

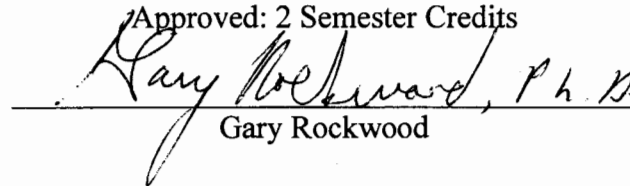
SEX APPEAL? GENDER DIFFERENCES IN UNDERGRADUATES' ATTITUDES
OF EATING DISORDERS COMPARED ALONG A CONTINUUM OF EATING
DISORDERED BEHAVIOR

by

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ABSTRACT

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Eating disorders are increasing in our society and are more prevalent on college campuses than in the general population (Harvey, 2003). Past research has indicated that there are differences between males and females in regards to their perceptions about body image and eating disorders. Past research has also indicated that there are differences between those with eating disorders and those without in regards to these issues.

The purpose of this study was to analyze data that will investigate undergraduates' feelings toward those suffering from eating disorders, assess how those

with eating disorders might view themselves and others more critically than those who do not have eating disorders, and assess perceptions of who is responsible for eating disorders. Participants were 122 undergraduate students the University of Wisconsin - Stout. They were asked to fill out two forms. The first form was the EAT-26, used to differentiate between high and low scorers, which indicated possible eating disordered beliefs and behaviors. The cut-off score used was twenty. The participants then filled out the Eating Disorders Perceptions Survey.

Data was analyzed using independent sample t-tests to assess differences between high and low scorers on the EAT-26, as well as to examine gender differences. Analysis indicated two significant findings. First, men were more concerned about their partner's physical appearance than women were. Second, women were more likely to claim to be aware of the signs and symptoms of an eating disorder. These findings, along with other insignificant findings are discussed.

Some suggestions for future research are made.

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CHAPTER I: INTRODUCTION

The eating disorders, anorexia nervosa and bulimia nervosa, are increasing in number in Westernized societies (Harvey, 2003). Adolescent females tend to be the hardest hit by the disorders, as they are the third most common chronic condition in that age group (Woods, 2004). Anywhere between one to three percent of females suffer from anorexia nervosa. The estimated percent of those suffering from bulimia nervosa could be as much as four percent of the population. The prevalence of eating disorders among female college students could be as high as twenty percent (Zuckerman, Colby, Ware, & Lazerson, 1986).

It is unknown why college students report such high rates of eating disturbances (Zuckerman, Colby, Ware, & Lazerson, 1986). However, college students are more likely than the average population to perceive themselves as being overweight. In a study conducted by Zuckerman, Colby, Ware and Lazerson (1986), twenty-eight percent of college females described themselves as terrified of being overweight. In that study, twenty-three percent of women and fourteen percent of men reported going on uncontrollable eating binges at least one time per week. While this behavior may not meet the complete criteria to identify an eating disorder, it is evidence to support the idea that there is a substantial portion of the college-aged population with troubled eating behaviors and beliefs.

Rates of eating disorders in males on college campuses are much smaller than they are in the general population (Shannon, 2004). Although the rates are less, the disorders tend to manifest in males and females with the same symptoms, and across the same range of socioeconomic status. Males are more likely, however, to suffer from

anorexia rather than bulimia. They are also less likely to be secretive about their disorder and more likely to develop the disorder at an earlier age than females (Steiger, 1989). Males who suffer from eating disorders tend to identify strongly with their mothers and describe themselves as having more “feminine” characteristics (Shannon, 2004). High self-ratings of femininity were related to depression and eating disturbances (Pettinati, Franks, Wade, & Kogan, 1987). Despite these slight differences between males and females, those afflicted with eating disorders suffer equally.

Anorexia nervosa (AN) and bulimia nervosa (BN) can be devastating for those suffering and for those trying to help the sufferer (Ansari, 1994). Anorexia nervosa is best described by its literal translation, “loss of appetite for nervous reasons”. The symptoms of anorexia nervosa include a morbid fear of becoming fat, distorted thinking that can exacerbate symptoms, problems regulating mood, and perfectionism.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision (DSM - IV-TR) (American Psychiatric Association, 2000) lists specific criteria that must be present in order for an individual to receive a diagnosis of anorexia nervosa. The first is an intense fear of gaining weight. The second is a severe disturbance in the way in which one views their body. The third criterion is the presence of amenorrhea or loss of the menstrual period in females for three months or longer. Finally, the individual must refuse to maintain normal body weight. Those suffering typically weigh less than 85% of their normal healthy body weight (Harvey, 2003). They typically suffer low self-esteem, feelings of ineffectiveness, and anxiety, depression, or both.

Extreme stress placed on the body causes hormonal and physiological abnormalities (Bassoe, 1990). Due to the extreme weight loss, the hypothalamic-pituitary

function in the brain of those suffering becomes impaired. Satiety and hunger signals are no longer detected. It is thought that those with anorexia starve for a certain period of time before their body simply “lets go” and they give in to bingeing (Russel, 2004). When this happens, the chances increase that the person will develop bulimia nervosa.

Nearly one half of those with anorexia nervosa will develop bulimia nervosa (Kassett, Gwirtsman, Kaye, Brandt, & Jimerson, 1988). Bulimia is similar to anorexia in some ways (Harvey, 2003). Both disorders are characterized by an intense fear of becoming fat. Both have idealized and exaggerated views of femininity (Pettinati, 1987). Both strive for perfection. Those with eating disorders tend to be hypersensitive to criticism. They have an extreme fear of failure and want to be seen as “good” by others. Serious health problems occur as a result of both disorders. Both are characterized by a distorted view of their bodies and other cognitive dysfunction.

The DSM IV – TR (American Psychiatric Association, 2000) also identifies specific criteria that must be present in order to receive a diagnosis of bulimia nervosa. The first criterion is the presence of bingeing, characterized by eating an extremely large amount of food in a short time and feelings of lack of control. The second criteria is purging through the use of vomiting, laxatives, diuretics, or another method. The third criterion is that the behaviors occur at least twice a week. The fourth criterion is self-evaluation regulated by how much the person weighs. The final criterion is that the symptoms do not occur during periods of anorexia nervosa.

The defining criterion for bulimia is the presence of a binge/purge cycle (Abraham, & Beaumont, 1982). A massive amount of food is consumed within a discrete period of time. This is the binge. The food is then purged through vomiting, enemas,

laxatives, or diuretics (Harvey, 2003). Excessive exercise and starvation is another lesser-used form of purging. Bulimia is often begun following a period of extreme dieting. It is thought that during this dieting, depriving the brain of necessary nutrients and minerals could have the same effect on the hypothalamus as when the anorectic starves (Bassoe, 1990). The woman no longer reacts to normal cues of hunger and satiety.

Bulimia was once thought to be a result of anorexia (Russell, 2004). This was due to its characteristic behaviors first being recorded in the 1970's as a result of force-feeding those with anorexia. In addition, the dreaded fear of fatness was common to both disorders. It was relatively unheard of before the 1960's, possibly reflecting the changing culture of Westernized societies. More research proved, however, that not all persons suffering from bulimia had been anorexic or emaciated prior to their first binge episode. Bulimia was first identified as a separate disorder in 1980, in the third edition of Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980).

