging. Early on, boys are commonly pushed to thrive in physical endeavors, while it is more socially acceptable for girls to be concerned with aesthetic appearances. After years of exposure to these expectations, it is not
surprising that adult men regarded the body in generally functional terms, and women viewed it almost solely in terms of appearance. Furthermore, the men tended to conceptualize their bodies as one entity, whereas women saw their bodies in terms of distinct parts. Indeed, a similar differentiation is apparent in media representations of men and women, as depictions of women commonly focus on body parts, whereas depictions of men focus more on the body as a whole (Myers and Biocca, 1992; Cusumano and Thompson, 1997). Accounts regarding the perception of their bodies revealed that women were much more likely to reference the body as an "object of display," while the majority of the men (and only the men) discussed the body in terms of its functionality. This result may also stem from the "double standard of aging" in which growing older can be beneficial to the appearance of men, but is rarely ever positive for women (Sontag, 1978; Halliwell and Dittmar, 2003).

Evidence from Quasi-experimental Studies

Few studies have directly investigated the link between diagnosed eating disorders in relation to media consumption, but many have received support for the hypothesis that media can influence aspects commonly associated with disordered eating (Levine, 2000; Tiggemann and Slater, 2003). Much of this research has attempted to relate media consumption to body dissatisfaction and eating disorder symptomatology through quasi-experimental research, most which followed similar procedures. Researchers exposed participants to pictures from magazines (Shaw, 1995; Cusumano and Thompson, 1997; Jung and Lennon, 2003; Hawkins et al., 2004) or short television segments (Myers and Biocca, 1992; Tiggemann and Slater, 2003), some which depicted
what Harrison and Cantor (1997) termed “thinness-depicting and thinness-promoting” (TDP) content, and some which did not. Participants were then assessed on some outcome measure or measures of eating attitudes. Analyses frequently showed that compared either to controls or within-subjects pretest measures, exposure, even brief in nature, to TDP media content was associated with lower levels of self-esteem, higher levels of body dissatisfaction, and demonstration of general eating disorder symptomatology. The oldest participants in all but one of these studies were under 30 years old. The exception used students in a continuing education program, where the highest age was 49 and the mean age was 24 and the standard deviation was 6.6 (Cusumano and Thompson, 1997).

**Extending the Current Research**

There appears, then, to be a link between consumption of media depicting young, thin, and beautiful women and several attributes of eating disorders and disordered eating. However, most of the studies regarding media influence have used immediate-effects designs in which consequences of on-the-spot exposure to TDP media were measured (see Myers and Biocca, 1992; Shaw, 1995; Cusumano and Thompson, 1997; Hawkins et al., 2004). In other studies, media content measures were highly restrictive, and did not allow for the possible range of responses to be indicated. This study accounts for respondents’ general use of media in their everyday lives and uses less restrictive media consumption measures. It therefore improves upon the methods utilized in other studies, as it will likely be a better reflection of individuals’ actual media use.
Additionally, the research conducted to date in this area has only used cohorts of adolescent or college-aged women. It is imperative to determine whether the findings of these studies are replicated in samples of adult women, because conclusions based on data that apply to younger women may not be relevant to older women. Therefore, the primary aim of this study is to extend the current research in order to determine whether the relationship between the media and eating disturbances that has been evidenced in groups of younger women holds true for adult women.

**Method**

*Overview*

Potential associations between media consumption and factors related to disordered eating were assessed in adult women. Females between 30 and 60 years of age (N=121) completed the 26-Item Eating Attitudes Test and three subscales of the Eating Disorders Inventory. They completed additional self-report measures regarding the duration and content of their media use. The key prediction was that greater media consumption, especially high TDP media consumption, would be positively associated with (a) eating disorder symptomatology, (b) body dissatisfaction, and (c) drive for thinness, and (d) maturity fears.

*Participants and Sampling*

Convenience sampling was used to recruit prospective participants, who were female graduate students, faculty, or staff members between the ages of 30 and 60 at a small private university. They were selected from the university’s online telephone and e-mail directory and sent an e-mail which asked them to complete a survey about various
attitudes and habits regarding their nutrition and health. They were notified that the survey was completely anonymous and confidential, and were given the option of completing the survey either in hard copy format or online (via SurveyMonkey.com). Out of 270 women who were sent participation requests, 121 responded, which represents a high response rate, 44.8%. All but 10 of the 121 participants completed the survey online.

Demographics of the sample appear in Table 1. The mean age of participants was 46.58; 90.9% were white; 76.86% were either married or in a domestic partnership; and 74.38% reported having at least one child. It should also be noted that only two respondents reported their occupation as “professor,” and only six indicated that they were graduate students, so the vast majority of the women in the sample (93.39%) were staff members. Staff jobs ranged widely and included employees from various academic departments (administrative assistants and academic coordinators), LTS (Library and Technology Services), Data Control, Accounts Payable, and Client Services.

