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COVER PHOTOGRAPH: Compliments of Mike Johnson

ATTITUDES TOWARD FOOD: COMPARISON OF ADDICTIVE BEHAVIORS IN WOMEN RECOVERING FROM SELF-DIAGNOSED EATING DISODERS VS. WOMEN WITH NO HISTORY

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This research compared attitudes toward food in those individuals who recovered from a self-diagnosed eating disorder to those individuals with no history of an eating disorder. The hypotheses tested were: 1) Women who claim to have struggled with an eating disorder in the past still show signs of addiction in their attitude toward food, even though the behavior of the eating disorder is no longer apparent. 2) Women with a history of anorexia will have the most negative attitude toward food; women with a history of bulimia will have a less negative attitude toward food, and women with a history of binge eating disorder will display the least negative attitude toward food. Hypothesis 1 was supported, while hypothesis 2 was not supported.

"Eating disorders are characterized by a persistent pattern of dysfunctional eating or dieting behavior associated with significant emotional, physical, and interpersonal distress" (http://www.licensedceu.com/course.php, 2007). Statistics collected in 2000 indicate that about one percent (1%) of female adolescents in the United States have anorexia nervosa; about one-three percent (1-3%) of young women have bulimia; around fifty percent (50%) of the women with anorexia develop patterns of bulimia later on; and around three percent (3%) have binge eating disorder (Maine, 2000).

These statistics represent a fragment of the problem, since they only include *reported* eating disorders. The Academy of Eating Disorders in Maryland suggests that at any given time, ten percent or more of late adolescent and young adult women report symptoms of eating disorders that may not satisfy full diagnostic criteria. These women do, however, often manifest personal distress and impairment through avenues of depression, anxiety, and low self-esteem (http://www.aedweb.org/eating_disorders/prevalence.cfm, 2007; Abrams, Allen & Gray, 1993).

Harrison (1997) holds the media responsible for this epidemic of eating disorders. Her study, surveying 232 women, revealed a strong relationship between media exposure that promotes or depicts thinness and the rate of bulimia and anorexia. Michael Strober, director of the Eating Disorder Program at UCLA Neuropsychiatric Institute, has considered other causes, which may contribute to eating disorders. Since 1996, he and an international team of researchers have been working to discover a genetic link for eating disorders (Liu, 2007). Strober estimates that more than fifty percent (50%) of the variance in eating disorders can be accounted for by such genetic links (http://www.gurze.com/client/client_pages/newsletter22.cfm, 2007). Similar findings from Holland, Sicotte & Treasure (1988) indicate that a genetic link is present. Their study examined twenty-five monozygotic twins who had both been diagnosed with anorexia. Analysis of their data suggested that up to eighty percent (80%) of anorexia nervosa might be accounted for by genetic factors.

If the causes of eating disorders are unclear, the road to recovery is every bit as difficult to assess. The Academy for Eating Disorders estimates that while nearly one-half of patients with anorexia nervosa recover, thirty-three percent (33%) recover slightly, and twenty percent (20%) do not improve. Similarly, approximately fifty percent (50%) of bulimic individuals completely recover, thirty percent (30%) recover somewhat, and twenty percent (20%) continue to meet full criteria for diagnosis (http://www.aedweb.org/eating_disorders/outcomes.cfm, 2007).

"Recovery" is not just maintaining a healthy weight, but also exhibiting a healthy attitude about food and a lack of destructive behaviors. Many former sufferers say that they "feel they are stronger people and more insightful about life in general and themselves in particular than they would have been without the disorder" (http://www.anred.com/stats.html, 2007, para. 16). About twenty percent (20%) of individuals with serious untreated eating disorders die. With treatment, however, that number falls to two-three percent (2-3%) and recovery rate is sixty percent (60%) (http://www.anred.com/stats.html, 2007). However, relapsing is a big concern for those who have recovered from eating disorders. Deter & Herzog (1994) conducted a follow up study of eighty-four anorexia nervosa patients after a twelve- year period, and found that about twenty-two percent (22%) relapsed after remission.

While numerous theories have been proposed to connect the behaviors of eating disorders to substance abuse behaviors, Davis & Claridge (1998) confirmed that both anorexic and bulimic patients received high scores on the Addiction Scale of the Eysenck Personality Questionnaire. This test also showed addictiveness and obsessive-compulsiveness is related simultaneously to weight preoccupation and excessive exercise in both patient groups. With any addiction, the dysfunctional behavior may be no longer apparent, but the attitudes and mentality of the addiction may still be present (Bamford, Brown, Burditt, Meyer, Morrison, & Waller, 2003). If eating disorders are indeed addictions, the same pattern should be found.

The following study examined the attitudes of individuals who have a history of one or more eating disorders compared with those who have never had an eating disorder. The following hypotheses were tested:

1) **Women who claim to have struggled with an eating disorder in the past still show signs of addiction in their attitude toward food, even though the behavior of the eating disorder is no longer apparent.**
2) **Women with a history of anorexia will have the most negative attitudes toward food; women with a history of bulimia will have a less negative attitude toward food, and women with a history of binge eating disorder will display the least negative attitude toward food.**

Method

Participants

This study was conducted using a convenience sample of women from southwest Michigan. The majority of the participants were women in the college setting, where ages ranged from 18-60 years of age. Incomplete and/or inaccurate surveys were discarded on as-needed basis. All of the participants who were approached participated voluntarily.

Apparatus

The data found in this study was obtained through a completion of a survey. (See Appendix A). Questions were designed to compare views, attitudes, and behaviors of women who have had an eating disorder to those who have no history of an eating disorder. Age, weight, and height were also recorded.

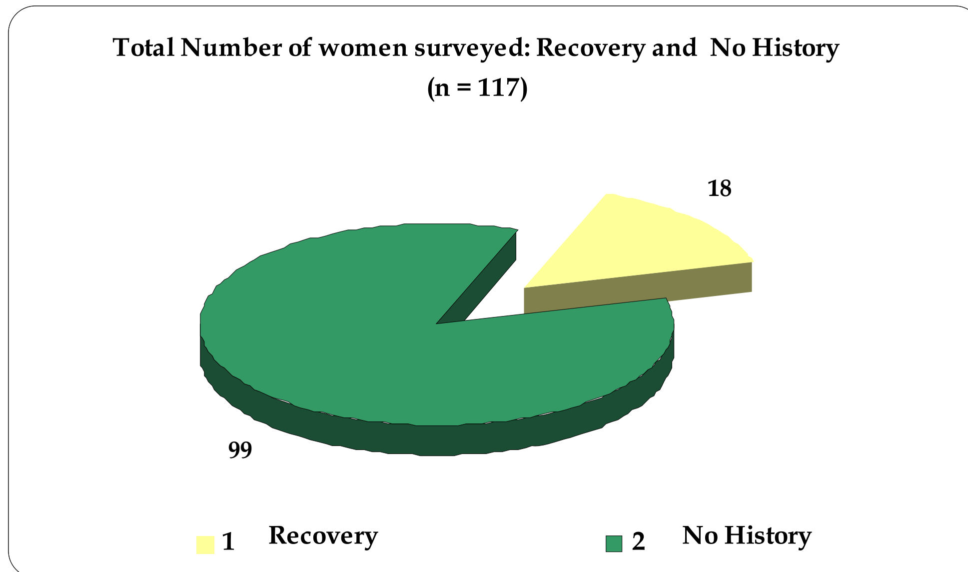
Procedure

Surveys were distributed to a convenience sample of women around southwest Michigan. Most of the surveys were distributed on college campuses. With the permission of the professors, surveys were offered before and after classes. The participants returned the surveys upon completion, and were unaware of the exact hypotheses being tested.

Results

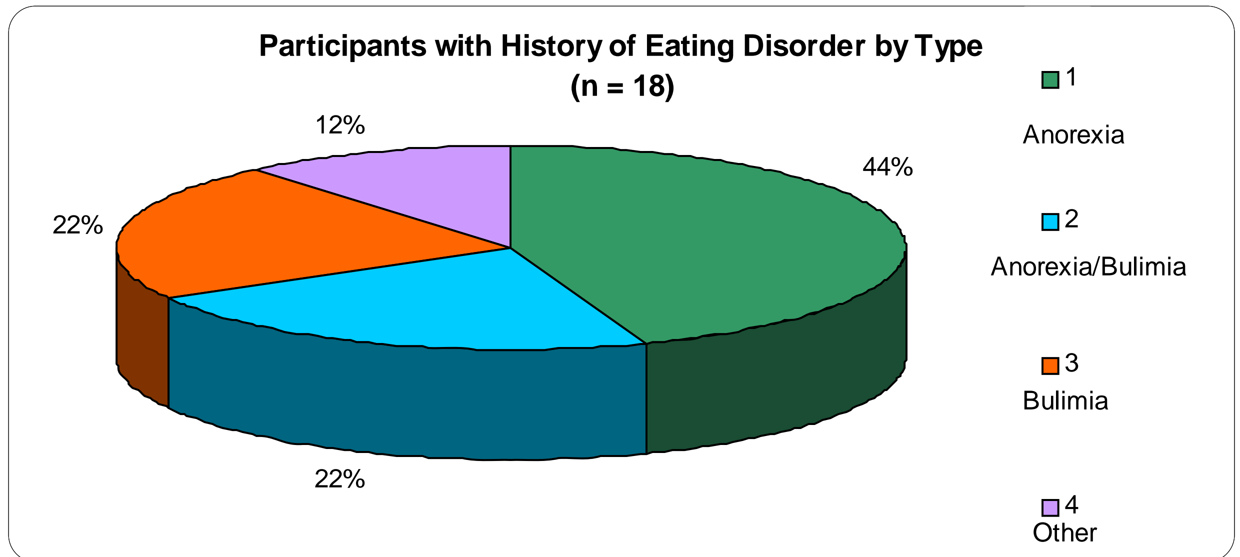
Collected surveys were organized first into two groups: (1) having *recovered* from an eating disorder and (2) having *no history* of an eating disorder. (See Graph #1).