Statement of the Problem

Anorexia nervosa and bulimia nervosa are notoriously difficult to detect and treat (Woods, 2004). This is evident in statistical data on patients in recovery. About fifty percent do well in in-patient treatment. Thirty percent make progress but continue to suffer symptoms. Twenty percent will do poorly. One percent will die (Bassoe, 1990). This could be due to inadequate treatment methods or a failure to completely understand the dynamics involved in developing an eating disorder.

Due to the victim's need to appear perfect to others, there is often a perceived need for secrecy and extreme shame felt by those suffering from the disorders (Shannon, 2004). Victims of anorexia and bulimia may keep their eating disorders secret for years due to fears of being judged or shamed. Adults suffering from eating disorders are at a higher risk for isolation from friends and family. As the disorder progresses, it becomes the main focus in the person's life. They invest more time, money, and energy into their disorder. This distorted thinking could prevent those suffering from seeking help, in addition to seeking the support of friends and family members after treatment has begun (Shannon, 2004).

The purpose of this study is to assess eating disordered beliefs and behaviors among undergraduate students. In addition, this study will explore how these beliefs and behaviors may affect individuals' perceptions of other undergraduate students regarding eating disorders. The practical implications of this study include gaining evidence to combat distorted thinking among those suffering from eating disorders.

Purpose of the Study

Despite the cognitive distortions and poor outcomes of patients in treatment for eating disorders, there are improved chances for those who are willing or able to reach out to friends and family members for support (Woods, 2004). In one study, the help and support of boyfriends, parents and best friends were all that were needed for those suffering eating disorders to make full recoveries without professional treatment. It is important that those suffering from eating disorders understand that they can reach out for help and that they are not alone.

The purpose of this particular study is to analyze data that will investigate individuals' feelings toward those suffering from eating disorders. If it is found that most individuals are empathic toward those suffering from eating disorders, this could make it easier for them to ask their friends, family, and significant others for help. In addition, this study was performed to examine data about how those with eating disorders might view themselves and others much more critically than those who do not have eating disorders. This information could have valuable implications in treating eating disorders as well as encouraging suffering individuals to seek treatment. Data will also be collected on individuals' perceptions of who is responsible for developing an eating disorder.

Another purpose of this study is to investigate eating disordered individuals' perceptions of others. Numerous studies have indicated that persons with eating disorders have low self-esteem and poor body image (Harvey 2003). Not much research is available on how individuals with eating disorders view others, or how judgmental they are of others' appearances.

Data comparing males' and females' perceptions about eating disorders will also be analyzed. This could yield information concerning future efforts to increase awareness in undergraduate students. These results could also indicate possible ways of enhancing treatment for those with eating disorders.

Null Hypotheses

The Eating Disorders Perceptions Survey was used in creating the null hypotheses of this study. For the purposes of this study, the EAT-26 yields only one score that is either indicative of eating disordered behaviors or of normal attitudes or eating behaviors.

Ho1: There is no difference between those with high and low scores on the EAT-26 in their identified importance of the physical appearance of their partner.

Ho2: There is no difference between males and females in the identified importance of the physical appearance of their partner.

Ho3: There is no difference between those with high and low scores on the EAT-26 in their identified level of awareness of the signs and symptoms of eating disorders.

Ho4: There is no difference between males and females in their identified level of awareness of the signs and symptoms of an eating disorder.

Ho5: There is no difference between scores on the EAT-26 and an individual's willingness to help someone suffering with an eating disorder.

Ho6: There is no difference between gender and an individual's willingness to help someone suffering with an eating disorder.

Ho7: There is no difference between scores on the EAT-26 and perceptions of who is responsible for eating disorders.

Ho8: There is no difference between gender and their perceptions of who is responsible for eating disorders.

Assumptions of the Study

Assumptions are being made in reporting the results of this study. The first assumption is that a score on the EAT-26 that is above the cut-off score for eating disordered behaviors and beliefs does indeed indicate the presence of eating disordered behaviors and beliefs. Although a higher score on the EAT-26 is not a definitive indication of an eating disorder, the assumption being made in this study is that a higher score is sufficient cause to suspect unhealthy beliefs, patterns, or behaviors.

Definition of Terms

Anexoria Nervosa: an eating disorder characterized by severe weight loss, either through restricting food intake or purging food eaten

Amenhorria: the cessation of menstruation brought on by starvation

Bulimia Nervosa: an eating disorder characterized by a cycle of bingeing and Purging

Enmeshment: “weak or ill-defined boundaries” (Bachner-Melman, 2003, p. 12)

Self-esteem: how one feels about him or her self

Self-efficacy: how effective one feels in his or her own life

Body-image: a person’s thoughts, beliefs and feelings about their body

Personality Disorders: a pervasive and enduring pattern of maladaptive behaviors that seem to characterize an individual.

Defense Style: use of psychological defense mechanisms that tends to become progressively more mature with age in healthy individuals.

Limitations of the Study

There are some limitations to be considered when interpreting the results of this study. First, the study was done using a sample of convenience, composed of undergraduate students at University of Wisconsin – Stout. The participants were predominantly Caucasian, heterosexual, and of a similar age group. The participants were of a similar cultural background. The results may not be able to be generalized over the entire population.

CHAPTER II: LITERATURE REVIEW

The purpose of this chapter is to provide background information on eating disorders, their causes, risk factors, and common features. Previous research investigating male and female differences in body image and eating disorder pathology will also be discussed. The first section discusses possible risk factors, and social and cultural influences. The second section discusses the role that the family plays, both in genetic contributions and interpersonal interactions. The following section overviews treatment information and possible physical complications of the disorders. The next section discusses the cognitive factors, including personality disorders and concomitant psychopathology. The fifth section talks about body image as a variation of gender. Finally, a summary follows.

Social and Cultural Influences

Many risk factors have been identified in the development of an eating disorder (Bassoe, 1990). Injuries, hospitalizations, interpersonal difficulties or stress have all been cited as preceding an episode of anorexia or bulimia nervosa. Genetics have also come under scrutiny as a predetermining factor in developing an eating disorder. While no one risk factor can be designated as causing an eating disorder, it is thought that the value placed on extreme thinness by Westernized culture plays a large role. Family dynamics are important as well. The one universal factor in triggering the development of an eating disorder is a significant loss of weight, either purposefully or accidentally (Harvey, 2003).

Social and cultural influences clearly play a role in the formation of an unhealthy body image and an eating disorder (Demarest, & Allen, 2000). Westernized societies have the highest rates of eating disorders. The westernized ideal image of beauty has been extremely thin for the last forty years. In developing countries, there is a trend toward an increasing incidence of eating disorders as westernized culture spreads. The media is largely blamed for portraying extremely thin women as the standard of ideal beauty.