Measures

Eating Disorder Symptomatology. Participants completed the 26-Item Eating Attitudes Test (EAT-26; see Appendix A). This measure was adapted from a longer version containing 40 items (Garner & Garfinkel, 1979; Garner, et al., 1982). It was originally intended to measure attitudes and behaviors of anorexic patients, and a high internal validity of .94 was demonstrated in a comparison of the scores of anorexic patients and non-patient “normals” (Garner and Garfinkel, 1979). A factor analysis on the longer version revealed three main subscales: dieting, bulimia and food

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preoccupation, and oral control. Items that did not fit into one of the three categories were removed from the EAT-40, and 26 questions remained. Highly reliable correlations were exhibited between the two versions for both anorexic and "normal" individuals (Garner et al., 1982). Other researchers have since demonstrated the internal reliability of the two tests and their applicability to diverse groups of people suffering from various eating disorders (Berland, Thompson, and Linton, 1986; Gross et al., 1986). The EAT-26 has been utilized in over 250 documented studies, for both clinical and non-clinical samples, and is commonly used as an initial screening device for eating disorders (Garner, Olmstead, and Polivy, 1983; Garfinkel and Newman, 2001) or as an assessment of eating behavior (Berland et al., 1986). Items on the EAT-26 include: I am terrified about being overweight; I feel extremely guilty after eating; and I cut my food into small pieces. Participants rate the frequency with which each item applies to them ("always," "usually," "often," "sometimes," "rarely," or "never").

Attributes Related to Eating Disturbances. Respondents also completed three sections of the Eating Disorders Inventory (EDI; see Appendix B), which was constructed in 1983 as a multi-scale assessor of behaviors and attitudes associated with anorexia nervosa and bulimia (Garner, Olmstead, and Polivy, 1983). A large pool of questions was used to produce eight subscales, each measuring different psychological dimensions that are commonly associated with eating disorders. The dimensions are: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears. The three subscales participants will complete are those thought to be the most related to media
consumption and aging. *Drive for Thinness* is characterized by “excessive concern with dieting, preoccupation with weight and entrenchment in an extreme pursuit of thinness.” The reliability coefficient for this scale in diagnosed anorectic patients and the female control group was .85. *Body Dissatisfaction* is an indication of the feeling that certain body parts are currently too large. Alphas for this scale were .90 and .91 for anorectics and controls, respectively. *Maturity Fears* “measures one’s wish to retreat to the security of the preadolescent years because of the overwhelming demands of adulthood.” This scale is included particularly because oftentimes disordered eating is associated psychological characteristics which indicate an avoidance of psychological maturity (Garner et al., 1983). It is possible that for adult women, media consumption could help appease maturity fears, and so greater media consumption may be related to greater maturity fears. Internal consistency for this subscale was .88 in the anorectic group and .65 in the female control group. Items on each of these three scales include: *If I gain a pound, I worry that I will keep gaining; I think that my hips are too big; and The happiest time in life is when you are a child*, respectively. Participants respond in the same manner as is done for the EAT-26.

*Media Consumption.* In terms of assessing media consumption, this study followed a design similar to that of Harrison and Cantor (1997). This team asked college students how many hours they spent watching television on a typical weekday, Saturday, and Sunday. To assess the content of television viewing, participants were also asked how much they watched each of six of the current year's popular television shows. The researchers characterized each in terms of how one of the main female characters was
represented. *Beverly Hills 90210* and *Melrose Place* were chosen to represent “thin” female bodies; *Seinfeld* and *Northern Exposure* represented “average” bodies; and *Designing Women* and *Roseanne* represented “heavy” bodies. For magazine consumption, participants were asked how many issues of magazines in each of five categories they read each month: “health and fitness,” “beauty and fashion,” “entertainment and gossip,” “news and current events,” and “men’s entertainment.” They summed the scores for all five categories to determine the overall frequency of magazine reading.

Their results showed significant associations between EAT scores and overall magazine reading, TDP magazine reading, and overall television viewing. They did not find any relation between EAT scores and TDP television viewing, however. This may be due in part to the measure (described above) which was used to assess the content of television viewing. By only allowing participants to choose from six shows, the measure was highly restrictive. If participants watched shows in addition to, instead of, or significantly more than any of those six, the assessment of their TDP viewing habits would be inaccurate.

Therefore, rather than limiting the content analysis to six television shows and certain types of magazines, the questionnaire in the current study included an open-ended question asking participants to list the five television programs they watch most consistently and the five magazines they read most consistently. Once all the surveys were completed, a master list was created which included all the television shows and magazines which participants indicated they regularly watch and read. Overall, 159
different television shows and 124 different magazines were listed. Each show and magazine was then rated by two independent raters in terms of how much it promoted and depicted thinness. The ratings ranged from 0-4 (half scores were given as well), where zero meant “not at all or hardly ever TDP” and 4 meant “extremely or always TDP.” In the cases in which the raters were not familiar with a show or magazine, they made efforts to become familiar with it either by actually exposing themselves to the source or by utilizing the Internet to gather enough information about it so that they felt comfortable giving it a rating. Once all the shows and magazines were rated by both raters, inter-rater reliability was calculated with a correlational analysis. The correlations of the two ratings were considered acceptable: For the television show ratings $r=.86$, $p<.01$, and for the magazine ratings $r=.92$, $p<.01$. The two ratings for each show and magazine were then averaged to form an overall TDP rating for each source. Next, average TDP TV and magazine ratings were calculated for each individual by summing the TDP ratings of each of the shows/magazines they listed and then dividing by the number of shows/magazines listed. For example, one participant listed *Prison Break*, *OC*, and *Two and a Half Men* as the television shows she watches most consistently. The former show was rated “1” by the first rater and “0.5” by the second. The show’s TDP rating was calculated by adding 0.5 and 1 and then dividing by 2 (the number of ratings). So *Prison Break* has a TDP rating of 0.75. *OC* was rated “4” and “3.5” by the respective raters, and thus has a TDP rating of 3.75. The final show was rated “2.5” and “3” which gives it a TDP rating of 2.75. The respondent’s overall TV TDP rating is the sum of the
three ratings divided by 3 (the number of shows). In this case, then, the overall rating is 2.42.