GRAPH # 1



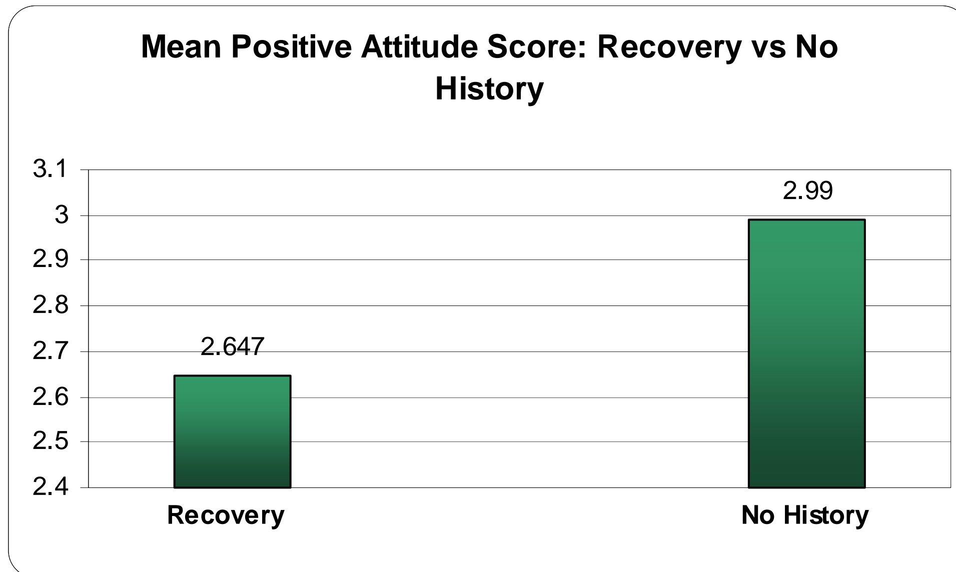
Data analysis was based on pre-determined scores designed to quantify the answers given concerning current attitudes women have toward food. Those women who have recovered from their self-diagnosed eating disorder were then broken into smaller groups in order to make a comparison among the different disorders. Out of those participants, forty-four percent (44%) claimed to have had anorexia; twenty-two percent (22%) claimed both anorexia and bulimia; twenty-two percent (22%) claimed solely bulimia; and the last twelve percent (12%) did not specify which disorder they struggled with. (See Graph #2).

GRAPH # 2



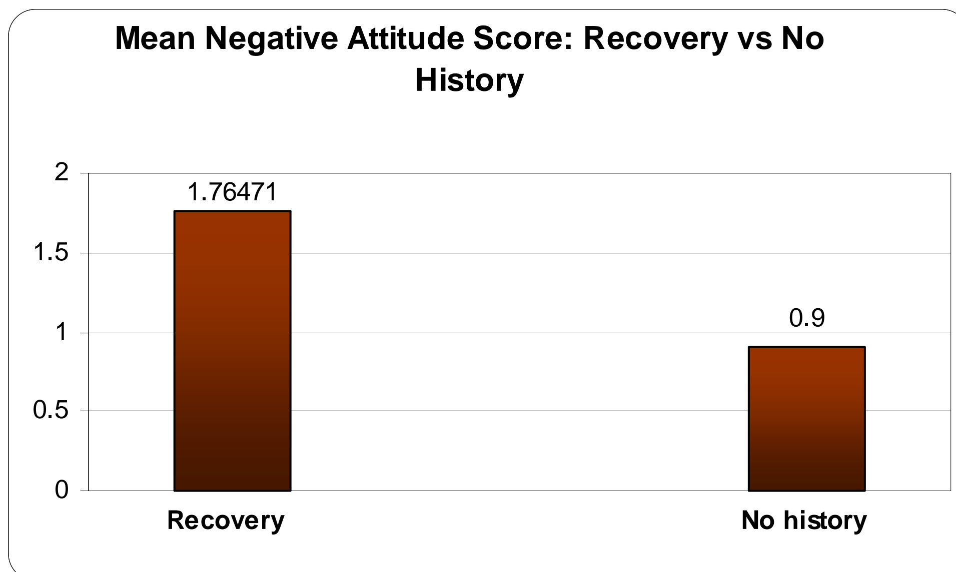
Multiple measures were used to test hypothesis #1, "women who claim to have struggled with an eating disorder still show signs of addiction in their attitude toward food, even though the behavior of the eating disorder is no longer apparent." Addictive behavior toward food was operationalized as the mean number of positive and negative words selected from the survey. The difference of the mean values with regard to positive words ("nourishing," "enjoyable," "a normal part of life," and "comforting") chosen between the two groups was not great enough to be of statistical significance, the results were in the predicted direction (Mann-Whitney Rank Sum Test. T= 862.000; P= .2777). (See Graph #3).

GRAPH # 3



On the survey, the negative words included: "full of calories," "fattening," "sickening," "bad," "disgusting," and "a necessary evil." The difference of the mean values of the negative words chosen between the two groups was greater than would be expected by chance (T= 1325.500; P= .013). (See Graph #4). Therefore, hypothesis one *was* supported.

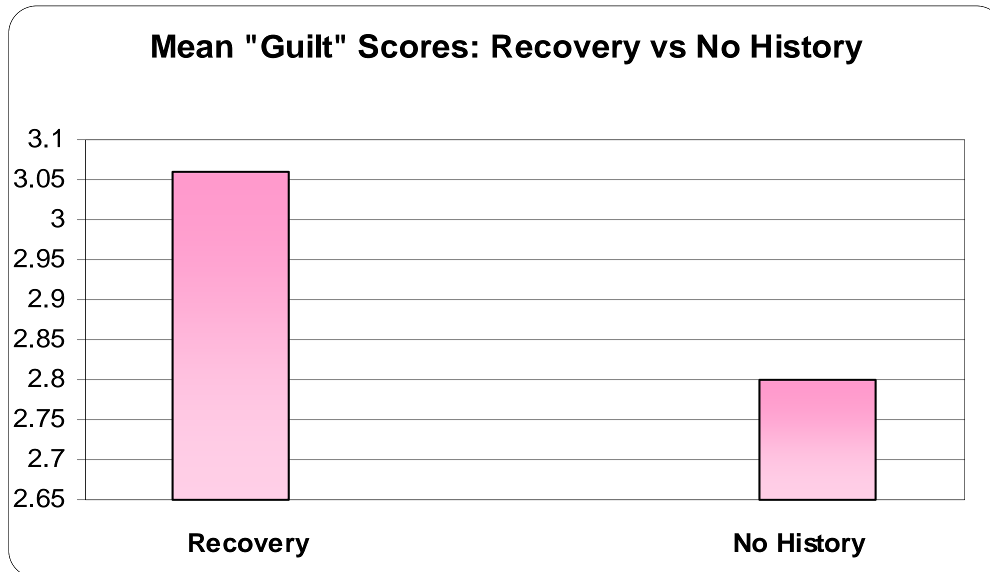
GRAPH # 4



The third indicator of continued addictive behavior after recovery was measured by the question on the survey regarding feelings of guilt associated with consuming unhealthy food. Although the difference in the mean value between those in recovery and those with no history was

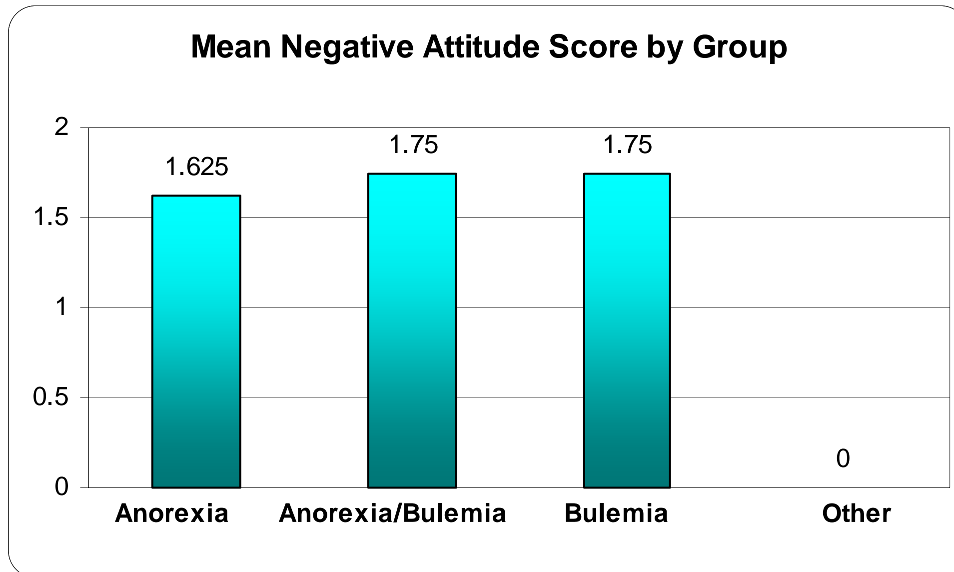
not great enough to exclude the possibility that the difference is due to the variability of random sampling (Mann-Whitney Rank Sum Test. T=1165.500; P= .210), the numbers were leaning in the predicted direction. (See Graph #5).

