



Prevalence of body dissatisfaction among a United States adult sample[☆]



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ABSTRACT

Body dissatisfaction (BD) is a primary determinant of eating disorders and has been linked to chronic disease via decreased likelihood of cancer screening self-exams and smoking cessation. Yet, there are few recent estimates of the prevalence of BD among United States adults. Using an internet-based, opt-in, cross-sectional survey, United States adults (N = 1893) completed assessments of demographic variables, body areas satisfaction, appearance evaluation, fitness evaluation, health evaluation, and overweight preoccupation. Results revealed that the range of BD is 13.4%–31.8% among women and 9.0%–28.4% among men. Compared to previous assessments of prevalence (1973, 1986, 1995, 1997), the prevalence of BD among United States adults may have plateaued or declined over time.

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1. Introduction

Body image is defined as a person's body-related self-perceptions and self-attitudes, including thoughts, feelings, and behaviors (Cash, 2003). In some cases, extreme levels of body dissatisfaction (BD) can result in eating disorders (e.g., anorexia nervosa, bulimia nervosa), which have a lifetime prevalence of 2.5% and 0.8% for United States women and men, respectively (Hudson, Hiripi, Pope, & Kessler, 2007). For those who seek treatment, annual treatment costs range from \$US 1288 to \$US 8042 per person, per year (Stuhldreher et al., 2012). BD is also known to negatively influence behavioral risk factors for chronic disease, which affect an even greater proportion of the US population. For example, breast cancer is the most common cancer among women, with a lifetime prevalence of 12.3% (Howlader et al., 2013). A recent literature review demonstrates that BD is associated with lower likelihood of engaging in breast cancer self-exams (Ridolfi & Crowther, 2013), which could provide early detection of the disease. BD is also associated with lower likelihood of smoking cessation (King et al., 2005), where smoking costs \$US 96.8 billion annually in lost productivity and is

responsible for almost 30% of cancer deaths (Centers for Disease Control, Prevention, 2008).

With such robust potential to influence health care costs as well as an individual's health and quality of life across the lifespan, it is imperative for behavioral scientists, clinicians, and public health professionals to be informed of the current overall prevalence of BD among the United States population, changes in BD prevalence over time, as well as understand which sub-populations are at risk. Salient to this study are four preceding national surveys assessing body image/BD among United States adults (Berscheid, Walster, & Bohrnstedt, 1973; Cash & Henry, 1995; Cash, Winstead, & Janda, 1986; Garner, 1997). Since 1972, a series of surveys have documented an increase in dissatisfaction in overall appearance among both men (15% to 43%) and women (23% to 56%). This often-cited research has led many to conclude that there is a 'normative discontent' or an 'epidemic' of BD in the United States, especially among women (Frederick, Jafary, Gruys, & Daniels, 2012; Rodin, Silberstein, & Striegel-Moore, 1984; Tantleff-Dunn, Barnes, & Larose, 2011). Since Garner (1997), however, very few studies have used national surveys of United States adults, and the few containing national samples, have either not used psychometrically valid measurement tools (Frederick, Peplau, & Lever, 2006), have used single-item measures of body satisfaction (Kruger, Lee, Ainsworth, & Macera, 2008), or have focused on specific United States subgroups (Peplau et al., 2009). Thus, a more recent assessment of overall prevalence of BD among United States adults is timely and the purpose of this study is threefold:

- To provide an overall estimate of the national prevalence of BD among United States men and women,

[☆] The data for this study was collected at Kansas State University, but analyzed and the manuscript composed at Georgia State University. Elizabeth A. Fallon is now at Georgia State University and Brandonn S. Harris is now at Georgia Southern University. Paige Johnson is a recent graduate of Kansas State University, and does not currently maintain a university affiliation. We thank the survey respondents for their time and the students who helped collect the data; specifically, laboratory assistants Joseph Lightner, Abby Banks, Madelaine Ellison, Annie Pipes, Tracy Engstrom, and Laura Moluf.

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- b. To examine differences in BD across population subgroups (e.g., sex, race/ethnicity, age, body mass index category),
- c. To compare the rates of BD of the present sample to previously published national samples.

2. Method

2.1. Participants

Demographic information for adult volunteers ($N = 1893$; age range 18–90 years) who completed an online survey are presented in Table 1.

2.2. Procedure

Prior to data collection, Institutional Review Board approval was obtained for an internet-based, opt-in survey taking participants approximately 20–30 min to complete.¹ To recruit United States adults across a wide geographical area, e-mail addresses were collected from publicly available websites in the United States. These websites primarily consisted of, but were not limited to, colleges/universities, public primary schools, state/local government, and faith-based organizations. Invitation emails for the study titled “Attitudes Towards Health Behaviors” contained the IRB informed consent information (e.g., general purpose of the study, IRB and contact information, and that the data would be used for research) and a link to the survey. While the survey respondents could choose to submit the survey anonymously, they could also choose to include their contact information to win a monthly drawing for \$15 to a national chain store. This drawing, as well as two follow-up e-mail reminders sent 1 and 2 weeks after the initial invitation were intended to increase response rate and survey completion rate. After the data collection period (August 2010–April 2011) ended, the data were de-identified.