Overall television viewing and magazine reading was determined by two questions which asked participants to choose one of 17 categories (each in increments of five hours, from <1 to 61+ hours per week) which best approximated the overall time they spent watching television and reading magazines each week. The media consumption survey appears in Appendix C.

Hypothesis

The key prediction was that for women of ages 30-60 more time spent watching television and reading magazines, especially high TDP television and magazines, would be positively related to several attributes of disordered eating: (a) eating disorder symptomatology, (b) body dissatisfaction, and (c) drive for thinness, and (d) maturity fears.

Procedure

Women who responded to the recruitment e-mail agreeing to complete the survey were sent either a link to the online survey or a hard copy of it, as per their preference. Before filling out the survey they read a consent letter which indicated that they would be participating in a study about various attitudes, habits, and feelings of women aged 30-60. The letter also reminded them of the confidentiality and anonymity of the study and informed them that by completing the packet and sending it back to the researcher (for those who completed the hard copy version) they consented to participate in the study according to the terms and conditions as described. Those who took the survey online
read the letter and had to accept the terms before they could continue. Participants then completed the survey, which included the EAT-26, the Drive for Thinness, Body Dissatisfaction, and Maturity Fears subscales of the EDI, and the media consumption measures.

**Results**

*Missing Data and Coding*

In cases where there was missing data for scale items (i.e. participants skipped a question), series means were substituted so that scale scores could be computed. For the categorical demographic data regarding “race/ethnicity” and “marital status”, dummy variables were computed so that both variables were condensed into two groups: white/nonwhite for the former variable and partnered/non-partnered for the latter (where “partnered” refers to those who indicated marital status as “married” or “domestic partnership” and “non-partnered” refers to those who indicated that they are “single”).

Media consumption variables were also recoded into high and low groups for both quantity and content of television watching and magazine reading. The goal for the coding was to break the groups up on the basis of the mean, with as close to equal amounts of respondents in each group. For TV hours/week, responses in the first three categories (<1 hour to 6-10 hours per week) were recoded into “low hours/week,” while responses in the 11-15 hour per week category and above were recoded as “high hours/week.” There were 56% of the respondents who fell into the “low hours/week” category, and 44% in the “high hours/week” group. Responses on magazine hours per week considered low were those that fell into the first quantity category (<1 hour week).
This comprised 40.5% of respondents, leaving 59.5% in the "high hours/week" group. The coding of high and low TDP consumption was more straightforward, since this variable was numerical. Participants whose show/magazine TDP rating was above the mean were in the high group, and those below the mean were in the low group. For television, high/low cutoff was 1.89. Fifty percent of participants were coded as high, and 50% as low. For magazines, 1.26 was the cutoff. There were 51% and 49% of respondents in the high and low groups, respectively.

Internal Consistency of Measures

Internal reliabilities of the measures were computed, with results as follows:
EAT-26, \( \alpha = .83 \): Drive for Thinness subscale, \( \alpha = .87 \): Body Dissatisfaction subscale, \( \alpha = .93 \): Maturity Fears subscale, \( \alpha = .68 \). These scores represent generally high internal consistency, and they are very similar to the alphas of the standardized measures.

Descriptive Statistics

Prior to conducting analyses, descriptive statistics were computed for the variables. These appear in Table 2. The average EAT-26 score was 7.28 (SD=7.02, Range=0-38); average drive for thinness score was 3.06 (SD=4.34, Range=0-18); average body dissatisfaction score was 11.98 (SD=8.40, Range=0-27), and average maturity fears score was 2.00 (SD=2.45, Range=0-13). The mean TV hours per week was 3.61 (SD=1.60, Range=1-8 or <1-35 hours), which indicates a response in the third choice category, 6-10 hours. Mean TV TDP rating was 1.89 (SD=.73, Range=.55-3.5). The mean magazine hours per week response was 1.84 (SD=.95, Range=1-5 or <1-20 hours).
which corresponds to 1-5 hours. Mean magazine TDP rating 1.26 (SD=1.11. Range=0-4).