GRAPH # 5



Hypothesis #2, "women with a history of anorexia will have the most negative attitude toward food; women with a history of bulimia will have a less negative attitude toward food, and women with a history of binge eating disorder will display the least negative attitude toward food" was not supported. After collecting the data it became obvious that a fourth category emerged: women who claimed to be in recovery from both anorexia and bulimia. Therefore, the attitudes of all four groups were compared to measure hypothesis two: (1) anorexia, (2) anorexia/bulimia, (3) bulimia, and (4) other. The strongest scores on the negative attitude scale were groups (2) anorexia/bulimia and (3) bulimia each with a mean value of 1.75. Group (1) anorexia, had a mean value slightly lower at 1.625, and group (4) other, had a mean value of zero. (See Graph 6). The difference of the mean values among these groups is not great enough to exclude the possibility that the difference is due to random sampling (Kruskal-Wallis One Way Analysis of Variance on Ranks; H= 2.454 with 3 degrees of freedom, P= 0.484).

GRAPH # 6



Discussion

Hypothesis number one, "women who claim to have struggled with an eating disorder in the past still show signs of addiction in their attitude toward food, even though the behavior of the eating disorder is no longer apparent" ***was*** **supported. In this study, "signs of addiction" specifically included having a negative attitude toward food, much as a former alcoholic might have negative associations for alcohol. The mean score of negative words chosen on the survey by those women in recovery from an eating disorder, as compared to those women with no history of an eating disorder was found to be significantly different. This indicates that, although women have recovered from the dysfunctional behavior of an eating disorder, more attention may be needed to help them regain a healthy mentality with regard to food. The mean scores of positive words chosen by the two groups were not significantly different. This is interesting, because it suggests an inner conflict that women recovering from eating disorder may vacillate between positive and negative emotions in reference to food.**

In the past decade, our understanding of eating disorders has grown. Stewart Cooper (1989) suggests that eating disorders are very similar to other chemical addictions. He says, "The specifics for eating disorders and chemical addictions do differ, but more in manifestation than in purpose" (para. 10). This concept of addiction to food should not serve as a label for individuals with the

disorder to hide behind, but should be used as an aid to understanding eating disorders. Alcoholics Anonymous, a well-known support group across America, is available for those who admit to having an addiction to alcohol, and want to change. Among this group, it is said that, "once you are an alcoholic, you are always an alcoholic". Behind this statement are numerous people who have learned that overcoming an addiction is a lifelong process. We understand that recovering alcoholics may need support. We should extend similar support to those who are recovering from eating disorders.

The second hypothesis, "women with a history of anorexia will have the most negative attitude toward food; women with a history of bulimia will have a less negative attitude toward food, and women with a history of binge eating will display the least negative attitude toward food" was *not* supported. All the scores comparing negative words chosen on the survey were relatively similar among the groups and the differences among them were not significant. The similarity among the groups puts all of the different disorders on the same plane for comparison, since one group did not display more negativity toward food. Therefore, similar kinds of support during recovery might be effective. In other words, even though the dysfunctional behavior is different in the various disorders, the post-recovery attitude is very likely the same.

Eating Disorders have a large genetic link, and it is common to see patterns of dysfunctional eating or other addiction among the family members of someone with such a disorder. Pope & Hudson (1982) suggest that up to fifty-three percent (53%) of individuals with reported eating disorders have a blood relative with a similar disorder (as cited in Cooper, 1989, para. 6). With this understanding, the next step for therapists and researchers should be to incorporate those individuals who have a history of an eating disorder in their research. Since some individuals have a predisposition toward these kinds of dysfunctional eating behaviors, the possibility exists that one's attitude and mentality change when the behavior has changed, but this is not likely. The entire pattern and cycle of disorders concerning food can be better understood by taking a closer look at what the lives of those individuals who struggled with eating disorders, months or years after they stopped harming their body in some way. It seems impossible to understand eating disorders, and how to help those people who struggle with them, without considering life after recovery.

In this study, participants were limited to women. Researchers at Harvard University Medical School suggest that up to twenty-five percent (25%) of adults with eating disorders are men (http://www.anred.com/stats.html, 2007), hence further research should include more participants of both genders. This research was based on a convenience sample of participants from a rural area with a majority gathered from community college campuses, local universities, local restaurants, and small churches. Therefore, a more representative sample of the population should be tested. In addition, more questions should be asked on the survey to compensate for possible false answers given because of reasons of social desirability. Simply having an anonymous survey is not enough, for it seems hard for people to be honest even with themselves, with regard to whether or not they have had an eating disorder. Therefore, with more participants and less room for dishonesty in the answers a better idea of true attitudes may emerge. When we look at life after recovering from eating disorders, we see that there are a lot of stones that still need to be turned. Trying to discover why people struggle with eating disorders, and how to best help them, is important; however, it is only half of the story. Now is the time to start looking at how the story ends.

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Appendix A

Age: _____ **Height: _____**

Have you ever thought you had an eating disorder? **Yes** **No**

If yes, which one? ______________________

Have you ever been medically diagnosed as having an eating disorder?

If yes, which one? ________________________

If you have answered "yes" to either of the above questions,

Have you recovered from your eating disorder? **Yes** **No**

How long has it been since you have recovered from the eating disorder?

0-1 year **2-5 yeas** **5-10 years**

Have you ever experienced a relapse? **Yes** **No**

What is your current weight? ________

How many meals do you eat a day? __________

How many calories do you eat a day? _________

Please circle answer that best suits you

I feel guilty when I eat unhealthy food

Strongly Agree **Agree** **Disagree** **Strongly Disagree**

I sometimes wish I still had my eating disorder.

Strongly Agree **Agree** **Disagree** **Strongly Disagree**

Please circle all the words that come to mind when you think about food:

A necessary evil **Full of calories**
Disgusting **Comforting**
Fattening **Enjoyable**
Bad **Normal part of life**
Nourishing **Sickening**

ATTITUDES TOWARD ENTERING ROMANTIC RELATIONSHIPS WITH PEOPLE WHO HAVE A PHYSICAL OR PSYCHOLOGICAL PROBLEM: PERSONAL EXPERIENCE, AGE, GENDER, AND SPIRITUALITY/RELIGION AS EFFECTORS

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This research investigates the effects of personal experience, age, gender, and spirituality/religion on willingness to enter romantic relationships with people who have physical or psychological problems. The hypotheses tested were: 1) Men and women will believe it is more acceptable to enter into a romantic relationship with an individual who has a physical problem as opposed to a psychological problem; 2) Men will be more accepting than women of a psychological problem in their romantic partner or potential mate; 3) Men will be less accepting than women of a physical problem in their romantic partner or potential mate; 4) Men and women will anticipate more support from family and friends in having a romantic relationship with someone who has a physical problem versus a psychological problem; 5) Men and women over the age of thirty-five years old will be more accepting of physical and psychological problems in a romantic partner or potential mate; 6) Men and women who define themselves as "spiritual or religious" will be more accepting of physical and psychological problems in a romantic partner or potential mate; 7) Men and women who have personally dealt with a physical or psychological problem will be more willing to enter into a romantic relationship with someone who has a physical or psychological problem; and 8) Men and women who have previously been involved in a romantic relationship with a partner who had a physical or psychological problem will be more reluctant to enter into a romantic relationship with someone who has a physical or psychological problem. Hypotheses 1, 4, 6, and 7 were supported. Hypotheses 2, 3, 5, and 8 were not supported.

History suggests that negative attitudes toward people with disabilities are not a new phenomenon (Vash, 2001, as cited in Smith, 2003). Since 1552 B.C., when mental retardation was first mentioned in writing, differences in people, such as physical disabilities or ethnic traits, were viewed as indicators of exiguity (http://www.mnddc.org/parallels/one/1.html). Aristotle (384-322 B.C.) felt laws should be written to disallow deformed children to live out normal lives. In Sparta, it was required by law that disabled or ill babies be abandoned and left to die (http://www.mnddc.org/parallels/one/1.html). Wealthy Romans, and later, royalty, often kept physically or mentally disabled people, called "fools" or "court jesters," for their personal entertainment (http://www.mnddc.org/parallels/one/4.html). After the Crusades, "idiot cages" made their appearance in town squares. Devised as a way to keep a watchful eye on people with disabilities, these were actual cages and probably provided a bit of entertainment to passers-by (http://www.mnddc.org/parallels/two/2.html).

This shocking treatment of people with disabilities has continued into the modern era. Readers of history are familiar with Hitler's "Final Solution," a program which resulted in the killing of six million Jews during World War II (Friedlander, 1995). What most people *do not* know is that an additional 200,000 or more people with physical and mental disabilities, as well as the chronically ill, were systematically exterminated from 1939 to 1941 as part of what Hitler called the "euthanasia" program (Gallagher, 1995). Gallagher goes on to suggest these same attitudes and beliefs, which made such atrocities possible, are existent even today.

Modern efforts to de-stigmatize people with disabilities have been varied. For example, legislation such as the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (Hergenrather & Rhodes, 2007), has attempted to decrease the stereotypes and prejudice faced by members of this social group, although success appears to have been somewhat limited (Gordon, Tantillo, Feldman, & Perrone, 2002). In other attempts, national organizations have made efforts to educate the public, with mixed results. For instance, the National Alliance for the Mentally Ill (NAMI) defines schizophrenia as "'a disorder of the brain, *caused by* problems with brain chemistry and brain structure,'" while the World Psychiatric Association defines it as "'a brain disorder *that affects* the chemistry, structure, and function of the brain'" (Dietrich, Matschinger, & Angermeyer, 2006, p.167). These seemingly opposite explanations can be confusing to the general population. However, both are operating on the belief that if a behavior can be attributed to something outside the person's control, there will be less stigma attached. Ironically, some evidence suggests that biogenetic causal explanations may be not only ineffective in reducing negative biases toward people with mental illness, but may even contribute to the proliferation of such attitudes (Dietrich et al., 2006).