Over the course of the recruitment period, 2665 individuals accessed the online survey. Using a “completers only” analysis for this study, participants failing to complete items assessing demographic variables or the multidimensional body self-relations survey were excluded from the analysis. The final sample for this study is 1893 adults, representing 37 US states.

2.3. Measures

2.3.1. Demographics

Consistent with the Behavior Risk Factor Surveillance (U.S. Department of Health and Human Services and Centers for Disease Control, Prevention (2010)) system, participants were asked to self-report their birth date (month, day, year), sex, race, ethnicity, and education level. Age groups were created to be consistent with those from previous research (Cash & Henry, 1995). Self-reported height and weight measurements were used to compute body mass index (BMI; weight [kg]/height [m²]). Subsequently, four BMI categories were created: underweight (BMI < 18.5), healthy weight (BMI 18.5 to <25), overweight (BMI 25.0 to <30.0), and obese (BMI ≥ 30.0; U.S. Department of Health and Human Services, National Institutes of Health, & National Heart Lung & Blood Institute, 1998).

2.3.2. Body areas satisfaction

Satisfaction with specific areas of the body was assessed using the Body Areas Satisfaction subscale of the Multidimensional Body-Self

Table 1
Sample characteristics by participant sex.

	Women (n = 1246)		Men (n = 647)	
	M	SD	M	SD
Age	42.50	14.00	47.77	16.27
BMI	25.86	6.75	26.90	5.38
	N	(%)	N	(%)
Age				
18–24 year	107	8.6	51	7.9
25–34 year	341	27.4	116	17.9
35–44 year	212	17.0	105	16.2
45–54 year	242	19.4	99	15.3
55–64 year	290	23.3	169	26.1
65 and over	54	4.3	107	16.5
BMI				
Underweight	32	2.6	6	0.9
Normal weight	673	54.0	262	40.5
Overweight	301	24.2	232	35.9
Obese	240	19.3	147	22.7
Race/ethnicity				
White/Caucasian	1074	86.2	558	86.2
Black/African American	30	2.4	9	1.4
Asian	47	3.8	32	4.9
Hispanic	37	3.0	13	2.0
Native American/Native Hawaiian/Pacific Islander	21	1.7	5	0.8
Other/don't know/prefer not to answer	37	3.0	30	4.6
Education				
Less than 4-year college				
Degree	188	15.1	56	8.7
4-year college degree	1055	84.7	590	91.2
Cohabitation status				
Married/cohabitating	802	64.4	474	73.3
Not married/cohabitating	435	34.9	169	26.1

Relations Questionnaire (MBSRQ; Cash, 2000). This measurement tool uses a 5-point Likert-type scale ranging from very dissatisfied (1) to very satisfied (5) to measure participants' satisfaction with nine specific aspects of their body (e.g., face, height, hair, muscle tone). Using this tool, BD was assessed in two ways. First, for each specific body area, individuals reporting ‘very dissatisfied’ or ‘dissatisfied’ were categorized as having BD. Second, the scores for each of the 9 items were averaged, with higher scores representing higher body satisfaction. According to a protocol from Cash and colleagues (Cash & Henry, 1995; Cash et al., 1986), a mean score of <3.0 is defined as BD. According to the Frederick and colleagues' protocol (Frederick, Forbes, Grigorian, & Jarcho, 2007; Peplau et al., 2009), a mean score of <2.75 is defined as BD. For this study, we present both protocol cut-off points (Fiske, Fallon, Blissmer, & Redding, under review). Finally, for this study, the internal consistency was good ($\alpha = .83$).

2.3.3. Appearance evaluation

Feelings of physical attractiveness or satisfaction with one's looks are measured using a 7-item Likert-type scale ranging from Definitely Disagree (1) to Definitely Agree (5). Scores on each item are averaged to create a mean score, where higher scores are indicative of greater satisfaction with appearance (Cash, 2000). For this study, the internal consistency was good ($\alpha = .89$) and we present both the Cash (scale means < 3.0) and Frederick (scale means <2.75) cut-off points.

2.3.4. Overweight preoccupation

Overweight preoccupation is a construct reflecting fat anxiety, weight vigilance, dieting, and eating restraint (Cash, 2000). It is assessed using a 4-item Likert-type scale ranging from Definitely Disagree (1) to Definitely Agree (5). Scores on each item are averaged to create a mean score, where higher scores are indicative of greater overweight preoccupation, and therefore greater BD (Cash, 2000). For this study, we present

¹ According to publication guidelines (American Psychological Association, 2010), we note that this data set comes from a previously published manuscript (Johnson, Fallon, Harris, & Burton, 2013), which focused on the associations between body satisfaction physical activity behavior change. The purposes of each manuscript necessitated multiple manuscripts for multiple audiences. Furthermore, the data from fitness evaluation, appearance evaluation, health evaluation and health orientation are novel and have not been published elsewhere.

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