Participants’ scores on these measures are similar to those that have been found in other studies. The standardized scores on the Drive for Thinness, Body Dissatisfaction, and Maturity Fears of the EDI are 5.0 (SD=.22), 10.2(SD=.34), and 2.5(SD=.33). This was the data for the female comparison group which had a mean age of 19.9 (Garner et al., 1983). In work conducted by Gupta and Schork (1993) a group of women with a mean age of 40.8 had scores of 4.7(SD=5.3) and 11.9(SD=7.8) for Drive for Thinness and Body Dissatisfaction, respectively.

Analyses

Bivariate Regression. To determine whether relationships were present between respondents’ media consumption habits and their scores on the dependent measures, bivariate regressions were performed on the independent variables. It was decided that due to the small sample size a .10 significance level is appropriate. The results of this analysis appear in Table 3. A positive significant linear relationship was revealed between body dissatisfaction and TV hours per week, \( R^2=2.96, p<.10 \). Women who watched more television were more likely they were to experience higher body dissatisfaction scores. Another positive significant linear relationship was revealed between body dissatisfaction and TV TDP rating, \( R^2=3.59, p<.05 \). Participants who watched shows with high TDP ratings were more likely to experience higher body dissatisfaction. None of the other relationships were significant.
**Multivariate Regression.** Multivariate regressions were performed to introduce the control variables in order to investigate the influence of the sample’s demographic characteristics on the outcome measures. The results of these analyses appear in Tables 4-7. For every independent variable, there was a significant linear relationship between marital status and scores on the Maturity Fears subscale: for TV hours per week, $R^2=1.49$, $p<.10$; for TV TDP rating $R^2=1.45$, $p<.10$; for magazine hours per week, $R^2=1.56$, $p<.10$; and for magazine TDP rating, $R^2=1.45$, $p<.10$. The nature of this relationship was such that partnered women were significantly more likely to exhibit maturity fears than were non-partnered women. Television TDP ratings were significantly associated with body dissatisfaction in this analysis as well: $R^2=3.33$, $p<.10$. When the demographic variables were controlled for, respondents who consumed high TDP TV continued to be more likely to have higher body dissatisfaction scores.

**Discussion**

The primary finding was that body dissatisfaction was related to both overall quantity of television viewing and the thinness-depicting and promoting content of television viewing. No significant results were found for the relation of magazine consumption habits to disordered eating attributes. This study replicates the findings of other studies in that it shows evidence of body dissatisfaction in older women. Moreover, it extends the findings of previous studies as it shows support for a relationship between television consumption and an attribute of disordered eating in adult women, a population for whom this link has not been previously investigated.
It should be noted that due to the survey method used in this study, these results are strictly correlational in nature. It may be the case that having a high level of body dissatisfaction leads women to engage in certain media habits. However, the literature and cultural trends (i.e. steady increases in disordered eating alongside increasingly slim body ideals) suggest that media consumption may play a role in the development of body dissatisfaction. The current method may be the most advantageous way to garner significant information and insight, as experimental studies in this area which would allow for more causal inference rarely mimic "real world" environments. However, researchers are working on causal models of media effects on eating disturbances (see Stice et al., 1994), which may allow for greater causal inference in future research.

The lack of significant associations for magazine consumption with body dissatisfaction may be a result of highly clustered responses for these variables. Eighty-five percent of women were in the first two quantity categories, which include 0 to 10 hours of magazine reading per week. The decision to consider anything from 1 hour of magazine reading per week and above as high stemmed from this fact. If high had been considered from six hours per week and above, only 15% of participants would fall into that category. So it may be the case that there was not sufficient differentiation between the high and low groups' effects to surface. Another possibility is that there was not enough differentiation between the category choices for magazine reading. Since people seem to read magazines much less than they watch television, it may have been warranted to use smaller category ranges. An open-ended format could also have been
used, but it was believed that the use of categories for the hours per week questions would allow for more accurate responses.

No effects were found for the dependent variables other than body dissatisfaction. In general, this may be a factor of the generally low consumption of media in this sample. While there is no way to precisely gauge the viewing habits of this group to that of others due to the immediate-effects design of the majority of other media-related studies in this area, general media use statistics regarding television viewing suggest that this group of women watches less television than individuals in the population at large. The most recent Nielsen Media Research (2005) report stated that during 2004-2005 the average person watched 4 hours and 32 minutes of television per day, which is almost 32 hours per week. The average range of hours watched per week in this sample was 6-10, and the most anyone reported watching was 31-35 hours per week. The majority of the sample (77.3%) watched less than 16 hours per week, which is half the amount of the national average.

The low quantities of television consumption may be related to the characteristics of the sample. All were women with full-time employment, most who have children (about 76%). Both of these factors could limit the opportunities these women might have to watch TV and read magazines. Or, media use may simply have not been high enough to bring out any relationships that might exist. Furthermore, the convenient sample may not be representative of the general population. The fact that all of the participants were employed may be of particular interest. In the previously cited study by Bennett and Stevens (1996) regarding weight anxiety, unemployed women experienced significantly
more weight anxiety than employed women. There may also be some influence of the University setting which affects their media habits. It might have been helpful, had resources and time permitted, to examine the media consumption habits of a more diverse group of women in the same manner as was done here in order to determine if stronger results would surface in women with higher media consumption. Similarly, it would have been useful to have had a cohort of young women participate in the study to determine whether comparable amounts of media consumption led to different results in the two age groups on the eating disturbance measures. Future research should also strive for a more representative sample in terms of race/ethnicity, marital status, and employment status so that findings can be generalizable to diverse populations.