Numerous studies have shown significant social stigma still exists toward people with disabilities (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Gordon et al., 2004). Kreitner & Kinicki (2007), for example, report that people with disabilities often face challenges in becoming employed. Furthermore, they point out that while approximately 75% of this segment of the population is unemployed, fully two-thirds of these potential employees are willing and able to work. Interestingly, data gathered in a Harris poll shows a higher rate of satisfaction by employers with

regard to their employees with disabilities. Because of this satisfaction, many employers are supportive of policies meant to increase the number of employed people with disabilities (Kreitner & Kinicki, 2007). This disparity, between the number of disabled persons who are actually employed and the number of those who are fully willing and able to work, clearly indicates that America and other Westernized cultures are ambivalent when it comes to their outlook on equal opportunities for people with disabilities (Chen, Brodwin, Cardoso, & Chan, 2002). In other research, simply the perception of a disability in a person can cause negative emotions, attitudes and opinions, as well as various forms of nonverbal communication and behaviors, in person without disabilities (Ryan, 1971, as cited in Park, Faulkner, & Schaller, 2003).

No discussion of social stigma and attitudes toward people with disabilities would be complete without considering the phenomenon of social distance, defined as "the relative unwillingness of one person to participate in relationships of varying degrees of intimacy with a person who has a stigmatized identity" (Bowman, 1987 and Link, Phelan, Bresnahan, Stueve, & Pescolido, 1999 both cited in Hergenrather & Rhodes, 2007, p. 67). Research seems to suggest that as social distance increases, attitudes become more positive. In fact, supportive data shows more positive attitudes in regard to working with someone who has a disability than in dating or marrying a person with a disability (DeLoach, 1994; Grand, Bernier, & Strohmer, 1982; Karnilowicz, Sparrow, & Shinkfield, 1994; Strohmer, Grand, & Purcell, 1994; Stovall & Sedlacek, 1983 as cited in Hergenrather & Rhodes, 2007).

While society's attitudes toward educational and vocational opportunities may have improved, attitudes have remained virtually unmoved on the social and personal fronts (Chen et al., 2002). Little research, for example, has been conducted to measure attitudes toward dating and marrying people with disabilities. With a 19.3% rate of disability in the American population (http://factfinder.census.gov/jsp/saff/ SAFFInfo.jsp?_pageId=tp4_disability), this is certainly an area worthy of study.

Obviously, a number of factors are taken into consideration when selecting a person to date or mate. Both sexes have a tendency to prefer partners who closely match their own level of attractiveness (Feng, 2002 as cited in Wier, M., 2006; Berscheid et al., 1971 as cited in Nevid, J.,

1984). Feng goes on to speculate this may be due to an evolutionary desire to preserve both parties' genes. Perina (2007) supports this point as well, reporting that our choice of partner is related to a need to make as few mistakes as possible in regard to reproduction. Vash (2001, as cited in Smith, 2003) "suggests that the current exclusion of persons with disabilities may be based on human insecurity manifested by the conscious avoidance of anyone who looks different, fearing that inclusion of someone with a disability will somehow weaken the dependability of the group (p.1)." This application of evolutionary theory may explain why Chinese and Taiwanese students have a greater acceptance of people with physical disabilities than toward those with developmental or psychological disabilities. Since Chinese people customarily view mental impairment and illness as a shameful reflection on the family (Chen et. al., 2002), it could be assumed that mentally impaired relatives are seen as a weak link in the family structure.

A review of various studies conducted on romantic relationships, mate selection, and attitudes toward people with disabilities (Chen et al., 2002; Corrigan et al., 2001; Dietrich et al., 2006; Friedlander, 1995; Gallagher, 1995; Gordon et al., 2004; Hergenrather & Rhodes, 2007; Nevid, 1984; Smith, 2003; and Wiegerink, Roebroeck, Donkervoort, Stam, & Cohen-Kettenis, 2006) reveals that few studies have investigated attitudes concerning dating or marrying people who have disabilities. However, recent research has suggested that people's physical and psychological differences or challenges affect their perceived attractiveness level by potential mates (Chen et al., 2002; Gordon et al., 2004). Rank order preferences of disabilities, as reported by occupational therapy students in Hong Kong, and measured by Tsang, Chan, & Chan (as cited in Chen et al., 2002) suggests that people are most positive toward physical disabilities and least positive toward mental illness and developmental disabilities.

Since little research has thus far been done in the area of attitudes toward romantic relationships with people who have physical or psychological disabilities, this study will begin by assessing people's general attitudes, while considering several basic variables as possible effectors of the attitudes as well. Therefore, this study will measure: 1) general attitudes toward entering romantic relationships with people who have physical or psychological problems; 2) how personal experience of these conditions, either within the participants themselves or in a previous partner,

affects these attitudes; 3) perceived in-group attitudes toward entering romantic relationships with a person who has a physical or psychological problem; and 4) whether age, gender, or spirituality/religion affect these attitudes. The following hypotheses were tested:

1. **Men and women will believe it is *more* acceptable to enter into a romantic relationship with an individual who has a physical problem as opposed to a psychological problem.**
2. **Men will be *more* accepting than women of a psychological problem in their romantic partner or potential mate.**
3. **Men will be *less* accepting than women of a physical problem in their romantic partner or potential mate.**
4. **Men and women will anticipate *more* support from family and friends in having a romantic relationship with someone who has a physical problem versus a psychological problem.**
5. **Men and women over the age of thirty-five years old will be *more* accepting of physical and psychological problems in a romantic partner or potential mate than younger participants.**
6. **Men and women who define themselves as "spiritual or religious" will be *more* accepting of physical and psychological problems in a romantic partner or potential mate.**
7. **Men and women who have personally dealt with a physical or psychological problem will be *more* willing to enter into a romantic relationship with someone who has a physical or psychological problem.**
8. **Men and women who have previously been involved in a romantic relationship with a partner who had a physical or psychological problem will be *more reluctant* to enter into a romantic relationship with someone who has a physical or psychological problem.**

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Method

Participants

Participants in this research project were a convenience sample comprised of people encountered in Berrien, Cass, and Kalamazoo counties of Michigan. They were approached after a church service in Coloma, Berrien County, throughout the Lake Michigan College-Napier Campus building, in two private counseling centers, in a psychology class at Western Michigan University, and through random contacts. Participants were 68 men, 73 women, and one unknown gender (n=142), ranging in age from 18 to 73 years.

Attrition

Of the 142 surveys completed, one was completed by an underage male and, thus, discarded. All remaining surveys were at least partially completed. Data provided was used as appropriate in the assessment of the survey responses.

Apparatus

The instruments used were surveys created by the researcher. (See Appendix A). Each survey consisted of seven questions, as well as information regarding age and gender. Questions one through five were to be answered using a five-point Likert scale, ranging from "1/no" to "5/yes." Questions six and seven required participants to select an answer from four, fixed-response choices. (NOTE: For purposes of this study, the terms "physical problem" and "psychological problem" were not operationalized and left to the interpretation of the participants.)

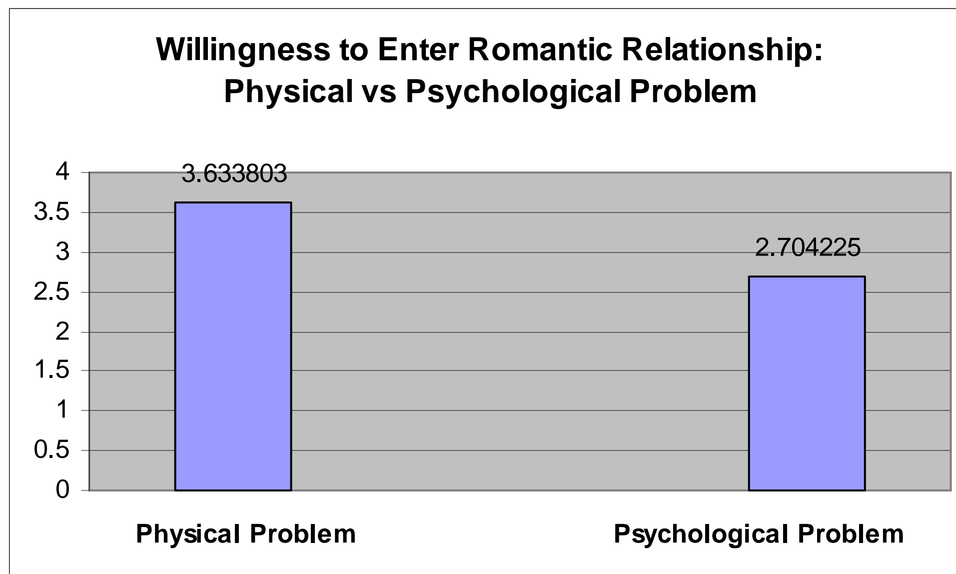
Procedure

Surveys were administered and collected over a four-week period throughout Berrien, Cass, and Kalamazoo counties in Michigan by the researcher, one male and one female counselor at both counseling centers, and a female psychology student at Western Michigan University. In addition, a few stacks of surveys were located in various departments of Lake Michigan College.

Results

Data from male (n=68), female (n=73), and unknown (n=1) participants was compiled jointly and entered into a computer spreadsheet program (total n=142). Data was then separated and analyzed according to the hypothesis being tested.

