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BODY-IMAGE DISTURBANCE AND A WEIGHT AND COMPETENCY  
STEREOTYPE AMONG COLLEGE WOMEN

by

Stuart G. Gibson

B. Sc. University of Alberta, 1986

A Thesis

Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
in Partial Fulfillment of the  
Requirements for the Degree  
of Master of Arts at the  
University of Windsor  
Windsor, Ontario, Canada  
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## ABSTRACT

The present study addressed the extent to which women's body-image and feelings of competency have been influenced by sociocultural pressures to be thin and successful in vocational life. Two female speakers were videotaped delivering a standard 5-minute speech with a "normal weight" and "overweight" body shape. One hundred and twenty five undergraduate women who did not have a history of eating disorders or obesity were randomly assigned to view one of four videotapes. Subjects then rated the speaker's speech competency, completed a number of body image measures and evaluated their own psychological, academic and social competence. Participants who viewed videotapes of "normal weight" speakers delivering a speech were expected to rate the speakers' speech competency more positively compared to participants who viewed videotapes of "overweight" speakers, but the results did not support this hypothesis. Also, it was hypothesized that lower self-ratings of academic, social, and psychological competence would be related to higher Body Mass Index, weight, and more negative body image, feelings of ineffectiveness, and desire for thinness. Results indicated that women who thought that they were overweight and/or who were unhappy with their appearance and shape, tended to feel socially incompetent

but weight and competency ratings were not correlated. Subject's current weight, body image, self-ratings of competency, and stimulus condition (overweight vs. normal weight speaker) were also expected to predict their ratings of the speaker's speech competency. However, the results did not support this hypothesis. Finally, Pearson product-moment correlations were calculated to assess the intercorrelations among body image measures employed in this study. Significant intercorrelations were found among EDI Body dissatisfaction, MBSRQ Appearance Evaluation, Body Areas Satisfaction (BASS), and Figure Ratings discrepancy (ideal -current shape). The results of this study are discussed in relation to previous research findings. Limitations of the videotapes and rating form are discussed as well as considerations for future research.

#### ACKNOWLEDGEMENTS

I would like to thank Cheryl D. Thomas for her enthusiastic supervision and collaboration. My gratitude is also extended to the other members of my committee, Dick Moriarty and Ann McCabe for their suggestions and support. I would also like to thank Tina Dine and Audrie Ryan for their cheerful assistance in the production of the videotapes. Finally, this document is dedicated wholeheartedly to my parents for their unconditional support.



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## CHAPTER I

### INTRODUCTION

#### Definitions

The construct of body image has generated a great deal of scientific research (Cash & Brown, 1987; Garner & Garfinkel, 1981; Slade, 1985) as well as media attention. Body image has been defined in numerous ways due to its complex and convoluted nature. As a result, a comprehensive understanding of body image and body image disturbance has remained elusive. Basically, body image refers to one's subjective experience of the way one's body looks. Body image is the picture that one gets when one looks in a mirror and the emotional response to one's appearance (Cash & Brown, 1987; Wardle & Foley, 1989). The emotional response to one's appearance includes feelings of physical attractiveness, physical effectiveness, and self-esteem (Lerner, 1976).

Cash and Green (1986) suggested that body image disturbance among women consists of weight preoccupation, body size overestimation, and body dissatisfaction. Garner and Garfinkel (1981) have delineated two basic components of body image disturbance. One component is body size distortion which involves a perceptual disturbance in which people are unable to assess their size accurately. The

second component is body dissatisfaction which refers to an attitudinal or affective reaction to the size and appearance of the body. According to Garner and Garfinkel (1981), these two components can operate conjointly or independently.