Additionally, it is not possible to compare the average TDP ratings of participants' media use to that of other samples, as this method of measurement has not been used before. It would consequently be of interest to examine the TDP media ratings of other populations.

The finding that having a partner was related to higher maturity fears than being single is somewhat counterintuitive. This subscale generally assesses the degree of respondents' desires to return to a less demanding, more comforting environment like that which is present in childhood. It might be expected, then, that women who have more maturity fears would be less likely to have a partner, since partnering-up is usually associated with more adulthood responsibilities and demands. This finding can make sense if we conceive of having a partner as contributing to the development of maturity fears. Once a woman takes on a partner, she may be expected to subsequently take on
other more demanding roles, such as that of a mother or career-woman, for example, which in turn could lead to new or increased anxieties about the rigors of being an adult. However, as only 11 of the 121 participants (about 9%) reported being single, versus 93 (about 77%) who have a partner, it is questionable as to whether this result would hold up in a larger sample size or one in which the proportion of partnered to non-partnered women was more equal.

In addition to the Maturity Fears subscale, another measure that would have been useful is one which directly assessed participant’s concerns about aging as they relate to body image or appearance. Several researchers have investigated this association, and Gupta and Schork (1993) have created an assessment measure. The findings have indicated that women who are more concerned with becoming less attractive due to the aging process have higher scores on measures related to disordered eating (Gupta, 1995; Lewis and Cachelin, 2001; Halliwell and Dittmar, 2003).

Finally, other studies on this and related topics have attempted to account for several personality or psychological variables that are hypothesized to mediate the effects of media exposure. These mediating factors commonly include awareness and/or internalization of social norms and the thin ideal in particular (Myers and Biocca, 1992; Striegel-Moore et al., 1986; Stice et al., 1994), gender role endorsement (Stice et al., 1994), and attachment style (Triosi, Massaroni, and Cuzzolaro, 2005). Future research which controls for such factors might allow for more precise development of theory regarding the relation of these and other variables to media effects on eating disturbances in older women.
Conclusion

Eating disorders and disordered eating have become more common in adult women than they ever have been before. It is therefore important that treatment and prevention efforts be improved so that the prevalence of these problems can begin to decrease. However, the bulk of the research on this subject has used only younger women as the focus. Previous research suggests that the causes of eating abnormalities and the mechanisms by which they occur might be different for women in different age groups. Accordingly, treatment and prevention programs that are developed based on data gleaned from samples of young women may be of no help to older women. The goal of this study, then, was to extend the current work.

In particular, the media was considered as an area in which to direct prevention efforts, because it is an ever present and highly influential source of norms and values in contemporary U.S. society. Furthermore, since the messages conveyed by the media are socially constructed, they can likely be de- or re-constructed into ones which do not support the proliferation of dangerous cultural values. It has been documented that eating abnormalities in younger women are related to media use, but until now this has not been tested among older cohorts. By focusing on women aged 30-60, this study extended the findings of previous work which related media consumption to dimensions of disordered eating in younger women. Women completed survey packets which included measures of eating disorder symptomatology, drive for thinness, body dissatisfaction, and maturity fears. It also contained a media consumption questionnaire to gauge the quantity and content of their media use.
The results indicated that more time spent watching television was significantly related to higher levels of body dissatisfaction. Also, greater amounts of thinness-depicting and promoting content were significantly related to higher levels of body dissatisfaction. These findings, in conjunction with previous research, indicate the existence of a link between television viewing and body dissatisfaction and also between television content and body dissatisfaction, for both younger and older women. These findings should be an impetus for further study regarding adult women, media use, and disordered eating. It is necessary that more efforts be made to examine the relevance of other findings based on younger women to older women. This will help reveal the areas and ways in which disordered eating differs between groups. More work is also required among diverse populations in terms of race/ethnicity, occupation, and marital status. Such work will make it easier to develop effective treatment and prevention programs for all people struggling with disordered eating.
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<th>Characteristic</th>
<th>Value</th>
<th>Percent of Sample</th>
</tr>
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<td>Sample Size</td>
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<td>Age (mean = 46.58; SD = 7.77)</td>
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<td>30-35 years</td>
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<td>36-40 years</td>
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<td>N=1 each</td>
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Table 1. Sample Demographics
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<tr>
<th>Variable Name</th>
<th>Mean</th>
<th>SD</th>
<th>Range of Sample</th>
<th>Possible Range</th>
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<tbody>
<tr>
<td><strong>Dependent Variables</strong></td>
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<tr>
<td>Overall disordered eating (EAT-26 Score)</td>
<td>7.28</td>
<td>7.02</td>
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<td>0-78</td>
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<tr>
<td>Drive for Thinness</td>
<td>3.06</td>
<td>4.34</td>
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<td>Body Dissatisfaction</td>
<td>11.98</td>
<td>8.40</td>
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<td>Maturity Fears</td>
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<td>2.45</td>
<td>0-13</td>
<td>0-24</td>
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<tr>
<td><strong>Independent variables</strong></td>
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<tr>
<td>TV hours/week</td>
<td>3.61 (6-10hrs)*</td>
<td>1.60</td>
<td>1-8 (&lt;1 to 31-35 hrs)</td>
<td>1-17</td>
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<tr>
<td>Magazine hours/week</td>
<td>1.84 (1-5hrs)</td>
<td>.95</td>
<td>1-5 (&lt;1 to 16-20hrs)</td>
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<tr>
<td>TV TDP rating</td>
<td>1.89</td>
<td>.73</td>
<td>.55-3.5</td>
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<tr>
<td>Magazine TDP rating</td>
<td>1.26</td>
<td>1.11</td>
<td>0-4</td>
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</table>