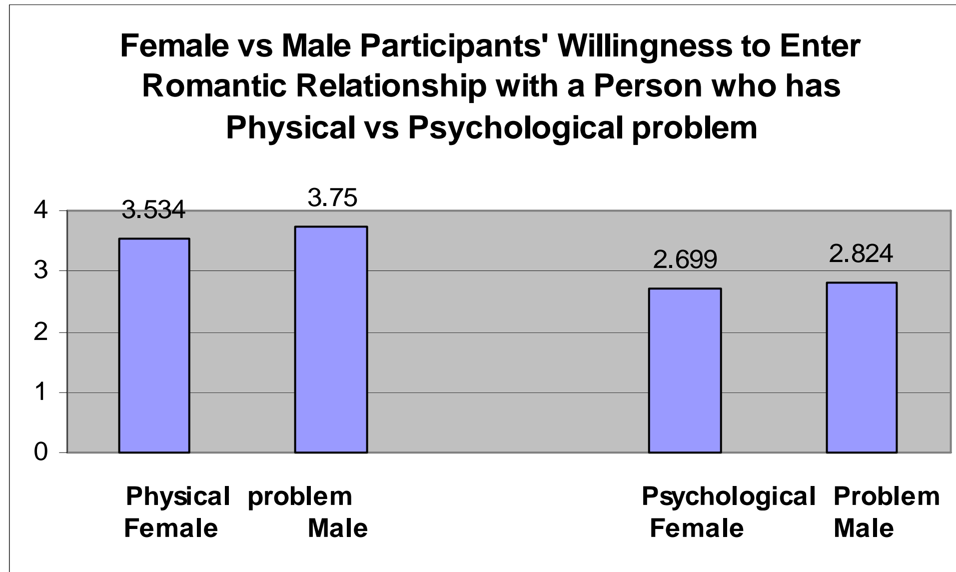
Hypothesis one, "men and women will believe it is *more* acceptable to enter into a romantic relationship with someone who has a physical problem as opposed to a psychological problem," was tested by assessing participants' responses to questions one and three on the survey. A mean score of 3.633803 was found for participants' willingness to "enter into a romantic relationship with someone who has a physical problem." A mean score of 2.704225 was found for participants' willingness to "enter into a romantic relationship with someone who has a psychological problem." A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=24154.00 n(small)=142 n(big)=142, P=<0.001) existed between the two sets of scores; therefore, hypothesis one was supported. (See Graph 1).



Graph 1

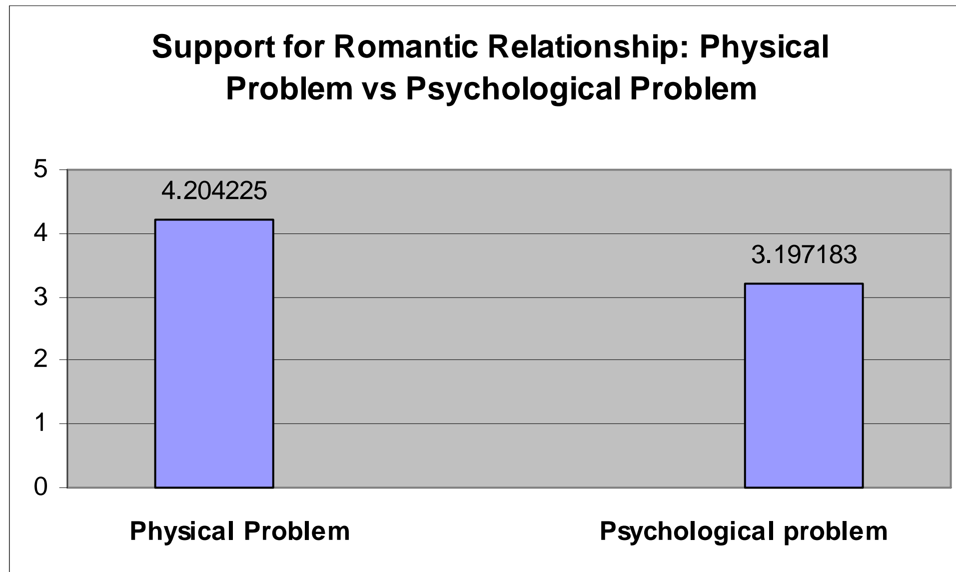
Hypothesis two, "men will be *more* accepting than women of a psychological problem in their romantic partner or potential mate," was tested by separating and analyzing responses to question three by gender. A mean score of 2.6990 was found for women, while a mean score of 2.8240 was found for men. A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=4966.50 n(small)=68 n(big)=73, P=0.5690) did not exist between the two sets of scores; therefore, hypothesis two was not supported. (See Graph 2).

Hypothesis three, "men will be *less* accepting than women of a physical problem in their romantic partner or potential mate," was tested by separating and analyzing responses to question one by gender. A mean score of 3.5340 was found for women, while a mean score of 3.7500 was found for men. A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=5125.50 n(small)=68 n(big)=73, P=0.2200) did not exist between the two sets of scores; therefore, hypothesis three was not supported. (See Graph 2).



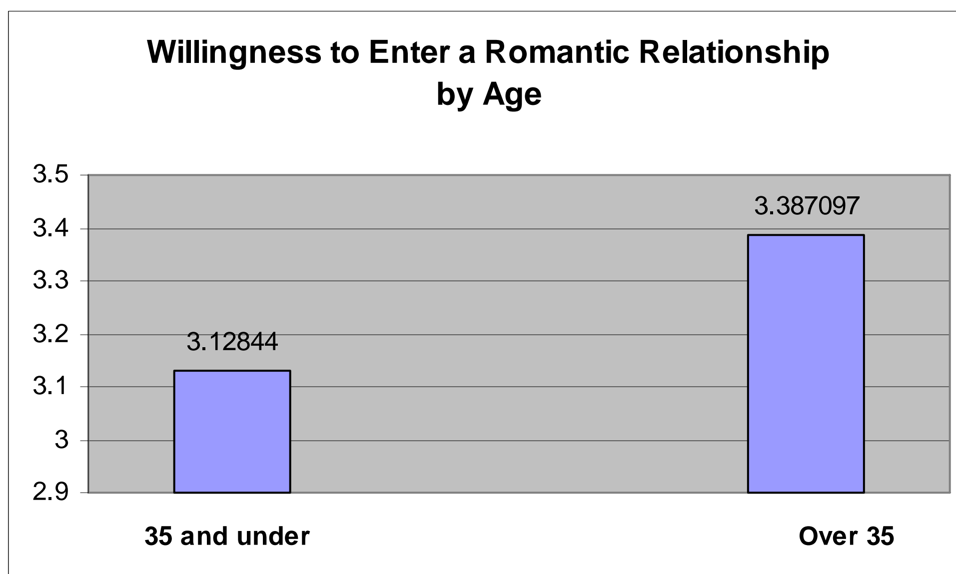
Graph 2

Hypothesis four, "men and women will anticipate more support from family and friends in having a romantic relationship with someone who has a physical problem versus a psychological problem," was tested by assessing participants' responses to questions two and four on the survey. A mean score of 4.204225 was found for the anticipation of "support from family and friends in having a romantic relationship with someone who has a physical problem." A mean score of 3.197183 was found for the anticipation of "support from family and friends in having a romantic relationship with someone who has a psychological problem." A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=24332.500 n(small)=142 n(big)=142, P=<0.001) existed between the two sets of scores; therefore, hypothesis four was supported. (See Graph 3).



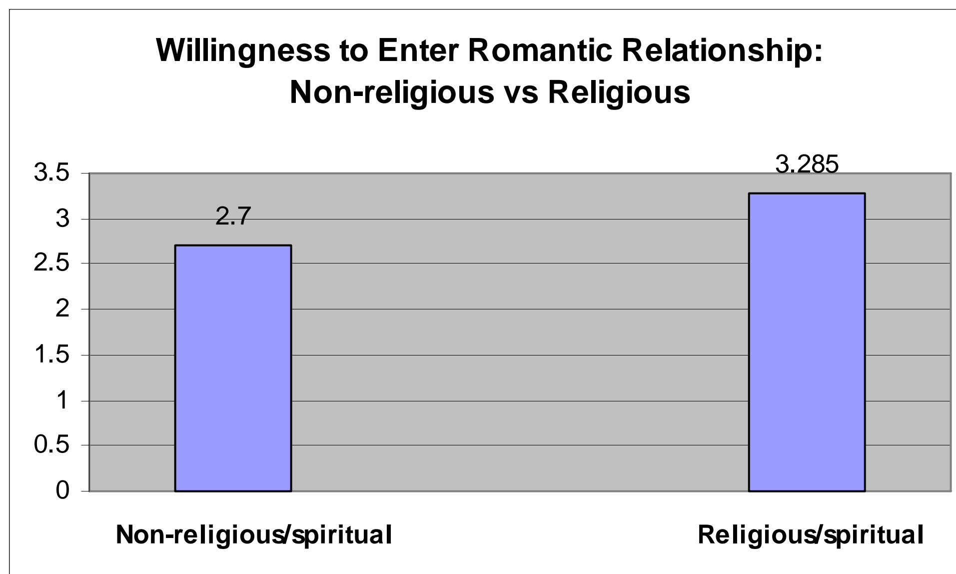
Graph 3

Hypothesis five, "men and women over the age of thirty-five years old will be *more* accepting of physical and psychological problems in a romantic partner or potential mate than younger participants," was tested by separating the data by age and assessing participants' responses to questions one and three on the survey. A mean score of 3.12844 was found for participants under the age of thirty-five years old, while a mean score of 3.387097 was found for participants over the age of thirty-five years old. A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=9489.000 n(small)=62 n(big)=218, P=0.167) did not exist between the two sets of numbers; therefore, hypothesis five was not supported. However, results were in the predicted direction. (See Graph 4).