Much of the research done on the media and its influence on body image has been etiological in nature (Field, 2000). Trends in fashion over the last forty years have moved toward a thinner, more androgynous shape for models. In one study done by Field (2000), women who read fashion magazines on a regular basis were more likely to be concerned about their weight or to be dieting than women who read them only sometimes. It is not clear why some internalize these ideals and others do not. Certain dynamics come into play that indicate distorted thinking and the presence of other mental disorders.

Family Dynamics and the Role of Genetics

Family dysfunction has long been recognized as being highly correlated with eating disorders (Harvey, 2003). These dynamics begin in infancy, when needs for support or security are not adequately met. The infant then forms insecure attachments. This leads to fear of their surroundings, preoccupation with the self, and low self-esteem.

These early conditions can then be carried into childhood, where they may be exacerbated by their parents' poor parenting (Harvey, 2003). Up to 40% of nine or ten

year old girls are on a diet because their mother encouraged them to lose weight. This can be termed “family projection process” (Bowen, 1992, as cited in Bachner-Melman, 2003), which describes a same sex parent instilling his or her own low self-esteem and poor body image in the child. Mothers of those with anorexia tend to be over-involved in their child’s life, overly critical, and controlling. Those with bulimia tend to have insecure attachments to their mothers, who are typically critical and abusive. Overly critical fathers have also been implicated in the development of an eating disorder

High achievement, unrealistic standards, and the need to impress others often characterize the family system (Bachner-Melman, 2003). In these homes, achievement is stressed and flaws are not often overlooked. Those with eating disorders often cite feelings of never being good enough for their parents, even though they are hopelessly enmeshed. Often parents will answer their children’s questions or reinterpret their children’s statements. An example of this is, “you aren’t sad; you are just tired.” In doing this, the parent trains the child to ignore their feelings and dissociate from their own experiences.

Those with eating disorders also tend to report a lack of conflict resolution in their families of origin (Bachner-Melman, 2003). Often a high priority is placed on peace within the home and portraying the image of an ideal family, even though chaos may be lurking below the surface. The conflict is often ignored, brushed off, or reinterpreted. Disagreement within the family is often seen as betrayal.

The eating disordered child is often pulled into the parental conflict, known as triangulation (Bachner-Melman, 2003). One of the parents will often expect the child to take sides with them against the other parent. The boundaries between parent and child

are often non-existent. The child is then made to feel guilty whether they take sides or not. Often, this takes the form of the mother and child forming an alliance with each other, with the father being excluded (Bowen, 1978, as cited in Bachner-Melman, 2003).

Those with bulimia tend to more frequently report having been the victims of abuse or neglect (Harvey, 2003). As many as 35% of those with bulimia have been sexually abused as a child. Other forms of abuse, such as emotional or physical, tend to be reported in higher numbers. Neglect is also commonly reported. Many of those with anorexia and bulimia are the children of parents who abuse alcohol or other drugs, or are mentally ill.

There is also some evidence that anorexia and bulimia are genetically transmitted (Killian, 1994). The first-degree relative of a person with anorexia is eight times more likely to develop anorexia than an individual without a family history of the disorder. The first-degree relative of a person with bulimia nervosa is four times more likely to develop bulimia than an individual without a family history of the disorder. Families of those with anorexia and bulimia are more likely to contain alcoholics, substance abusers, and those with major affective disorders.

Some more evidence on the heritability of eating disorders has been gained from twin studies (Harvey, 2003). Twins had a tendency to develop the same eating disorders and to follow similar courses of the illnesses. In one study, identical and fraternal twins were compared. Identical twins were more likely to have anorexia nervosa if their twin had it (Cosh, 2002). Genes accounted for 74 percent of the variance of the occurrence of anorexia nervosa and 58 percent of the variance in bulimia nervosa.

Also, inherited lower levels of serotonin, norepinephrine and dopamine have been associated with the development of eating disorders (Harvey, 2003). Those with Obsessive compulsive disorder (OCD) have been found to share the same disturbances in their serotonin neurotransmitter systems (Kennedy & Garfinkel, 1992). In addition, those suffering from an eating disorder are more likely to have a family member with OCD.

Treatment Methods and Physical Complications

Given the strong evidence for the biological cause and heritability of eating disorders, it is not surprising that more and more clinicians are resorting to biological treatments such as drug therapies (Kennedy & Garfinkel, 1992). These pharmacotherapies act directly on the neurotransmitter systems that are not functioning properly. Antidepressants such as clomipramine and fluoxetine are commonly used to treat eating disorders, OCD, and depression. Hormone therapies have also had some success in treating eating disorders and depression.

Drug therapies alone are often not sufficient to deal with the distress experienced by those suffering with an eating disorder and co morbid conditions (Kennedy & Garfinkel, 1992). These drug therapies cannot alter patient's beliefs and feelings about their weight, or increase their self-esteem. Cognitive behavioral therapy is often the best therapy to use when treating an individual with bulimia nervosa. Keeping a daily food record to track the bingeing and purging behavior often becomes a central part of the treatment. Exposure and response prevention (ERP) is also used with bulimia patients. In this technique, the client is exposed to the foods that trigger a binge. The client then eats the food, but is prevented from purging the food afterward.

Other forms of therapy used in treating bulimia are group therapy, interpersonal therapy, and psychodynamic therapy (Kennedy & Garfinkel, 1992). Group therapy has been found to be especially beneficial to bulimia patients. Psychodynamic therapies have not been well studied but it is believed that incorporating techniques from all therapies may be beneficial depending on the individual client and their circumstances.

Family therapy is crucial in treating both anorexia and bulimia due to the strong family dysfunction that is usually associated with the disorder (Baird & Sights, 1986). The focus of family therapy is often individuation of the child, with an emphasis on learning to recognize and interpret their inner states and feelings. Often, being forced to make their own choices and develop their own identity is a significant part of the patient's recovery.

Research on the effectiveness of various treatments of anorexia nervosa is limited (Kennedy & Garfinkel, 1992). A combination of dietary advice, family counseling, and some cognitive-behavioral therapies are generally used in treating AN. Those with anorexia nervosa tend not to respond as well as those with bulimia nervosa to drug treatments.

The effects from eating disorders can be devastating, both physically and psychologically (Woods, 2004). Due to hormonal abnormalities brought on by malnutrition, the thyroid, pituitary gland and amygdala are often found to have regulatory problems. Ability to cope with stress is significantly decreased, as is mood, libido, and energy (Harvey, 2003). Serotonin and tryptophan, the neurotransmitters responsible for elevated mood and mood regulation, are decreased.

Those suffering with anorexia and bulimia are more susceptible to infections (Harvey, 2003). Dental erosion, acid reflux disease and osteoporosis are all long-term effects of the purging common to bulimia. Abnormal heart rhythms may develop, in addition to problems swallowing or ruptures to the esophagus. Those with eating disorders are at a higher risk for developing concomitant psychiatric conditions. In addition, they are more likely to engage in self-destructive or impulsive behavior such as sexual promiscuity, self-mutilation, or abuse alcohol or substances. It is not surprising that eating disorders, collectively, have the highest mortality rate of any mental disorder.