*TV and Magazine hours/week information are based on categorical data. Participants chose one of seventeen categories which were comprised of 5 hour time increments, from “<1 hour per week” to “61+ hours per week”.

Table 2. Descriptive Statistics for Dependent and Independent Variables
<table>
<thead>
<tr>
<th>Independent Variables‡</th>
<th>EAT-26</th>
<th>Drive for Thinness</th>
<th>Body Dissatisfaction</th>
<th>Maturity Fears</th>
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<tr>
<td>TV hours/week</td>
<td>-.80 (.85)</td>
<td>-.80 (.80)</td>
<td>2.96 (1.52)*</td>
<td>-.18 (.45)</td>
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<td>TV TDP rating</td>
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<td>.99 (.79)</td>
<td>3.59 (1.50)**</td>
<td>.13 (.45)</td>
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<td>Magazine hours/week</td>
<td>1.31 (1.30)</td>
<td>.42 (.81)</td>
<td>-2.00 (1.55)</td>
<td>-.69 (.45)</td>
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<tr>
<td>Magazine TDP rating</td>
<td>-.86 (1.28)</td>
<td>.03 (.79)</td>
<td>1.23 (1.53)</td>
<td>-.03 (.45)</td>
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</tbody>
</table>

† Unstandardized regression coefficients; standard errors are in parentheses.
‡ Each independent variable was collapsed into “high” and “low” categories prior to analysis.
* $p<.10$; **$p<.05$

Table 3. Bivariate Regression Analysis
<table>
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<tr>
<th>TV hours/week† ‡</th>
<th>EAT-26</th>
<th>Drive for Thinness</th>
<th>Body Dissatisfaction</th>
<th>Maturity Fears</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.73 (1.50)</td>
<td>-.92 (.93)</td>
<td>2.67 (1.77)</td>
<td>-.36 (.50)</td>
</tr>
</tbody>
</table>

Control Variables

| Age            | -.05 (.10) | -.05 (.06) | -.08 (.11) | -.02 (.03) |
| Race/Ethnicity | -.51 (1.54) | .15 (.93)  | -2.67 (1.77)| -.21 (.50) |
| Number of Children | -.56 (.76) | -.08 (.46) | 1.02 (.87) | -.02 (.24) |
| Marital Status (partnered/ non-partnered) | .66 (2.60) | .70 (1.59) | -1.34 (3.02) | 1.49 (.85)* |

† Unstandardized regression coefficients: standard errors are in parentheses.
‡ Independent variable appears in bold. Dependent variable appears in italics.
* p < .10

Table 4. Multivariate Regressions on Control Variables by TV hours/week
<table>
<thead>
<tr>
<th>TV TDP rating†‡</th>
<th>EAT-26</th>
<th>Drive for Thinness</th>
<th>Body Dissatisfaction</th>
<th>Maturity Fears</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.45 (1.48)</td>
<td>.66 (.90)</td>
<td>3.33 (1.69)*</td>
<td>.02 (.48)</td>
</tr>
</tbody>
</table>

Control Variables

| Age | -.05 (.10)  | -.05 (.06)  | -.04 (.11)  | -.02 (.03) |
| Race/Ethnicity | -.35 (1.53) | .35 (.93)  | -2.64 (1.74) | -.16 (.50) |
| Number of Children | -.53 (.75)  | -.05 (.46)  | .76 (.86)  | .00 (.24) |
| Marital Status (partnered/non-partnered) | .55 (2.63) | .45 (1.59) | -1.15 (2.99) | 1.43 (.85)* |

† Unstandardized regression coefficients: standard errors are in parentheses.  
‡ Independent variable appears in bold. Dependent variable appears in italics.  
* p<.10