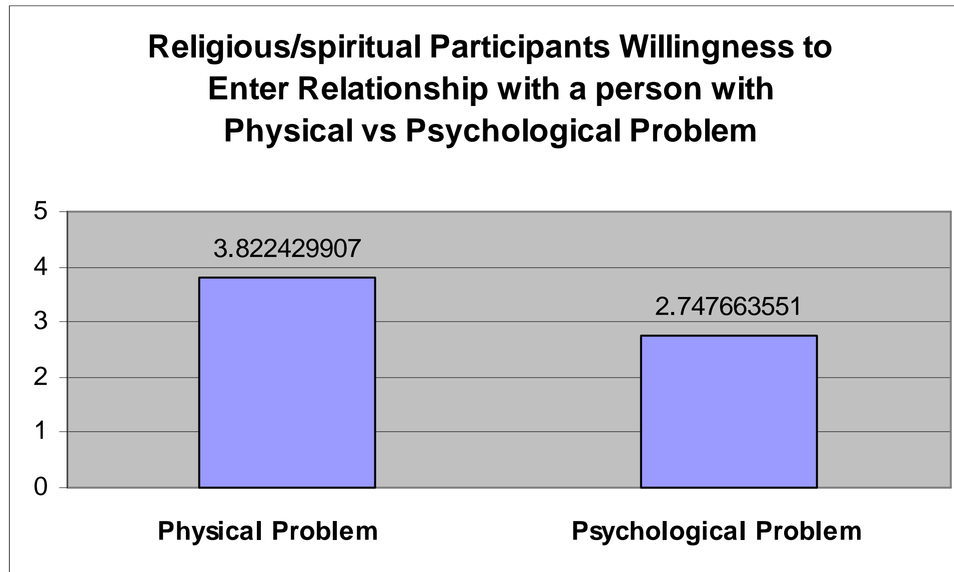


Graph 4

Hypothesis six, "men and women who define themselves as "spiritual or religious" will be *more* accepting of physical and psychological problems in a romantic partner or potential mate," was tested by assessing participants' responses to question five on the survey. Likert scores of one and two were classified "not spiritual/religious." Likert scores of four and five were classified "spiritual/religious." Scores of three were considered neutral and not included in the analysis of data. A mean score of 2.70 was found for participants' who consider themselves nonreligious or spiritual. A mean score of 3.285 was found for participants who consider themselves religious or spiritual. A Mann-Whitney Rank Sum Test determined a statistically significant difference did exist (T=5336.500 n(small)=50 n(big)=214, P=0.008) between the two sets of numbers; therefore, hypothesis six was supported. (See Graph 5). Additionally, a Two Way Analysis of Variance determined there was no statistically significant interaction between gender and religion for physical problems (P=0.271) nor for psychological problems (P=.0938). Although not addressing a specific hypothesis, it was interesting to note that upon further analysis of the data, religious/spiritual participants showed a significantly greater acceptance of dating an individual with a physical problem than for dating an individual with a psychological problem (T=14071.00 n(small)=107 n(big), P=0.001). (See Graph 5a).

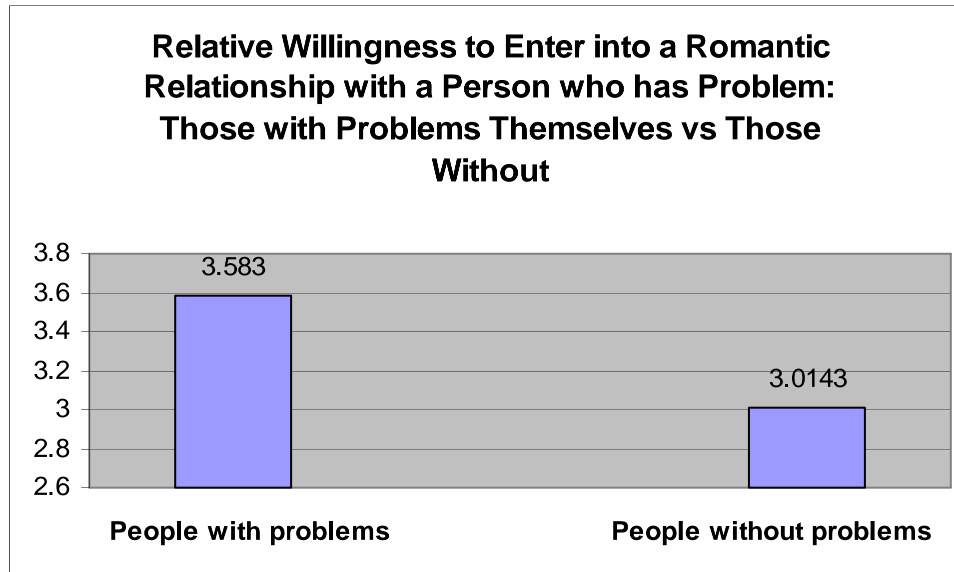


Graph 5



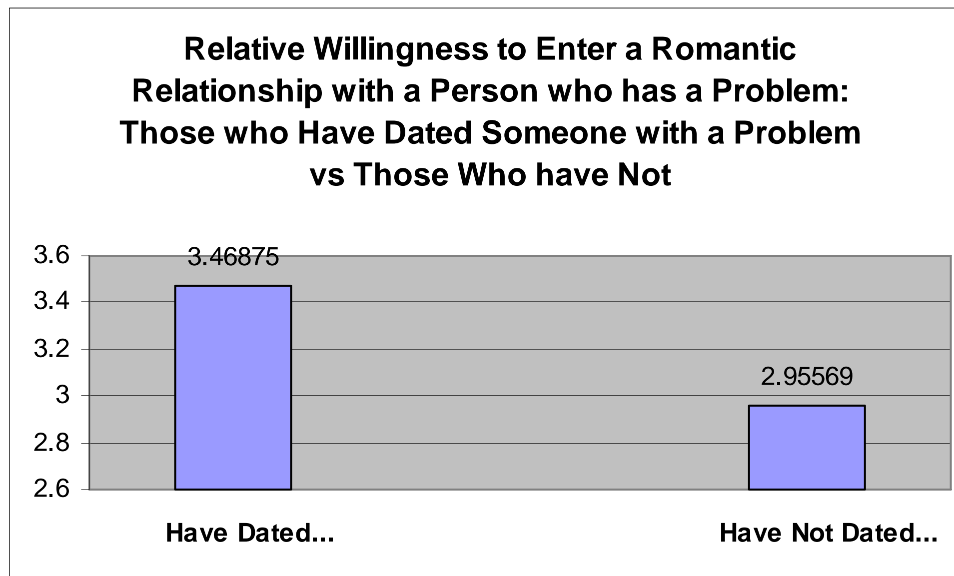
Graph 5a

Hypothesis seven, "men and women who have personally dealt with a physical or psychological problem will be *more* willing to enter into a romantic relationship with someone who has a physical or psychological problem," was tested by separating and analyzing responses to questions one and three, based on the participants' response to question six on the survey. All participants who chose "yes" answers to question six were included in one group, while participants who responded "no" were assigned to a second group. A mean score of 3.583 was found for the willingness of participants with physical or psychological problems to enter into a romantic relationship with a person who has a physical or psychological problem. A mean score of 3.0143 was found for the willingness of participants with no physical or psychological problems to enter into a romantic relationship with a person who does have physical or psychological problems. A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=11972.500 n(small)=72 n(big)=210, P=0.003) did exist between the two sets of numbers; therefore, hypothesis seven was supported. (See Graph 6).



Graph 6

Hypothesis eight, "Men and women who have previously been involved in a romantic relationship with a partner who had a physical or psychological problem will be *more reluctant* to enter into a romantic relationship with someone who has a physical or psychological problem," was tested by separating and analyzing responses to questions one and three, based on the participants' response to question seven on the survey. All participants who chose "yes" answers to question seven were included in one group, while participants who responded "no" were assigned to a second group. A mean score of 3.46875 was found for the willingness of participants to enter into a romantic relationship with a person who has a physical or psychological problem, when they have done so in the past. A mean score of 2.95569 was found for the willingness of participants to enter into a romantic relationship, with a person who has physical or psychological problems, when they have not done so in the past. A Mann-Whitney Rank Sum Test determined a statistically significant difference (T=20084.500 n(small)=128 n(big)=158, P=0.001) did exist between the two sets of numbers; however, it was in the direction opposite that of the hypothesis, revealing that people who *have* had a romantic relationship in the past with an individual who had a physical or psychological problem are more willing to do so, than people who have *not* had a romantic relationship with an individual with a physical or psychological problem. Therefore, hypothesis eight was not supported. (See Graph 7).



Graph 7

Discussion

The first hypothesis, "men and women will believe it is more acceptable to enter into a romantic relationship with someone who has a physical problem as opposed to a psychological problem," was supported (T=24154.00 n(small)=142 n(big)=142, P=<0.001) . One male participant qualified his answer to question three by writing, "Always date someone crazier than you." His answer to question seven indicated he has a psychological problem. Additionally, one female participant also qualified her answers with written comment. For question one, regarding physical problems, she wrote, "Probably not if the problem is ED [erectile dysfunction]." For question three, regarding psychological problems, she wrote, "It depends on the problem." Interestingly, her comment seemed to indicate very definite and specific ideas of what is acceptable when it comes to physical problems. When it comes to psychological problems, however, her comment seemed to indicate more uncertainty and left much more room for rejection, based on the specific problem of an individual. Her answer to question seven also indicated she has a psychological problem, as well as a physical problem.

Previous research by Socall and Holtgraves (1992) supports these results, finding that

participants were much more likely to reject a mentally ill person behaving in a particular manner, than a physically ill person behaving in an identical manner, thereby indicating a stronger prejudice toward psychological disabilities than toward physical disabilities, when all other factors are equal. While it is encouraging to see much progress has been made in the acceptance of individuals with physical problems, the prejudice that still clearly exists toward individuals with psychological problems is disappointing.

