



# Prevalence of body dissatisfaction among United States adults: Review and recommendations for future research<sup>☆</sup>



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## ABSTRACT

As the evidence supporting the role of body dissatisfaction (BD) in chronic disease risk factors and health behaviors increases, documenting the prevalence of BD is an essential first step in determining to what degree BD is a public health problem. Therefore, the primary purpose of this study is to critically evaluate research examining the population prevalence of BD among U.S. adults. Seven studies were located and provided estimates of prevalence of BD among U.S. adults that were extremely varied (11%–72% for women, and 8%–61% for men). While some of the variation may be due to increases in BD over time, the literature is also clouded by a lack of randomly selected samples, lack of consistency in measurement tools, lack of consistency in operational definitions of BD, and lack of standardized cut-off points for BD. Recommendations for improving BD prevalence research to enable public health research are provided.

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## 1. Introduction

Body image is a complex multidimensional construct encompassing an individual's body-related self-perceptions and self-attitudes, including thoughts, beliefs, feelings, and behaviors (Cash, 2003). To date, the vast majority of research has focused on body dissatisfaction (BD) because it is a primary determinant of eating disorders (e.g., anorexia nervosa, bulimia nervosa), which have a lifetime prevalence of 2.5% for women and 0.8% for men within the U.S. (Hudson, Hiripi, Pope, & Kessler, 2007). More recently, BD research has expanded to explore its role as a potential contributor to a range of behavioral risk factors for chronic disease in non-clinical populations (Heinberg, Thompson, & Matzon, 2001). For example, BD has been associated with decreased likelihood of cancer screening self-exams (Ridolfi & Crowther, 2013), decreased success in smoking cessation (King, Matacin, White, & Marcus, 2005), lower physical health related quality of life (Wilson, Latner, & Hayashi, 2013), decreased mental health and sexual

functioning (Davison & McCabe, 2005), and increased pro-smoking attitudes and behaviors (Potter, Pederson, Chan, Auburn, & Koval, 2004).

Given that 69% of the U.S. population is overweight or obese (USDHHS, 2013) and therefore at greater risk for heart disease, stroke, diabetes, cancer, cognitive decline, and depression it is particularly important to understand the complex relationship between BD and overweight, obesity and healthy weight control behaviors. Longitudinal research has shown that individuals reporting BD are likely to report lower physical activity and fruit and vegetable consumption 5 years later (Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006). Other research has shown that weight dissatisfaction, specifically, is both a risk factor for obesity among young adults as well as a motivating factor for weight loss in middle-aged and older adults (von Lengerke, Mielck, & KORA Study Group, 2012). Similarly, when examining physical activity behavior change, Johnson, Fallon, Harris, and Burton (2013) found that body satisfaction was associated with lower odds of beginning exercise, but greater odds of long-term maintenance. Clearly, better understanding of the relationships between BD and healthy weight management behaviors, including physical activity and healthy diet, is needed.

As we continue to improve our monitoring of behaviors related to chronic diseases, it is important to also begin to document and monitor the status of their potential antecedents and correlates. As the quantity and quality of evidence supporting the role of BD in chronic disease risk factors grows, documenting the prevalence of BD is an essential first

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step in making an argument for increased resources to study BD (and its influence on health outcomes/health behaviors) as a public health problem. Therefore, the primary purpose of this study is to identify and critically evaluate epidemiological and commonly cited research examining the prevalence of BD among U.S. adults. This study informs epidemiologists, behavioral scientists, clinicians and public health professionals on the current state of knowledge regarding the prevalence of BD, in terms of quantity, quality and future research directions.

## 2. Methods

A literature search was conducted using PubMed, Google Scholar, and PsycInfo using the following keywords: body image, body image disturbance, body image dissatisfaction, weight/shape dissatisfaction, prevalence, and thin ideal internalization. Reference sections of located articles were also searched to identify new articles. Articles were included if they recruited national samples predominantly from the U.S., adults ( $\geq 18$  years), were written in English, quantitatively assessed BD or body satisfaction, and reported the percent of the study sample that was defined by the study as having BD. We explicitly excluded the numerous studies of BD that only reported mean levels of BD in smaller, localized, non-representative samples as our interest is in determining population levels of the construct (see Fig. 1).

Information extracted from these articles included the study's author(s), year of publication, publication type (peer-reviewed, non-peer reviewed), BD measurement tool, operational definition of BD as defined by author-described cut-off points, as well as information regarding the sample and recruitment methods. Where possible, prevalence rates for sample subgroups were noted (sex, race/ethnicity, age, etc.).