Patients can become chronic (Kennedy & Garfinkel, 1992). As each year passes, the individual's chances of making a full recovery decrease. These patients often do not respond well to long-term hospitalizations. They do better if admitted for short terms, usually to stabilize the reemergence of symptoms.

Cognitive Disturbances, Comorbidity, and Personality Disorders

A possible cause, and one of the largest problems in treating an eating disorder, is the distorted thinking and cognitive deficits that are often seen in persons suffering from the disorder (Etringer, Altmaier, & Bowers, 1989). Many of those with eating disorders have been found to have excessive guilt feelings around dieting, exercise, and eating behaviors (Bybee & Zigler, 1996). There is a high co-morbidity between eating disturbances and depression, including pervasive feelings of hopelessness, ineffectiveness, and lack of emotional regulation (Etringer, Altmeier, and Bowers, 1989). Despite these factors, those with eating disorders are likely to have unrealistically high standards for themselves, coupled with an intense drive for perfection. Both groups tend

to have high moral standards, rigid adherence to traditional values, and can be judgmental of others' moral behavior (Casper, Hedeker, & McClough, 2001).

This distorted thinking may also lead those suffering from an eating disorder to grossly overestimate the size of their bodies (Harvey, 2003). Harvey (2003) named this syndrome Body Dysmorphic Disorder, common among women and Muscle Dysmorphic Disorder, common among males. Those with Body Dysmorphic Disorder tend to overestimate the size of their bodies. This is usually the result of cultural messages or possibly biological causes. This syndrome typically occurs concurrent with an eating disorder.

In contrast, those with Muscle Dysmorphic Disorder, especially common in males, tend to underestimate the amount of muscle mass they have (Harvey, 2003). These males tend to see themselves as too weak, not muscular enough, or not masculine enough. This may cause them to spend hours in the gym or take other unhealthy measures to build muscle, such as steroid use. This overestimation or underestimation of body size could then be perceived by the eating disordered individual as coming from others, rather than realizing that it is their own distorted perception.

In addition to these comorbid conditions, Obsessive compulsive disorder is also highly correlated with the occurrence of eating disorders (Kennedy & Garfinkel, 1992). Eating disorders and OCD share many symptoms such as obsessive thoughts. In one study among OCD patients, conducted by Kennedy and Garfinkel (1992), up to 17% were found to have anorexia nervosa, in comparison to around one to three percent affected in a normal population. Based on these findings, it is reasonable to assume that eating disorders occur more frequently among individuals with other mental disorders.

Eating disorders have also been found to occur more frequently among those with personality disorders (Kennedy & Garfinkel, 1992). Personality disorders can be described as an enduring set of maladaptive characteristics and traits. The DSM IV- TR recognizes three such “clusters” of personality disorders (American Psychiatric Association, 2000). The first is the odd or eccentric group and includes paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder. The second group is the impulsive or dramatic cluster. This group consists of the borderline, histrionic, narcissistic, and antisocial personality disorders. Finally, the anxious or fearful cluster consists of the avoidant, dependent, and obsessive compulsive personality disorders.

Personality disorders are very common among those with eating disorders and can indicate a poor prognosis in treatment (Fahy, Eisler & Russell, 1993). The evidence of personality disorders can be detected during the beginning stages of anorexia nervosa. It is thought to be unlikely that the personality disorders are the result of an eating disorder. Rather, they are thought of as predetermining features in the development, course and prognosis of the diseases. Personality disorders tend to be more prevalent in those with bulimia nervosa.

Certain personality disorders occur more frequently among those with eating disorders (Harvey, 2003). Those with anorexia nervosa are most often diagnosed with avoidant and dependent personality disorders. Those diagnosed with avoidant personality disorder tend to be perfectionists. They function well in society and set high standards for themselves and others. On the contrary, those diagnosed with dependent personality disorder tend to very controlled and isolate themselves from others.

Certain personality disorders tend to accompany bulimia nervosa as well (Harvey, 2003). Those personality disorders are borderline and histrionic personality disorders. Borderline personality disorder is the most commonly occurring personality disorder among those with bulimia nervosa. This person is characterized by unstable moods, impulsively, and insecurity. They tend to drive people away from them and live in chaos due to their uncontrollable tempers. They are terrified of being abandoned and they tend to idolize others. They are extremely sensitive and unable to comfort themselves. They often feel rejected and disappointed by those that they love. Similarly, those with histrionic personality disorder crave attention. They are impulsive and often engage in attention-seeking behaviors. Those suffering with anorexia nervosa and bulimia nervosa tend to have similar personality features as well. Personality features such as moral rigidity, perfectionism, and inability to accept criticism may account for the defense styles common to those with eating disorders.

Defense style is the way in which people use psychological defenses to manage unpleasant feelings (Schmidt, Slone, Tiller, & Treasure, 1993). They are ways in which individuals manage unpleasant feelings and control impulses. Examples of defense mechanisms are projection, denial, and rationalization. Mature defenses are defined as those that allow the individual to manage unpleasant feelings and use humor or admiration to cope with trauma. Immature defenses are said to be those that force the individual into fantasy or dissociation; acting out aggressively; development of somatic complaints; blaming others; or isolation. Those with AN and BN were found to have less mature defense styles than their peers did. Those with bulimia nervosa tended to have less mature defense styles than those with anorexia nervosa. This is believed to be due,

however, to the increased family dysfunction and childhood trauma experienced by those with bulimia nervosa.

Body Image Variations as a Function of Gender and Eating Pathology

Regardless of family dynamics and gender, women are typically more dissatisfied with their bodies than are males (Demarest, & Allen, 2000). In one study by Demarest and Allen (2000) both men and women misjudged what they thought would be perceived as attractive by the opposite sex. Men identified bulkier shapes as being attractive to women. Women, on the other hand, thought that men would find thinner silhouettes attractive. Both the men and the women exaggerated what the opposite sex actually found attractive. Caucasians were the most likely to exaggerate this difference. Women felt that men would be more attracted to thinner figures, but this was not what men indicated as being the most attractive to them. In addition, women did not correctly identify what parts of the body men would find attractive. It is not clear what caused these cognitive distortions to be present, but culture is thought to play a role in them.

Research has indicated that women are somewhat justified in assuming that males are attracted to a very thin figure (Cohn & Adler, 1992). Men are more likely to judge women's attractiveness based on their size and shape than on other attributes, especially personality characteristics. Women, on the other hand, are more likely to judge men's attractiveness based on personality characteristics or personal virtues. According to one study done by Stiles, Gibbons, & Schnellman (1990), this preference was first evident in ninth grade adolescents.

This discrepancy in what others find attractive is not simply a function of gender. College women with abnormal eating behaviors are more likely to over-estimate how thin a woman should be in order to be considered attractive by men (Zellner, Harner, & Adler, 1989). Women were more likely than men to identify a thinner ideal than men, and more likely to desire a thinner body than what they felt they had. This pressure might also arise from female to female comparisons of what is an ideal weight (Cohn & Adler, 1992).