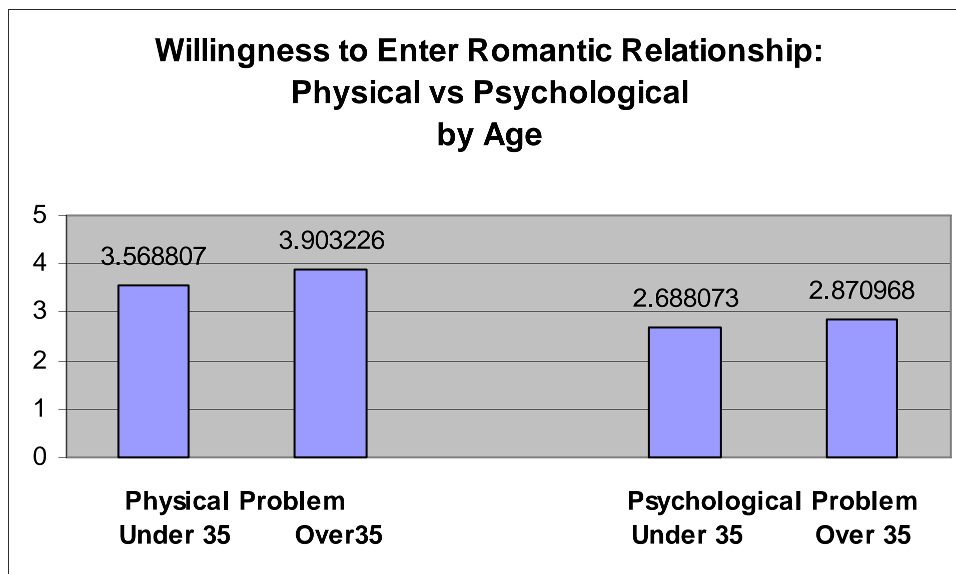
For the second hypothesis, "men will be *more* accepting than women of a psychological problem in their romantic partner or potential mate," results were in the predicted direction, as men were slightly more accepting than women of a psychological problem. However, there was not a statistically significant difference; therefore, hypothesis two was not supported (T=4966.500 n(small)=68 n(big)=73, P=0.2200) . These results are actually in conflict with those of Hergenrather & Rhodes (2007) and Gordon, Minnes, & Holden (1990), as cited in Hergenrather & Rhodes, 2007), who found a more positive attitude toward people with disabilities in female college students than in male college students. The difference in the results of this present study may be explained by the survey questions, which did not operationalize "physical problem," "psychological problem," or "romantic relationship." In both studies mentioned above, the term "disability" was used, rather than "problem," and in some cases, was specifically defined, while the terms "marriage" and/or "dating" were used, rather than "romantic relationship."

The third hypothesis, "men will be *less* accepting than women of a physical problem in their romantic partner or potential mate," was not supported (T=5125.00 n(small)=68 n(big)=73, P=.2200). Surprisingly, male participants reported a *higher* rate of acceptance toward people with physical problems, as well as psychological problems. Prior research has suggested men place more importance on physical attractiveness than women when selecting a romantic partner (Nevid, 1984). Therefore, it was interesting to note that in this study, men were more accepting of *both* physical and psychological problems.

The fourth hypothesis, "men and women will anticipate more support from family and friends in having a romantic relationship with someone who has a physical problem versus a psychological problem," was supported by a statistically significant difference (T=24332.500

n(small)=142 n(big)=142, P=<0.001). This is consistent with the results of hypothesis one, in that both women and men are more accepting of physical problems than psychological problems in people with whom they anticipate a romantic relationship. The results for hypothesis three could also be explained by the participants' desires to have in-group approval, by family and friends, of their own personal viewpoints regarding romantic relationships with people who have physical or psychological problems. An alternative explanation could be that participants were merely projecting their own feelings in anticipation of family and friends' responses.

For hypothesis five, "men and women over the age of thirty-five years old will be *more* accepting of physical and psychological problems in a romantic partner or potential mate than younger participants," results were in the predicted direction, as men and women over the age of 35 years old were slightly more accepting of having a romantic relationship with someone who has a physical problem than with someone who has a psychological problem. However, a statistically significant difference was not found to exist (T=9489.000 n(small)=62 n(big)=218, P=0.167); therefore, hypothesis five was not supported. In testing this hypothesis, the experimenter expected age and experience to mellow negative feelings toward people different from one's self, but the results would seem to indicate attitudes remain generally constant throughout one's lifetime. (See Graph 8).



Graph 8

The sixth hypothesis, "men and women who define themselves as "spiritual or religious" will be *more* accepting of physical and psychological problems in a romantic partner or potential mate than those who do not," was supported by a statistically significant difference (T=5336.500 n(small)=50 n(big)=214, P=0.008). These results were expected and suggest religion and spirituality affect attitudes toward having romantic relationships with people who have physical or psychological problems.

Results for hypothesis seven, "men and women who have personally dealt with a physical or psychological problem will be more willing to enter into a romantic relationship with someone who has a physical or psychological problem," did show a statistically significant difference (T=11972.500 n(small)=72 n(big)=210, P=0.003) and therefore, was supported. Possible explanations for this could be empathy, in-group identification (Stangor, 2000), or familiarity (Corrigan et al., 2001).

Hypothesis eight, "men and women who have previously been involved in a romantic relationship with a partner who had a physical or psychological problem will be *more reluctant* to enter into a romantic relationship with someone who has a physical or psychological problem," was clearly not supported (T=20084.500 n(small)=128 n(big)=158, P=0.001). This supports prior research that indicates familiarity with disabilities has an inverse affect on negative attitudes toward disabilities (Holmes et al., 1999 as cited in Corrigan, 2001, p. 220).

The results of this study are somewhat encouraging, as the data suggests attitudes have improved with regard to the acceptance of people with physical problems, specifically within the social context of dating or marriage. Conversely, minimal progress appears to have been made with regard to the acceptance of people with psychological problems. Chen et al. (2002) asserts,

> **For full acceptance of people who have disabilities into mainstream culture, there needs to be positive attitudes not only in areas such as employment and education, but within the interpersonal domains, including social and personal relationships. Negative attitudes toward dating and marriage indicate that persons with disabilities still are not fully accepted within society. When researchers find positive attitudes in these areas, perhaps full inclusion and integration will have become realized. (p. 10)**

Progress made toward people with physical disabilities is not enough. Society needs to progress in

their attitudes toward psychological disabilities as well.

Several variables may have affected the outcome of this study:

1) The terms "physical problem," "psychological problem," and "romantic relationship" were not operationalized, leaving the interpretation up to the participants. While this was done intentionally, in the hopes of pulling intuitive answers from the survey takers, it also created more questions and less clarity in the analysis of the results. Operationalizing the terms, or studying specific problems or disabilities, would improve the accuracy of the results.

2) This study used a convenience sample of 142 participants from a fairly rural area. A larger study, including participants from other regional and demographic areas, would provide data more representative of the population.

3) The survey instrument required self-scoring. Therefore, some of the data collected may not be accurate. Participants may have under- or over- assessed their attitudes and/or those of their family and friends. They may also have been doubtful or unclear about their answers to some of the questions, or even the questions themselves.

4) Social desirability may also be a factor in survey responses. Participants may have consciously or unconsciously answered the questions in such a way as to be perceived more favorably by the survey administrators.

Research of attitudes toward entering romantic relationships with people who have physical or psychological problems has been extremely limited to date. Clearly, there is a need for more to be done in this area. Future research should take a deeper look at the issues presented in this study. A study of how people define words or terms, such as "physical problem" or "psychological problem," and what conditions or illnesses would be included under such labels, would more clearly illustrate the perspective and attitudes of the participants. Furthermore, studying attitudes toward particular physical and psychological problems, such as bipolar disorder or quadriplegia, would be helpful as well, in identifying and addressing specific negative attitudes and their causes. In addition, more questions should focus on familiarity and in-group effect on attitudes. This data would be helpful in

developing a better understanding of what influences society's acceptance of people who have physical or psychological problems. Finally, research in the future should also include the study of people who *have* physical or psychological problems and their attitudes toward marriage and dating.

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Appendix A

AGE ____________

GENDER _____________

Please mark an "X" on the line that most closely matches your answer to the question.

Thank you for your participation in this survey!

CONFIDENTIAL SURVEY

Would you enter into a romantic relationship with someone who has a physical problem?

___________	___________	___________	___________	___________
NO		**UNSURE**		**YES**

Do you think your friends and family would be supportive if you entered into a romantic relationship with someone who has a physical problem?

___________	___________	___________	___________	___________
NO		**UNSURE**		**YES**

Would you enter into a romantic relationship with someone who has a psychological problem?

____________	____________	____________	____________	____________
NO		**UNSURE**		**YES**

Do you think your friends and family would be supportive if you entered into a romantic relationship with someone who has a psychological problem?

____________	____________	____________	____________	____________
NO		**UNSURE**		**YES**

Do you consider yourself to be a religious or spiritual person?

____________	____________	____________	____________	____________
NO		**UNSURE**		**YES**

Are you a person with a physical or psychological problem?

_____________ YES, I have a physical problem.

_____________ YES, I have a psychological problem.

_____________ YES, I have both a physical problem and a psychological problem.

_____________ NO, I do not have either type of problem.

Have you ever been in a romantic relationship with someone who has a physical or psychological problem?