Comparing body image research results has been problematic because of the variety of conceptualizations and operational definitions of body image. In the past, different body image investigators have concentrated on measuring only one or two dimensions of body image. For instance, the majority of clinical research on body image has been limited to the perceptual component of the body image construct. The reason for this limited focus on the perceptual aspect of body image is that eating disordered people tend to be inaccurate in their body size estimations (Bruch, 1962). Body image in the general population has been a focus of study within social psychology. Satisfaction with the body and feelings of physical attractiveness have been investigated by researchers such as Cash, Cash, and Butters (1982); Cash, Winstead, and Janda (1986) and Hesse-Biber, Clayton-Matthews, and Downey (1987). Overall, social psychologists have concentrated on possible psychosocial conditions which might influence the satisfaction and evaluation of the body as opposed to psychopathological disturbances in the ability to estimate body size.

In more recent research, multiple aspects of body image have been simultaneously assessed. In particular, the perceptual and affective components of body image have been investigated in both eating disordered and normal populations (Cash & Brown, 1987; Keeton, Cash, and Brown, 1990; Slade, 1985; Thomas & Freeman, 1990). Consequently, operational definitions of body image and body image disturbance have become more specific.

#### Research Findings in Clinical Populations

Body size distortion. Significant differences in the accuracy of body size estimations have been found between controls and people with eating disorders using body part size estimation techniques (Slade & Russell, 1973; Slade, 1977; Willmuth, Leitenberg, Rosen, Fondacare, and Gross, 1985) and distorting image techniques (Garfinkel, Moldofsky, Garner, Stancer, and Coscina, 1978; Freeman, Thomas, Solyom, and Miles, 1983). However, there are numerous studies in which significant differences between controls and eating disordered subjects have not been observed. Contradictory findings have been observed with both body part size estimation techniques (Button, Fransella, and Slade, 1977; Casper, Halmi, Goldberg, Eckert, and Davis, 1979; Ben-Tovim & Crisp, 1984; Birtchnell, Lacey, and Harte, 1985) and distorting image techniques (Garfinkel, Moldofsky, & Garner, 1979; Touyz, Beaumont, Collins, McCabe, and Jupp, 1984).

Also, it has been observed that many different groups of people overestimate their body sizes. Body size overestimation has been observed in obese, normal thin women, pregnant women, neurotics, and schizophrenics (Cash & Brown, 1987). These contradictory and nonspecific results have led to recent speculation about the construct validity of certain perceptual measures of body image (Cash & Brown, 1987; Keeton et al., 1990).

Body dissatisfaction. Research which has measured the attitudinal/affective component of body image has provided more consistent evidence than research which has measured only the perceptual component of body image. For instance, anorexics, bulimics, and weight-preoccupied non-eating disordered people reported greater body dissatisfaction than controls on the Eating Disorder Inventory (Garner & Olmsted, 1984). Anorexics have also been found to evaluate their bodies less favourably than controls who were matched for age and social economic status (Cash & Brown, 1987). As a result, evidence that people who exhibit eating disorders possess less favourable body attitudes as compared to various comparison groups (Cash & Brown, 1987) support the inclusion of extreme body dissatisfaction as a diagnostic criterion for eating disorders in the DSM-III-R (American Psychiatric Association, 1987).

### Research Findings in Non-Eating Disordered Populations

Until recently, the study of body image disturbance in the non-eating disordered population has been indirect. Traditionally, non-eating disordered subjects have been used as normal controls who are compared to eating disordered groups in body image research (Cash & Brown, 1987; Garner & Garfinkel, 1981; Slade, 1985). Many investigators now suggest that body image disturbance is not limited to people with eating disorders. A large proportion of college women have demonstrated body shape dissatisfaction, weight preoccupation, and body size overestimation (Birtchnell, Dolan, & Lacey, 1987; Hesse-Biber et al., 1987; Keeton et al., 1990; Mintz & Betz, 1989).

In terms of body size distortion, Birtchnell et al. (1987) and Dolan, Birtchnell, and Lacey (1987) suggested that body width overestimation is related more to current weight than to concern about weight and shape, or to the presence or absence of an eating disorder. Other researchers agree that overestimation is common in college populations. Thompson and Thompson (1986) reported that both males and females have a tendency to overestimate body widths as measured by the Body Image Detection Device (BIDD). Cash and Green (1986) suggest that underweight people may display more body size overestimation as compared to normal and overweight people.