Summary

There are many possible causes and risk factors for developing an eating disorder. Social and cultural influences play a role. Family dynamics and genetics can play a role. Treatment methods vary depending on the individuals' specific circumstances and needs for medical treatment. Overall, women tend to be more dissatisfied with their body image than men and have a lower self-esteem. Both men and women exaggerate what the opposite sex would find attractive. Men are more likely to judge a woman based on how thin she is, and women are more likely to perceive that they need to lose weight.

The purpose of this study is to investigate how various perceptions and beliefs differed as a function of gender and eating pathology, as indicated by the EAT-26 survey. The EAT-26 and the Eating Attitudes and Perception Survey will be discussed in more detail in the following chapter. Statistical procedures will also be discussed.

CHAPTER III: METHODOLOGY

As stated previously, anorexia nervosa and bulimia nervosa are notoriously difficult to detect and treat (Woods, 2004). Thirty percent make progress but continue to suffer symptoms. Twenty percent will do poorly. One percent will die (Bassoe, 1990). As the disorder progresses, it becomes the main focus in the person's life. More and more becomes invested in the disorder, and could prevent those suffering from seeking help, in addition to seeking the support of friends and family members after treatment has begun (Shannon, 2004). If those in need of treatment perceived that they would have the help and support of family members and significant others in their lives, it is hypothesized that they would be more willing to seek treatment and to reach out to others during that treatment.

This study was performed in order to survey attitudes and perceptions on college campuses concerning eating disorders and body image. This section will address the sample population; survey instruments used; data collection procedures; methods of data analysis; and limitations of the study.

Subject Selection and Description

The sample population was 122 undergraduate college students at University of Wisconsin – Stout in Menomonie, Wisconsin. The students ranged in age from 18 to 49. Sixty-seven of them were male and fifty-five of them were female. They had a broad range of prospective majors. Students were recruited from education, business, technology, and human development classes. The study was explained to the students and participation was voluntary.

Instrumentation

Two surveys were used to collect the data. The first survey was the Eating Attitudes Test – 26 (EAT-26). This survey instrument collects data that can indicate the possibility of disordered eating behaviors and beliefs (Fischer & Corcoran, 1994). This is an objective measure, with questions given in a likert format. A high score of 3 is given for extreme answers such as “always”, and a score of 1 or 2 given for answers such as “often” or “very often”. The cut-off score used with this instrument is 20. If a participant’s score is higher than 20, that does not mean that the person has an eating disorder. It is only suggestive of a possible problem.

When used to discriminate between anorectic and normal subjects, The EAT-26 has internal consistency of .94 as assessed by coefficient alpha (Fischer & Corcoran, 1994). The coefficient was .79 when used with only anorectics. Known factor group validity was also tested. The Restraint scale, weight fluctuation, extroversion, and neuroticism were shown to be independent. Studies done with recovered anorexics also indicated that the scale was sensitive to change in the subjects’ self-reported change in behaviors and attitudes.

The EAT-26 has been shown to be reliable and valid when used to detect the presence of eating disordered beliefs and behaviors (Williamson, Anderson, Jackman, and Jackson., 1995). It can discriminate between anorexia and bulimia when using a cut-off score of 30. The EAT-26 was not intended to diagnose an eating disorder or discriminate between eating disorders in the current study. It was intended only to indicate disordered behaviors and beliefs.

The second survey used was the Eating Disorders Perceptions Survey.

This instrument was designed for the present study to survey various attitudes and perceptions concerning body image, eating disorders, and beliefs. The survey was divided into four subscales: weight related perceptions; eating disorder awareness; helping behaviors and concern; and attributions. No reliability and validity data are available for the Eating Disorders Perceptions Survey.

The first subscale, weight related perceptions, measured individuals' beliefs about body image and what they found to be attractive in members of the opposite sex. The second subscale, eating disorder awareness, measured how knowledgeable individuals were about the signs and symptoms of eating disorders, and their experiences with eating disordered individuals. The third subscale, helping behaviors and concern, measured individuals' willingness to participate in a treatment and recovery program with an individual and whether or not they would be willing to confront somebody they suspected of having an eating disorder. The final scale, attributions and blame, surveyed who or to what individuals attributed responsibility for the development of an eating disorder (see Appendix A).

Data Collection Procedures

Three undergraduate classes were visited shortly after class time had begun. One class was in the business major, one class was predominantly composed of education majors, and the final class was predominantly composed of Human Development and Family Studies majors. The purpose of the study was explained to the students. Students were asked to sign a consent form that stated that they were participating voluntarily and

that they might withdraw their participation at any time. The consent forms were collected first. They then filled out both surveys. The class was advised that any student wishing to receive follow up services concerning the subject matter of the study was to call the principle researcher or the campus counseling center. Both phone numbers were provided for students to write down if they chose to do so.

Data Analysis

The data for the study was then analyzed using independent sample t-tests. The t-tests were used to discover any significant differences between subjects with high versus low scores on the EAT-26 in relation to the four subscales of the Eating Disorder Perceptions Survey (EDPS). Also t-tests were used to discover any significant differences between males and females in relation to the four subscales of the EDPS.

Limitations

One of the limitations of this study is that the participants may not be representative of the entire undergraduate population in the United States. The participants were predominantly Caucasian American. There was little ethnic and racial diversity among the sample. The participants might have thought that they were expected to participate and this might have changed the way they answered the questions. Two surveys were used and this might have caused some students to randomly pick answers to complete them quickly. Finally, only nine participants, eight women and one man, had scores that were indicative of pathological eating beliefs and behaviors. This is much lower than expected, and could have affected the results of the study.

CHAPTER IV: RESULTS

Introduction

The purpose of this study was to gain information about college-aged individuals' beliefs and perceptions concerning body image and eating disorders. Undergraduate students were surveyed on a number of factors, including their own eating behaviors and beliefs. Sixty seven males and fifty five females participated in the study. Independent t-tests were then performed to analyze the data, comparing the four subscales on the Eating Disorders Perceptions Survey with total scores on the EAT-26 and gender. A two-tailed alpha level of .05 was used to indicate significant results.

Ho1: There is no difference between those with high and low scores on the EAT-26 in their identified importance of the physical appearance of their partner.

A t-test was conducted to determine whether there were any significant differences between high and low scorers on the EAT-26 in terms of individuals' identified importance of their partner's physical appearance. Data analysis revealed no significant difference between those with high and low scores on the EAT-26 and the identified importance of their partner's physical appearance ($t = 1.233, p = .960$). As a result, null hypothesis Ho1 was not rejected.

Table 1**t-test Between Those with High and Low Scores on the EAT-26 Regarding the Importance of Physical Appearance of their Partner**

EAT	M	SD	df	t	p
Hi Scores	3.0	.676	120	1.233	.960
Low Scores	3.01	.688			

Ho2: There is no difference between males and females in the identified importance of the physical appearance of their partner.

A t-test was conducted to determine whether there was any significant difference between an individuals' gender and their identified importance of the physical appearance of their partner. Data analysis revealed a significant difference between an individuals' gender and the identified importance of physical appearance of their partner ($t = 4.197, p = < .001$). Therefore, null hypothesis Ho2 was rejected and it was concluded that there is a difference between males and females in the identified importance of physical appearance of their partner. Males placed more emphasis on their partner's physical attractiveness than did females.