Table 5. Multivariate Regressions on Control Variables by TV TDP Rating
<table>
<thead>
<tr>
<th></th>
<th>EAT-26</th>
<th>Drive for Thinness</th>
<th>Body Dissatisfaction</th>
<th>Maturity Fears</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Magazine hours/week†‡</strong></td>
<td>.98 (.151)</td>
<td>.11 (.92)</td>
<td>-1.81 (1.75)</td>
<td>-.53 (.49)</td>
</tr>
<tr>
<td><strong>Control Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.06 (.10)</td>
<td>-.05 (.06)</td>
<td>-.06 (.11)</td>
<td>-.02 (.03)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-.55 (1.54)</td>
<td>.26 (.94)</td>
<td>-2.77 (1.78)</td>
<td>-.08 (.50)</td>
</tr>
<tr>
<td>Number of Children</td>
<td>-.52 (.75)</td>
<td>-.02 (.46)</td>
<td>.88 (.87)</td>
<td>.00 (.24)</td>
</tr>
<tr>
<td>Marital Status (partnered/ non-partnered)</td>
<td>.35 (2.65)</td>
<td>.57 (1.6)</td>
<td>-.61 (3.06)</td>
<td>1.56 (.85)*</td>
</tr>
</tbody>
</table>

† Unstandardized regression coefficients; standard errors are in parentheses.
‡ Independent variable appears in bold. Dependent variable appears in italics.
* p<.10

Table 6. Multivariate Regressions on Control Variables by Magazine hours/week
<table>
<thead>
<tr>
<th></th>
<th>EAT-26 Drive for Thinness</th>
<th>Body Dissatisfaction</th>
<th>Maturity Fears</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Magazine TDP rating†‡</strong></td>
<td>-1.05 (1.51)</td>
<td>-.42 (.92)</td>
<td>.89 (1.76)</td>
</tr>
<tr>
<td><strong>Control Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.09 (.10)</td>
<td>-.06 (.06)</td>
<td>-.05 (.11)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-.42 (1.52)</td>
<td>.27 (.92)</td>
<td>-2.52 (1.99)</td>
</tr>
<tr>
<td>Number of Children</td>
<td>-.52 (.75)</td>
<td>.03 (.46)</td>
<td>.88 (.87)</td>
</tr>
<tr>
<td>Marital Status (partnered/</td>
<td>.40 (2.63)</td>
<td>.52 (1.60)</td>
<td>-.87 (3.06)</td>
</tr>
<tr>
<td>non-partnered)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Unstandardized regression coefficients; standard errors are in parentheses.
‡ Independent variable appears in bold. Dependent variable appears in italics.
* p<.10

Table 7. *Multivariate Regressions on Control Variables by Magazine TDP Rating*
References


Appendix A

26-Item Eating Attitudes Test (EAT-26)*

Instructions: Circle the choice below each question which best describes your habits or attitudes.

1. I am terrified about being overweight.
   Always     Usually    Often    Sometimes    Rarely    Never

2. I avoid eating when I am hungry.
   Always     Usually    Often    Sometimes    Rarely    Never

3. I find myself preoccupied with food.
   Always     Usually    Often    Sometimes    Rarely    Never

4. I go on eating binges where I feel that I may not be able to stop.
   Always     Usually    Often    Sometimes    Rarely    Never

5. I cut my food into small pieces.
   Always     Usually    Often    Sometimes    Rarely    Never

6. I am aware of the caloric content of foods that I eat.
   Always     Usually    Often    Sometimes    Rarely    Never

7. I particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.).
   Always     Usually    Often    Sometimes    Rarely    Never

8. I feel that others would prefer if I ate more.
   Always     Usually    Often    Sometimes    Rarely    Never

9. I vomit after I have eaten.
   Always     Usually    Often    Sometimes    Rarely    Never

10. I feel extremely guilty after eating.
    Always     Usually    Often    Sometimes    Rarely    Never

11. I am preoccupied with a desire to be thinner.
    Always     Usually    Often    Sometimes    Rarely    Never

12. I think about burning up calories when I exercise.
    Always     Usually    Often    Sometimes    Rarely    Never
13. Other people think that I am too thin.
   | Always | Usually | Often | Sometimes | Rarely | Never |
14. I am preoccupied with the thought of having fat on my body.
   | Always | Usually | Often | Sometimes | Rarely | Never |
15. I take longer than others to eat my meals.
   | Always | Usually | Often | Sometimes | Rarely | Never |
16. I avoid foods with sugar in them.
   | Always | Usually | Often | Sometimes | Rarely | Never |
17. I eat diet foods.
   | Always | Usually | Often | Sometimes | Rarely | Never |
18. I feel that food controls my life.
   | Always | Usually | Often | Sometimes | Rarely | Never |
19. I display self-control around food.
   | Always | Usually | Often | Sometimes | Rarely | Never |
20. I feel that others pressure me to eat.
   | Always | Usually | Often | Sometimes | Rarely | Never |
21. I give too much time and thought to food.
   | Always | Usually | Often | Sometimes | Rarely | Never |
22. I feel uncomfortable after eating sweets.
   | Always | Usually | Often | Sometimes | Rarely | Never |
23. I engage in dieting behavior.
   | Always | Usually | Often | Sometimes | Rarely | Never |
24. I like my stomach to be empty.
   | Always | Usually | Often | Sometimes | Rarely | Never |
25. I have the impulse to vomit after meals.
   | Always | Usually | Often | Sometimes | Rarely | Never |
26. I enjoy trying rich new foods.**
   | Always | Usually | Often | Sometimes | Rarely | Never |
*Title did not appear on actual survey.