In terms of body dissatisfaction, Hesse-Biber et al. (1987) reported that 27.6 percent of a sample of college women were anxious when they looked at themselves in a mirror and 7.3 percent were repulsed or depressed about their body image. Hesse-Biber et al. (1987) found that female college students were less satisfied with their bodies and desired more weight change than college men. For women, the more weight change they desired, the more impaired their body images were (Hesse-Biber et al., 1987). Cash et al. (1986) conducted a body image survey in conjunction with Psychology Today. According to Cash et al. (1986)'s results, only seven percent of the female respondents indicated that they had little concern about their appearance. In addition, 55 percent of the female respondents indicated that they were dissatisfied with their weight (Cash et al., 1986).

In summary, non-eating disordered people have been observed to overestimate their body sizes (Birtchnell et al., 1987; Cash & Green, 1986; Dolan et al., 1987; Thompson & Thompson, 1986). Also, a high proportion of non-eating disordered young women are dissatisfied with their weight and shape (Cash et al., 1986; Hesse-Biber et al. 1987).

### Cult of Thinness

Individuals with clinical eating disorders struggle to control their weight and shape by means of dieting and

exercise (Hsu, 1989). However, a vast majority of people without clinical eating disorders, particularly college women, also struggle to control their weight and shape by exercise and dieting (Cash et al., 1986; Hesse-Biber, 1989; Hesse-Biber et al., 1987; Mintz & Betz, 1988). For instance, recent findings indicate that 28 percent of college women engage in some sort of dieting behaviour and that 10.6 percent of this skip meals more than once daily (Mintz & Betz, 1988). As a result, the proportion of underweight women in our society is alarming. A recent Canadian Health and Welfare Technical Report (cited in Moriarty & Moriarty, 1989) shows that 41.6 percent of Canadian women between the ages of 20 and 24 are underweight if the body mass index (BMI) is used. Body mass index is the ratio of body weight (in kilograms) to height (in metres) squared.

Hsu (1989) and Hesse-Biber (1989) suggested that eating disorders are prevalent among college-aged women because young women tend to be preoccupied with their weight and shape. Other investigators have suggested that college women are preoccupied with their weight and shape because our culture exerts pressure on women to be slim (Garner, Garfinkel, Schwartz, & Thompson, 1980; Hesse-Biber, 1989; Hsu, 1989). Moreover, this sociocultural pressure on women to be thin appears to be related to excessive dieting and body image disturbances among young women. The

sociocultural pressure on women to be slim has been described as a "cult of thinness" (Hesse-Biber, 1989; Hsu, 1989). In summary, Garner (1984) suggested five specific sociocultural influences which are associated with the increase in the prevalence of eating disorders:

- 1) Pressure to be thin
- 2) Glorification of youth
- 3) The changing roles of females
- 4) Media images and marketing of the superwoman
- 5) The sport and fitness craze

Hesse-Biber et al. (1987) also suggests that the weight ideal for female beauty in Western society has undergone a dramatic downward shift making females, already targets of society's pressure to look slim, adhere to an even stricter ideal weight standard. Banner (1983) suggests that this "cult of thinness" can be traced back to the 1960's when curvaceous movie stars were supplanted by thin fashion models as the ideals of female beauty in Western society. Schwartz, Thompson, and Johnson (1982) reported evidence to support this suggestion based on their study of preference polls from Madam Tussaud's Wax Museum in London. During the 1970's, Twiggy replaced Elizabeth Taylor as "the most beautiful woman in the world" (Schwartz et al., 1982).

Similarly, Garner et al., (1980) found that the ideal body shape for females has become thinner over two decades (1969 to 1980). These investigators reported a decrease in

measurements of Playboy centrefolds and Miss America contestants plus an increase in the number of diet articles in women's magazines over the last two decades.