Table 2**t-test Between Males and Females Regarding the Importance of Physical Appearance of their Partner**

Gender	M	SD	df	t	p
Males	3.23	.660	120	4.179	.000*
Females	2.74	.620			

* significant at $p < .001$

Ho3: There is no difference between those with high and low scores on the EAT-26 in their identified level of awareness of the signs and symptoms of eating disorders.

A t-test for independent sample was conducted to determine whether there was a significant difference between those with high versus low scores on the EAT-26 and an individuals' awareness for the signs and symptoms of an eating disorder. Data analysis revealed no significant difference between those with a high and low score on the EAT-26 and levels of awareness of an eating disorder ($t = .905$, $p = .367$). Therefore, null hypothesis Ho3 was not rejected.

Table 3**t-test Between Those with High and Low Scores on the EAT-26 in the Level of Awareness of the Signs and Symptoms of an Eating Disorder**

EAT	M	SD	df	t	p
High Scores	3.79	.532	120	.905	.367
Low Scores	3.60	.604			

Ho4: There is no difference between males and females in their identified level of awareness of the signs and symptoms of an eating disorder.

A t-test for independent sample was conducted to determine whether there was a significant difference between males and females in their level of awareness of the signs and symptoms of an eating disorder. Data analysis revealed that there was a statistically significant difference between males and females and their identified level of awareness in the signs and symptoms of an eating disorder ($t = 2.284$, $p = < .05$). Therefore, null hypothesis Ho4 was rejected. It was concluded that gender does play a role in an individual's identified level of awareness of the signs and symptoms of an eating disorder. Women claimed to be have more awareness than men did.

Table 4

t-test Between Males and Females in the Level of Awareness of the Signs and Symptoms of an Eating Disorder

Gender	M	SD	df	t	p
Male	3.51	.664	120	2.284	.024*
Female	3.75	.484			

* significant at $p < .05$

Ho5: There is no difference between scores on the EAT-26 and an individual's willingness to help someone suffering with an eating disorder.

A t-test was conducted to determine whether there was a significant difference between those with high scores and those with low scores on the EAT-26 regarding an individual's willingness to help someone suffering with an eating disorder. Data analysis

revealed that there was no significant difference between individuals with high scores and individuals with low scores and their willingness to help someone suffering from an eating disorder ($t = 1.230$, $p = .221$). Therefore, null hypothesis Ho5 was not rejected.

Table 5

t-test Between Those with High and Low Scores on the EAT-26 in Individuals' Willingness to help the Victim of an Eating Disorder

EAT	M	SD	df	t	p
High Scores	4.63	.389	120	1.230	.221
Low Scores	4.39	.572			

Ho6: There is no difference between gender and an individual's willingness to help someone suffering with an eating disorder.

A t-test independent sample was conducted to determine whether gender would be a factor in an individual's willingness to help someone suffering from an eating disorder. Data analysis revealed no significant differences between gender in regards to individual's willingness to help someone suffering with an eating disorder ($t = .881$, $p = .380$). Therefore, null hypothesis Ho6 was not rejected.

Table 6

t-test Between Males and Females in Individuals' Willingness to help the Victim of an Eating Disorder

Gender	M	SD	df	t	p
Male	4.37	.602	120	.881	.380
Female	4.46	.513			

Ho7: There is no difference between scores on the EAT-26 and perceptions of who is responsible for eating disorders.

A t-test independent sample was conducted to determine whether there was a significant difference between individuals with high scores and low scores on the EAT-26 in regards to their perceptions of who is responsible for an eating disorder. Data analysis revealed no significant differences between individuals with low and high scores on the EAT-26 and perceptions of who was responsible for an eating disorder ($t = .526$, $p = .600$). Therefore, null hypothesis Ho7 was not rejected.

Table 7

t-test Between Those with High and Low Scores on the EAT-26 in their Perceptions of Who is Responsible for an Eating Disorder

EAT	M	SD	df	t	p
High Scores	3.74	.969	120	.526	.600
Low Scores	3.92	.803			

Ho8: There is no difference between gender and their perceptions of who is responsible for an eating disorder.

A t-test of independent samples was conducted to determine whether gender would be a factor in individuals' perceptions of who is responsible for an eating disorder. Data analysis revealed that there was no significant difference between an individual's gender and who they believed to be responsible for an eating disorder ($t = 1.220$, $p = .225$). Therefore, null hypothesis Ho8 was not rejected.

Table 8**t-test Between Males and Females in their Perceptions of Who is Responsible for an Eating Disorder**

Gender	M	SD	df	t	p
Male	3.83	.602	120	1.220	.225
Female	4.00	.755			

Summary

In summary, the following results have been produced by this study. Two of the eight null hypotheses were rejected. Null hypothesis Ho2 was rejected, indicating that there is a significant difference between males and females in the identified importance of physical appearance of their partner. The results from this study indicate that males place more importance of the physical attractiveness of their partner. Null hypothesis Ho4 was also rejected, and it was concluded that gender does play a role in an individual's identified level of awareness of the signs and symptoms of an eating disorder. Women were more likely to identify themselves as having high awareness of eating disordered beliefs and behaviors. No significant differences were found between high versus low scores on the EAT-26 on any of the four variables investigated. Conclusions and recommendations for future study will be discussed in the following chapter.

CHAPTER V: DISCUSSION

This chapter will summarize the research and data presented in this study. Recommendations for future study and how this information applies to college aged individuals and those suffering with an eating disorder will also be addressed.

Summary

In summary, eating disorders are becoming more prevalent in our society and they are a bigger problem on college campuses than in the general population (Zuckerman, Colby, Ware, & Lazerson, 1986). There are many risk factors that could predispose an individual to develop an eating disorder (Harvey, 2000; Bassoe, 1990; and Field, 2000). Those suffering from an eating disorder are often secretive about their behaviors and hesitant to reach out for help (Woods, 2004). They often have distorted thought processes and comorbid conditions are common. Defense styles are often immature and treatment progresses slowly if at all (Schmidt, Slone, Tiller, & treasure, 1993). Eating disorders strike women more often than men. Women are more dissatisfied with their body images overall, and women with eating disorders are more likely to perceive thinner women as being more attractive (Demarest & Allen, 2000; and Zellner, Harner, & Adler, 1989). Men are more likely to judge attractiveness on a woman's size and shape (Cohn & Adler, 1992).

The purpose of this study was to collect data concerning individual's perceptions of eating disorders. The study was also designed to collect data that would investigate eating disordered individuals' perceptions of others. One hundred twenty-two undergraduate students at University of Wisconsin - Stout participated in the study. The

Eating Attitudes Test-26 (EAT-26) was used to identify pathological beliefs and behaviors. The Eating Disorders Perceptions Survey was designed for the purpose of this study to collect information about undergraduates' perceptions and beliefs about eating disorders. The four sub-scales were weight related perceptions, eating disorder awareness, helping behaviors and concern, and attributions.