**Item 26 is reverse-scored.

Scoring:
Response..........................Numerical Score
(A) Always..........................3
(B) Usually..........................2
(C) Often..............................1
(D) Sometimes.......................0
(E) Rarely............................0
(F) Never.............................0

Total Score = Numerical sum of the selected values
Eating Disorder Inventory (EDI)*

Instructions: Circle the choice below each question which best describes your habits or attitudes.

1. ** I eat sweets and carbohydrates without feeling nervous.
   Always  Usually  Often  Sometimes  Rarely  Never

2. I think that my stomach is too big.
   Always  Usually  Often  Sometimes  Rarely  Never

3. I wish that I could return to the security of childhood.
   Always  Usually  Often  Sometimes  Rarely  Never

4. I think about dieting.
   Always  Usually  Often  Sometimes  Rarely  Never

5. I think that my thighs are too large.
   Always  Usually  Often  Sometimes  Rarely  Never

6. ** I think that my stomach is just the right size.
   Always  Usually  Often  Sometimes  Rarely  Never

7. I feel extremely guilty after overeating.
   Always  Usually  Often  Sometimes  Rarely  Never

8. I think that the happiest time in life is when you are a child.
   Always  Usually  Often  Sometimes  Rarely  Never

9. I am terrified of gaining weight.
   Always  Usually  Often  Sometimes  Rarely  Never

10. ** I feel satisfied with the shape of my body.
    Always  Usually  Often  Sometimes  Rarely  Never

11. ** I would rather be an adult than a child.
    Always  Usually  Often  Sometimes  Rarely  Never

12. ** I like the shape of my buttocks.
    Always  Usually  Often  Sometimes  Rarely  Never
<table>
<thead>
<tr>
<th></th>
<th>13. I exaggerate or magnify the importance of weight.</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
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<tr>
<td>14.</td>
<td>I wish that I could be younger.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I think that the demands of adulthood are too great.</td>
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<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I think my hips are too big.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I feel happy that I am not a child anymore.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I am preoccupied with the desire to be thinner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>If I gain a pound, I worry that I will keep gaining.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I feel that people are happiest when they are children.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I think that my thighs are just the right size.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I think my buttocks are too large.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I think that my hips are just the right size.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I think that the best years of your life are when you become an adult.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>Usually</td>
<td>Often</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
</tbody>
</table>
*Title did not appear on the actual survey.
**These items are reverse scored.

Drive for Thinness Subscale Items: 1, 4, 7, 9, 13, 18, 19
Body Dissatisfaction Subscale Items: 2, 5, 6, 10, 12, 16, 21, 22, 23
Maturity Fears Subscale Items: 3, 8, 11, 14, 15, 17, 20, 24

Scoring:
Response............................Numerical Score
(A) Always.........................3
(B) Usually.........................2
(C) Often............................1
(D) Sometimes......................0
(E) Rarely...........................0
(F) Never............................0

Total Score = Numerical sum of the selected values
Appendix C

Media Consumption Questionnaire

Instructions: Please answer the questions below about your media consumption habits.

1. On average, how many hours do you spend watching television each week? (Please check the space next to the most appropriate answer.)

   ____ <1 hour        ____ 31-35 hours
   ____ 1-5 hours     ____ 36-40 hours
   ____ 6-10 hours    ____ 41-45 hours
   ____ 11-15 hours   ____ 46-50 hours
   ____ 16-20 hours   ____ 51-55 hours
   ____ 21-25 hours   ____ 56-60 hours
   ____ 26-30 hours   ____ 61+ hours

2. Please list the television programs (up to 5 max.) you watch most consistently.

3. On average, how many hours do you spend reading magazines each week? (Please check the space next to the most appropriate answer.)

   ____ <1 hour        ____ 31-35 hours
   ____ 1-5 hours     ____ 36-40 hours
   ____ 6-10 hours    ____ 41-45 hours
   ____ 11-15 hours   ____ 46-50 hours
   ____ 16-20 hours   ____ 51-55 hours
   ____ 21-25 hours   ____ 56-60 hours
   ____ 26-30 hours   ____ 61+ hours

4. Please list the magazines (up to 5 max.) you read most consistently.
Date of Birth: 11/01/1982

Place of Birth: Trenton, NJ

Hometown: Hamilton, NJ

Parents: Lynn and Larry Baldasari

Institutions Attended/Degrees: Lehigh University, 2001-05
B.A. in Political Science and Psychology
Minor in Sociology
Degree Date: May, 2005

Lehigh University, 2005-2006
M.A. in Sociology
Degree Date: May, 2006

Research Interests: Gender, race, and class inequalities; mass communication, sociology of politics; social psychology

Honors/Affiliations: Lehigh University Presidential Scholar
Departmental honors in Psychology: May, 2005
Member: Phi Beta Kappa, national honor society
Member: Phi Sigma Pi, national honor fraternity
Member: Psi Chi, national Psychology honor society
Member: National Society of Collegiate Scholars (NSCS)
END OF TITLE