Silverstein, Peterson, and Perdue (1986a) also reported a decrease in the curvaceousness of women in two women's magazines and an increase in articles about obesity and eating disorders over the period of 1901 to 1981.

Silverstein et al. (1986a) suggests that pressures on women to reduce weight, as reflected in the print media, coincided with lower average body weights and various symptoms of eating disorders among college women over the same 80 year period. In summary, there appears to be a link between an increasing sociocultural pressure on women to possess a thin body shape and an increasing prevalence of weight-concern, dieting, and eating disorders in women (Hesse-Biber, 1989; Hsu, 1989). In addition, Hsu (1989) suggests that societal pressure for thinness among women, combined with psychological factors such as poor body-concept, role confusion, and achievement conflicts may predispose women toward more intense dieting behaviour, and place them at risk for developing eating disorders (Hsu, 1989).

#### Weight and Competency Stereotype

According to Silverstein, Perdue, Peterson, Vogel and Fantini (1986b), eating disorders among women are not simply instances of individual psychopathology; rather, they are

manifestations of a societal bias against women.

Silverstein et al. (1986b) suggest that curvaceousness is associated with femininity, and that femininity is associated with a lack of intelligence and professional incompetence. Results from experimental research support the connection between curvaceousness and perceived competence. Klienke and Staneski (1980) varied bust sizes of women in photographs and observed that women with large bust sizes were perceived as less intelligent, competent, moral, and modest than the same women with smaller bust sizes. In addition, Beck, Ward-Hull, and McLearn (1976) found that women who stress academic achievement, higher education, and professional careers prefer less curvaceous bodies.

Silverstein et al. (1986b) added to these findings on the connections between competence and adherence to a slim, noncurvaceous standard of bodily attractiveness. According to Silverstein et al. (1986b), the bodies of women in popular women's magazines become less curvaceous when the proportion of employed American women working in professional jobs or the proportion of American women graduating from college rises quickly. In addition, women who thought that their fathers did not think they were intelligent tended to desire slimmer bodies as compared to women who did not feel that way (Silverstein et al., 1986b).

Silverstein et al. (1986b) hypothesized that the

association between curvaceousness and a lack of perceived intelligence and competence is an important cause of eating disorders in women. More explicitly, women may exhibit eating disorders because they are considered to be less intelligent, competent, and professional than men; women with more curvaceous and "feminine" shapes are considered to be less competent than other women (Silverstein et al., 1986b). Silverstein et al. (1986b) proposed that a cultural stereotype around curvaceousness, competence, and intelligence may help to explain why eating disorders are more common in upper and upper-middle class women who are most likely to aspire to professional positions than other women.

#### Rationale for the Present Study

In today's society, women are encouraged to possess a thin, beautiful and glamorous body shape in addition to maintaining successful careers and family lives. The mass media portray stereotypes of thin and beautiful women who are successful and competent. A prime example of this cultural stereotype around weight and competency is the motion picture, Working Girl. The current study investigated the operations of a cultural stereotype around weight and competency. It was assumed that a cultural stereotype around weight and competency influences women's evaluations of themselves and others. In terms of

evaluating others, to what extent does a speaker's shape influence a woman's evaluations of this speaker's competency? This research question is similar to Klienke and Staneski (1980) who reported that curvaceous women were rated as being less competent and intelligent as compared to noncurvaceous women.

In terms of evaluating themselves, to what extent does a woman's weight and body image influence her own self-ratings of competency? That is, do overweight women and/or women with negative body image report more incompetence as compared to normal weight women and/or women with a content body image? This research question was intended to replicate findings by Hesse-Biber et al. (1987) and Keeton et al. (1990). Hesse-Biber et al. (1987) reported that negative body image was related to impaired self-ratings of psychological, social, and academic competence whereas Keeton et al. (1990) reported a positive correlation between appearance evaluations and scores of global psychological adjustment among women.