Data analysis indicated that only two of the eight hypotheses were found to be statistically significant. Null hypothesis Ho2 was rejected suggesting that there was a difference between males and females in the identified importance of the physical appearance of their partner. Males placed more emphasis on the importance of their partner's appearance than did females. The second significant finding made was that gender does play a role in the identified level of awareness of the signs and symptoms of an eating disorder. Females were more likely than males to be aware of the signs and symptoms of an eating disorder. No significant differences were found between the individuals scoring within the normal range on the EAT-26 and those with scores indicating pathological thoughts and behaviors, in regards to the four sub scales of the Eating Disorders Perceptions Survey.

Conclusions

This study yielded data similar to other studies. Nine individuals reported disordered beliefs and behaviors as indicated by a score of twenty or higher on the EAT-26. Eight of those individuals were female and one was male. This is fairly consistent with national data that place the ratio at ten to one (Shannon, 2004). This study found data to support the hypothesis that men place more emphasis on the physical appearance

of their partner than women do. This was consistent with past research as well (Cohn & Adler, 1992). Analyses of individual items on the four sub-scales of the Eating Disorders Perceptions Survey revealed the following. Men agreed more often than women that they found thin people to be more attractive. Men also indicated that their partner's looks were very important to them more often than women did. Men were not more likely than women, however, to indicate that they only dated a certain type of person. This could indicate that although men place a high importance on their partner's appearance, it is not the primary factor in choosing a mate.

This study also yielded results indicating that women were more aware of the signs and symptoms of an eating disorder than men were. However, men were more likely to have indicated that they have dated somebody with an eating disorder. This is an interesting finding and could have important implications in how eating disorders are approached and discovered in dating relationships. This could also have important implications in ways in which college campuses might increase awareness about eating disorders.

There was no difference found between men and women in their willingness to help an individual suffering with an eating disorder. The conclusion can be drawn that although men place a high importance on physical appearance, they are not any less likely than women to help their partner obtain treatment for an eating disorder. Men were just as likely as women to say that they valued their partner's health more than having their partner look a certain way. This could be very important information in helping eating disordered individuals ask for the support that they need.

Some results were found that were contradictory to past research. Individuals with disordered beliefs and behaviors, as identified by a score of 20 or greater on the EAT-26, did not differ significantly in their beliefs and perceptions from those without a score indicating this. This is contradictory to past research in which it was found that women with eating disordered beliefs and behaviors would be more critical of others' appearances (Zellner, Harner, & Adler, 1989). Those with eating disordered beliefs and behaviors did not indicate that they placed more importance on appearance or on dating a certain type.

There were no statistically significant differences found between those with a high and low score on the EAT-26 regarding who they felt was to blame for an eating disorder. This is contradictory to research done by Schmidt, Slone, Tiller, and Treasure (1993) that indicated that individuals with eating disorders tend to blame others as a defense mechanism. The participants in this study who scored high on the EAT-26 did not blame others more frequently for the occurrence of eating disorders than those with low scores on the EAT-26. It is highly surprising that no statistically significant differences between those with high scores and low scores on the EAT-26 existed on any of the eight hypotheses tested. It is possible that the restricted number of eating disordered participants contributed to the lack of significant findings in that regard. Other possible reasons could be that the participants were trying to appear in a good light. They might have feared that their answers would be matched with them. They might have misunderstood the questions. It is possible that this particular cultural climate differs from that of the national culture.

This study also found data that differed significantly from the national averages in a few ways. Eating disorders on college campuses have been estimated to be around 20 percent (Zuckerman, Colby, Ware, & Lazerson, 1986). This study found that only seven percent of the population surveyed had pathological eating beliefs and behaviors, as indicated by a score of 20 or greater on the EAT-26. This incidence of pathological beliefs and eating behaviors was higher than that of the general population however, which is estimated at about five percent (Woods, 2004).

Recommendations

Recommendations will be made for the following: ways of increasing awareness on college campuses and implications for treatment. The current study found that men place a higher importance on physical appearance than women do. It was also found that women indicated a higher level of awareness of the signs and symptoms of an eating disorder than men did. As a result, it is recommended that college campuses increase efforts to inform males about the signs and symptoms of an eating disorder.

Men indicated that they had dated somebody with an eating disorder more often than women. This is not surprising, due to the fact that women evidence higher rates of eating disorders than men do (Shannon, 2004).

There were no significant differences in men and women's willingness to help an individual suffering from an eating disorder, with both groups strongly suggesting that they would be willing to be of help to eating disorder victims. This could indicate that individuals suffering in silence with an eating disorder are doing so needlessly. They could find the help that they need in their partner. Ideas for future research could include

involving the individual's partner in treatment. Further research could also be done to investigate why the incidence of eating disorders among this population was so low.

There are ways in which the current study could be improved. Validity and reliability measures could be found for the Eating Disorders Perceptions Survey. This would give added confidence in the validity of the results. A larger sample population could have been used, especially in relation to those endorsing eating disordered beliefs and behaviors. More research could have been done on specific knowledge known by college students about eating disorders.

There is a lot of available information about eating disorders. There is still a need, however, for improvements in their prevention and treatment. Efforts should be made to heighten awareness about the signs, symptoms, and causes of eating disorders. More research should be conducted in ways to improve treatment. Finally, only increased awareness will remove shame from those suffering in silence with eating disorders.

References

- Abraham, S. F., & Beumont, P.J.V. (1982). How patients describe bulimia or binge eating. *Psychological Medicine*, 12(3), 625-635. Retrieved from Ebscohost database December 5, 2004.
- Ansari, F. (1994). What information would be important to give to the family of an individual with bulimia or anorexia nervosa? *European Eating Disorders Review*, 2(3), 163-167. Retrieved from Ebscohost database December 5, 2004.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders, fourth edition – text revision.
- Bachner-Melman, R. (2003). Anorexia nervosa from a family perspective – why did nobody notice? *The American Journal of Family Therapy*, 31, 39-50. Retrieved from Ebscohost database December 5, 2004.
- Baird, Pryor, & Sights, Judith R., 1986. Low self-esteem as a treatment issue in the psychotherapy of anorexia and bulimia. *Journal of Counseling and Development*, 64(3), 449-451. Retrieved from Ebscohost database December 5, 2004.
- Bassoe, H. H. (1990). Anorexia/bulimia nervosa: The development of anorexia nervosa and of mental symptoms. *Acta Psychiatr Scand*, 361(82), 7-13. Retrieved from Ebscohost database December 5, 2004.
- Bybee, J., & Zigler, E. (1996). Guilt, guilt-evoking events, and eating disorders. *Current Psychology*, 15(2). Retrieved from Ebscohost database December 5, 2004.
- Casper, R. C., Hedeker, D., & McClough, B.A. (2001). Personality dimensions in eating disorders and their relevance for subtyping. *Journal of the American Academy of*