_____________ YES, a physical problem.

_____________ YES, a psychological problem.

_____________ YES, both a physical problem and a psychological problem.

_____________ NO, never.

Men's Attitudes towards Women's Body Size: History of Eating Disorders as a Factor

Cody Brown

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This research examined the female body type men most prefer, and their willingness to enter into a relationship with a woman previously overweight or underweight. The hypotheses tested were: 1) Men will in fact indicate that they do prefer a female body type that is thinner than the norm. 2) The stigma of the overweight female is so strong that men will be reluctant to enter into a relationship with an attractive woman who <u>used</u> to be overweight but is no longer. None of the hypotheses were supported.

It is easy to understand why so many women have problems with their eating. Virtually everywhere one looks, whether on TV, billboards, magazines, or the Internet, female beauty is portrayed as synonymous with being young and impossibly thin. The pressure on women to be thin starts at an early age. For example, research suggests that for girls aged 10-13 years, the pressure to be thin, which they perceive as coming from the media, can lead to increased body dissatisfaction (Blowers, Loxton, Flesser, Occhipinti, & Dawe, 2003).

Another factor that must be considered when investigating the causes of eating disorders is the role of men's attitudes towards women's weight. The Western ideal of female beauty, while not universally shared, exerts a significant influence on women around the world. American culture seems to require women to posses a trinity of traits in order to be considered attractive; youth, height, and thinness (Hargreaves & Tiggemann, 2004). Yet while the attractive American man might be described as tall, muscular and athletic, American culture accepts a much broader range of body types and characteristics as attractive for men (Humphreys & Paxton, 1999). In her book, <u>The Beauty Myth</u>, author Naomi Wolf claims that American women are under significant pressure from men to be thin (Wolf, 1991). Rozin & Fallon (1988) found that women whose ages spanned two generations believed that the men in their corresponding generations preferred much thinner women than these men actually claimed to prefer. Indeed, in comparing men's preferences along racial lines, African-American men appear to prefer a heavier female figure than their White American

counterparts (Freedman, Carter, Sbrocco, & Gray, 2004). On the other hand, Benninghoven, Raykowski, Solzbacher, Kunzendorf, & Jantschek (2006) compared females with anorexia nervosa and bulimia nervosa to females without eating disorders, in terms of their perceptions of society's ideal female body. They also measured men's perceptions of what they thought constituted the most attractive female body type. The estimation of society's ideal female body type by all three female groups did *not* differ from men's perceptions of the most attractive female body. This study poses an interesting question: if men do prefer a female body type that is unhealthy for women, are men, in fact, contributing to the epidemic of eating disorders among women?

In an attempt to address this question, two hypotheses were tested in this study: *Hypothesis 1*. Men will in fact indicate that they do prefer a female body type that is thinner than the norm; *Hypothesis 2*. The stigma of the overweight female is so strong that men will be reluctant to enter into a relationship with an attractive woman who used to be overweight but is no longer.

METHOD

Participants

Participants in this research project consisted of a convenience sample of 60 men from retail establishments and academic institutions in southwest lower Michigan, including Harding's Market in Buchanan, and the Niles, Benton Harbor, and South Haven campuses of Lake Michigan College. Men ranged in age from 18 to 60 years old.

Apparatus

The data in this study was collected by means of a survey. (See Appendix A). The questions on the survey were designed to identify the degrees to which men were willing to be in a relationship with women who were previously overweight or underweight. The survey also assessed the female body type men most prefer.

Procedure

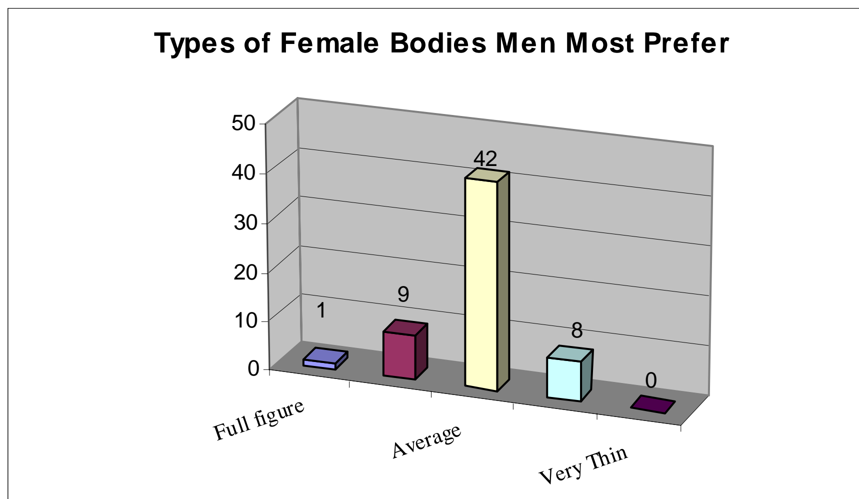
Surveys were distributed both in person and through third parties, at the aforesaid establishments in southwest lower Michigan. Participants were told that the surveys were being used to gather data for a research class at Lake Michigan College. Participants were unaware of the hypotheses being tested, and they immediately returned the completed surveys.

Results

Data from participant surveys (n=60) were complied together.

Hypothesis 1, "men in fact do prefer a female body that is thinner than the norm," was tested by tabulating participant answers to survey question #2. Overall, most participants (n=42; 87%) indicated that they in fact preferred a female body type that was average or above average weight. (See Graph 1). Hypothesis 1 was not supported.

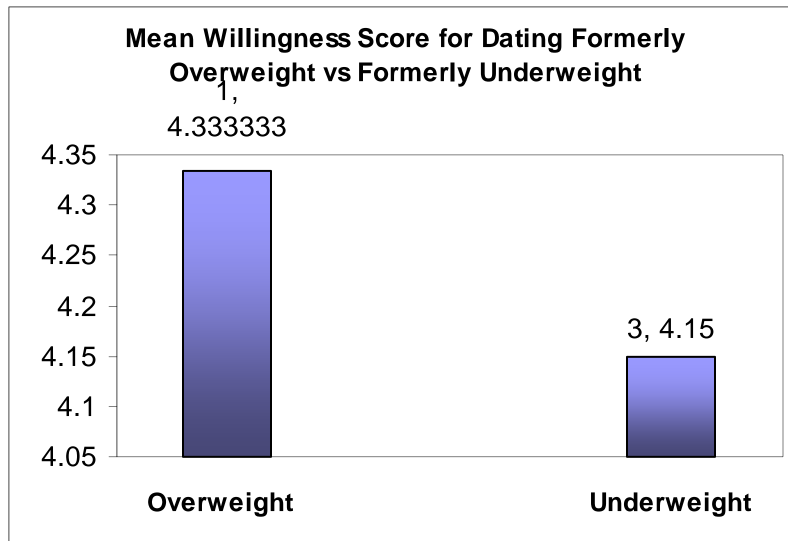
Graph 1



Hypothesis 2, "the stigma of the overweight female will be so strong that men will be reluctant to enter into a relationship with a woman who used to be overweight but is not anymore" was tested by tabulating participant answers to survey question #3, a five-point Likert scale, where 5 indicated "definitely would" and 1 indicated "definitely would not". In total, most participants

(n=42; 78%) indicated that they would not be reluctant to enter into a relationship with a woman who used to be overweight. (See Graph 2). Hypothesis 2 was not supported.

Graph 2



The hypothesis that "men will in fact indicate that they do prefer a female body type that is thinner than the norm" was not supported. Indeed, the vast majority of participants preferred average – sized women. The second hypothesis, that "the stigma of the overweight female will be so strong that men will be reluctant to enter into a relationship with a woman who used to be overweight but is not anymore" also was not supported. Again, the resounding majority of participants responded that they 'definitely' or 'probably' would ask a formerly overweight woman out on a date. Interestingly, when the prospective woman was previously underweight, participants also answered in the affirmative, but to a slightly smaller degree. Rozin & Fallon (1988) found that mothers and daughters believed that men in their respective generations preferred much thinner women than these men actually did. Therefore, the results of this research are consistent with the findings of Rozin & Fallon (1988).

Obviously, there are several factors that may have contributed to and restricted the results of this research. Participants were drawn from a convenience sample, and that sample consisted of only 60 participants. A study with more participants would strengthen the integrity of the results. Also, differences in race and ethnicity were not accounted for. Including these variables, while not changing the results, could serve to highlight different preferences among the races.

But perhaps the survey questions themselves were the primary factor influencing the results. Due to the frankness of the questions, and the sensitive subject matter, the issue of social desirability must be taken into account. Most people will avoid being seen in an unflattering light – that is, most people will try to avoid looking brazenly prejudiced. In fact, several potential participants refused to answer the survey when they read the questions, even after they were assured of confidentiality and anonymity. Certainly researchers in the future should try to create an instrument that poses the questions in a less obvious way to the participants. Eating disorders among women are a serious issue. It is important that we understand that it is not just a women's issue.

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Appendix A

1. **Age ______________**

2. **Personally, I prefer women who are:**

Full-figured__________Average_________Very Thin
5 4 3 2 1

3. **Suppose you meet a woman who you find attractive. You're thinking about asking her out. You then learn that she used to be <u>OVERWEIGHT</u>, because she had an eating disorder. Would you <u>still</u> ask her out?**

Definitely________Probably________Not_________Probably__________Definitely
<u>would</u> **sure** **not** <u>would not</u>

4. **Suppose you meet a woman who you find attractive. You're thinking about asking her out. You then learn that she used to be <u>UNDERWEIGHT</u>, because she had an eating disorder. Would you <u>still</u> ask her out?**

Definitely________Probably________Not_________Probably__________Definitely
<u>would</u> **sure** **not** <u>would not</u>

5. **Have you ever dated a woman with an eating disorder?**