## 3. Results & discussion

Table 1 displays the information extracted from the seven included studies. Initially, these results appear to confirm previous reports of an increasing “normative discontent” among U.S. adults as rates generally appear to be increasing over time. However, a closer examination of the methodologies across studies suggests several methodological

problems with operational definitions, cut-off points, and measurement tools.

### 3.1. Research design

Large sample sizes ( $N > 800$ ) were reported for all seven studies. However, only one study used random sampling (Kruger, Lee, Ainsworth, & Macera, 2008) and only three others (Berscheid, Walster, & Bohrnstedt, 1973; Cash & Henry, 1995; Cash, Winstead, & Janda, 1986) commented on the representativeness of the sample. Additionally, five studies (Berscheid et al., 1973; Cash et al., 1986; Frederick, Peplau, & Lever, 2006; Garner, 1997; Kruger et al., 2008) reported prevalence based solely on single-item measures, which are now discouraged due to known poor psychometric properties of single items (Thompson, 2004). Finally, only four of the seven studies were peer-reviewed (Cash & Henry, 1995; Frederick et al., 2006; Kruger et al., 2008; Peplau et al., 2009), and while this does not negate these studies' findings, peer-review is necessary and an accepted vetting by the scientific field, and non-peer-reviewed studies should be given less weight by the academic community.

### 3.2. Operational definitions and cut-off points

The most prominent measurement tool across studies was the Multidimensional Body Self-Relations Questionnaire (MBSRQ; Cash, 2000) and its precursors (Berscheid et al., 1973; Cash & Henry, 1995; Cash et al., 1986). Of the five studies using this measure (Berscheid et al., 1973; Cash & Henry, 1995; Cash et al., 1986; Garner, 1997; Peplau et al., 2009), however, there was poor consensus on analysis procedures and cut-off points for BD. Specifically, three of the five studies using the MBSRQ focused solely on item-by-item analyses (Berscheid et al., 1973; Cash et al., 1986; Garner, 1997). One reported using subscale mean scores for the appearance evaluation and overweight preoccupation subscales (BD cut-off for each scale  $< 2.74$ ; Peplau et al., 2009). And only one reported both item-by-item analyses and subscale means for the Body Areas Satisfaction Scale, overweight preoccupation scale and the appearance evaluation scale (BD cut-off for each scale  $< 3.0$ ; Cash & Henry, 1995).

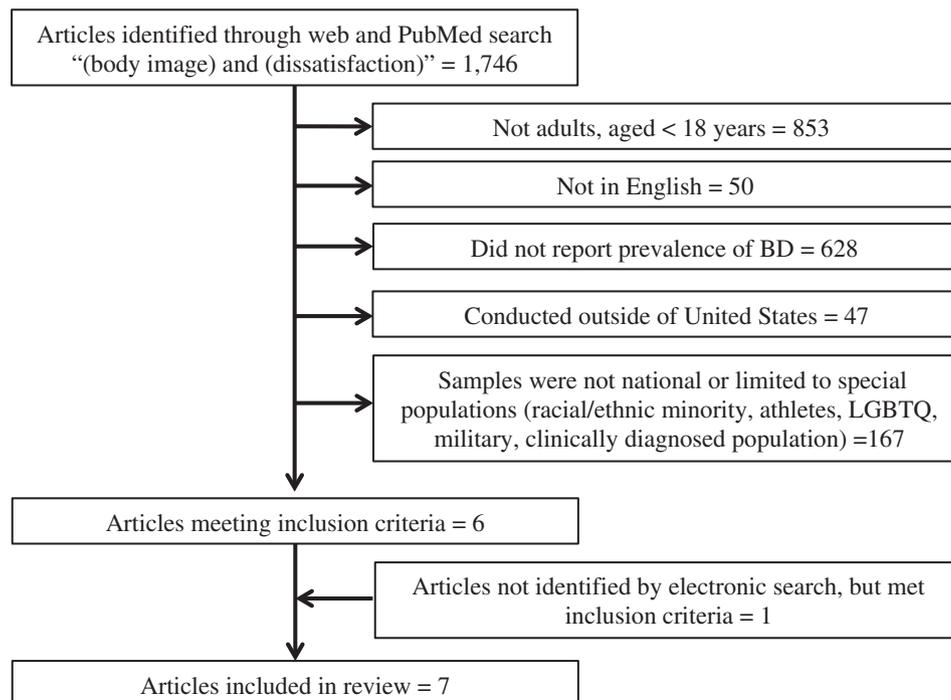


Fig. 1. Flow chart for article selection.

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