- Child and Adolescent Psychiatry*, 31(5), 830-840. Retrieved from Ebscohost database December 5, 2004.
- Cohn, L. D., & Adler, N. E. (1992). Female and male perceptions of ideal body shapes. *Psychology of Women Quarterly*, 16, 69-79. Retrieved from Ebscohost database May 15, 2005.
- Cosh, C. (2002). Starving for information. *News magazine*, 29(22), 4-5. Retrieved from Ebscohost database May 3, 2005.
- Demarest, J., & Allen, R.(2000). Body image: Gender , ethnic, and age differences. *Journal of Social Psychology*, 140(4), 465-473. Retrieved from Ebscohost database May 1, 2005.
- Etringer, B.D., & Altmaier, E.M., & Bowers, W. (1989). An investigation into the cognitive functioning of bulimic women. *Journal of Counseling and Development*, 68, 216-219. Retrieved from Ebscohost database December 5, 2005.
- Fahy, T. A., Eisler, I., & Russel, M. (1993). Personality disorder and treatment response in bulimia nervosa. *British Journal of Psychiatry*, 162, 765-770. Retrieved from Ebscohost database December 5, 2004.
- Field, A. (2000). Media influence on self-image: The real fashion emergency. *Healthy Weight Journal*, 14(6), 88-91.
- Fischer, J, & Corcoran, K. (1994). Measures for clinical practice. New York, New York: The Free Press.
- Harvey, S. (2003). Eating disorders: Anorexia and bulimia. *Eating Disorders*, 1(20). Retrieved from Ebscohost database December 5, 2004.

- Kassett, J. A., Gwirtzman, H. E., Kaye, W. H., Brandt, H. A., & Jimerson, D. C. (1988). Pattern of onset of bulimic symptoms in anorexia nervosa. *American Journal of Psychiatry*, 145(10), 1287-1288. Retrieved from Ebscohost database December 5, 2004.
- Kennedy, Signey H., & Garfinkel, Paul E., 1992. Advances in diagnosis and treatment of anorexia nervosa and bulimia nervosa. *Canadian Journal of Psychiatry*, 37(5), 309-315.
- Mitchel, P. D. (1993). Current attitudes to anorexia and bulimia nervosa: the needs, benefits and ways of changing. *Eating Disorders Review* 1(2), 121-129. Retrieved from Ebscohost database December 5, 2004.
- Pettanati, H. M., Franks, V., Wade, J., & Kogan, L. (1987). Distinguishing the role of eating disturbance from depression in the sex role self-perceptions of anorexic and bulimic inpatients. *Journal of Abnormal Psychology*, 96(3), 280-282. Retrieved from Ebscohost database December 5, 2004.
- Russel, G.F.M. (2004). Thoughts on the 25th anniversary of bulimia nervosa. *European Eating Disorders Review*, 12, 139-152. Retrieved from Ebscohost database December 5, 2004.
- Schmidt, U., Slone, G., Tiller, J., & Treasure, J. (1993) Childhood adversity and adult defense style in eating disorder patients – a controlled study. *British Journal of Medical Psychology*, 66(4), 353-362. Retrieved from Ebscohost database December 5, 2004.
- Shannon, R. L. (2004). Eating disorders in adolescent males. *Professional School Counseling*, 8(1), 98-102. Retrieved from Ebscohost database December 5, 2004.

- Steiger, H. (1989). Anorexia nervosa and bulimia in males: Lessons from a low-risk population. *Canadian Journal of Psychiatry*, 34(5), 419-424. Retrieved from Ebscohost database December 5, 2004.
- Stiles, D. A., Gibbons, J. L., & Schnellman, J. (1990). Opposite-sex ideal in the USA and Mexico as perceived by young adolescents. *Journal of Cross-Cultural Psychology*, 21, 180-199. Retrieved from Ebscohost database May 15, 2005.
- Williamson, D. A., Anderson, D. A., Jackman, L.P., & Jackson, S. (1995). Assessment of eating disorder thoughts, feelings, and behavior. *Appetite*, 27, 223-233. retrieved from Ebscohost database May 5, 2005.
- Woods, S. Untreated recovery from eating disorders. *Adolescence*, 39(154), 361-372. Retrieved from Ebscohost database December 5, 2004.
- Zuckerman, D. M., Colby, A., Ware, N.C., & Lazerson, J. A. (1986). the prevalence of bulimia among college students. *American Journal of Public Health*, 9(76), 1135-1137. Retrieved from Ebscohost database December 5, 2004.

1 2 3 4 5

EATING DISORDER AWARENESS

8) I am aware of the signs/symptoms of an eating disorder.

1 2 3 4 5

9) Colleges should do more to raise awareness about eating disorders and body image issues.

1 2 3 4 5

10) I do not think eating disorders are very common.

1 2 3 4 5

11) I do not think eating disorders have very serious health risks.

1 2 3 4 5

12) I believe an eating disorder is simply refusing to eat.

1 2 3 4 5

HELPING BEHAVIORS/ CONCERN

13) I would continue a relationship with a person if they disclosed they had an eating disorder.

Strongly Disagree	1 2 3 4 5	Strongly Agree
----------------------	-----------------------	-------------------

14) I would encourage the person to get help.

1 2 3 4 5

15) I would do things to try to help the person.

1 2 3 4 5

16) I would be willing to participate in a treatment program with the person.

1 2 3 4 5

17) I would confront their partner about eating disorder symptoms/signs/beliefs.

1 2 3 4 5

18) My partner's health is more important than looking good.

1 2 3 4 5

ATTRIBUTIONS

19) I believe eating disorders are all about being skinny.

1 2 3 4 5

20) I believe treating an eating disorder is the sole responsibility of the afflicted person.

1 2 3 4 5

21) I believe the person is to blame for his or her own eating disorder.

1 2 3 4 5

22) Who do you feel is responsible for an eating disorder? Circle only the best choice: the afflicted person their family society
the media other: _____

Johnson, Anne

From: Johnson, Anne
Sent: Thursday, June 16, 2005 10:51 AM
To: 'sabiha ahmad'
Subject: RE: info

Dear Sabiha:

Thank you for your interest in attending the Graduate School here at the University of Wisconsin-Stout. We have received your e-mail inquiry. We have mailed you a packet of information.

If you have any questions after receiving this information, please do not hesitate to contact me. You can also refer to our web site for more information at: <http://www.uwstout.edu/grad/>

Since you are an international applicant please be sure to read the following information:
http://www.uwstout.edu/grad/is_1.html

Again, thank you for your interest in attending the UW-Stout Graduate School.

*Anne Johnson
UW-Stout, Graduate School
130 Bowman Hall
Menomonie WI 54751
715/232-1322 fax 715/232-2413
johnsona@uwstout.edu*

From: sabiha ahmad [mailto:sabihamu@yahoo.com]
Sent: Saturday, May 21, 2005 6:10 AM
To: Johnson, Anne
Subject: info

hi
i am interested in doing Masters/MS nutrition /dietetics from ur university. could u send me the brochures of ur university, international students application forms, or other required documents by post.

my postal add is
Ms sabiha ahmad
113 jawahar nagar
srinagar
jammu & kashmir
india
190008
91-0194-2310723
cell 9906545641
email: sabihamu@yahoo.com
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Teachers' Attitudes toward Shared Reading,
Guided Reading, and Learning Centers

by

Debra M Molzahn

A Research Paper
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