Third, to what extent does a woman's weight, body image and self-ratings of competency influence her evaluations of another woman? That is, do overweight women or women with disturbed body image make different evaluations of speakers as compared to normal weight or women with a content body image? Moreover, to what extent do women's self-ratings of

competency relate to their competency ratings of other women?

### Hypotheses

Three primary hypotheses were tested:

Hypothesis 1. Participants who viewed videotapes of normal weight speakers delivering a speech would rate the speakers' speech competency more positively as compared to participants who viewed videotapes of overweight speakers.

Hypothesis 2. Lower self-ratings of academic, psychological and social competence would be related to higher Body Mass Index, weight and more negative body image, feelings of ineffectiveness and desire for thinness.

Hypothesis 3. Stimulus condition (normal weight vs. overweight speaker) and subject's current weight, body image and self-ratings of competence would predict subject's competence ratings of the female speaker.

Finally, given current concerns regarding the construct validity of body-image measures, (Cash & Brown, 1987; Keeton et al., 1990; Thomas & Freeman, 1990), the relationships among body image measures were assessed.



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## CHAPTER II

### METHOD

#### Subjects

One hundred and thirty-one female undergraduates at the University of Windsor were recruited from Introductory Psychology classes. The inclusionary criteria were as follows: age between 19 and 25; single, never married; no children; and no history of treatment for obesity, anorexia nervosa or bulimia. Women who agreed to participate after listening to a brief description of the study supplied their names, telephone numbers, and available times for testing on a sign-up sheet. Appointments for group testing were made by telephone. Six of the 131 women reported prior treatment for obesity. This reduced the total sample size to 125.

The mean age of the women in the final sample was 19.68 years ( $SD = 0.95$ ). Their mean height was 1.66 metres ( $SD = 0.06$ ), and their mean weight was 61.82 kilograms ( $SD = 9.94$ ). Mean Body Mass Index in the total sample was 22.47 ( $SD = 3.48$ ). Body Mass Index (BMI) is a ratio of body weight (in kgs) to height (in ms) squared. A BMI which is lower than 19 (20th percentile for women of ages 20 to 29) is considered to be a health risk (Ministry of State, Fitness, and Amateur Sport, 1986). Subjects gave written consent prior to participation (See Appendix C) and were

treated according to ethical standards for research with human subjects (American Psychological Association, 1990, Canadian Psychological Association, 1986). They all received one full percentage point toward their final course grade for participation.

### Materials

Video stimuli. Two female drama students were recruited to assist in the development of "weight and competency" stimuli. The women (both aged 20) were chosen due to their similarity in physical appearance (height, weight, hair colour, etc.), and willingness to appear in videotapes which were to be shown to subjects.

Videotapes were made of the two drama students as they recited a standard 5-minute speech. The speech was a short criticism of chemical companies that spill toxic wastes into the St. Clair River. The speech is included in Appendix A. The two drama students rehearsed the speech prior to videotaping to ensure that their speech recitals were as similar as possible.

Two simultaneous videotapes were made for each drama student's recital. One videotape was made using a regular video camera whereas the other videotape was made with a camera which has a special image-distorting device. This is the same camera which was developed by Freeman et al. (1983) for their Video Distorting Technique; degree of distortion

was set at 128% of actual body size. Thus, four videotapes were made: Speaker A "Normal Weight", Speaker A "Overweight", Speaker B "Normal Weight" and Speaker B "Overweight".

Speech rating form. The speech rating form, developed for the current study, consists of questions directed at speech content and speech performance. However, the response from only one question was used as a dependent variable (Question C. 1; "On a scale of 0 to 100, where 0 = not at all competent and 100 = extremely competent, how would you rate the overall competence of the speaker?). The speech rating form is included in Appendix B.

General Research Questionnaire (GRQ). The GRQ was comprised of two sections: Section 1 included 7 basic demographic questions and several questions intended to ensure that subjects met the inclusion criteria for participation. Section 2 was a 27-item self-report measure of comparative academic, social and psychological competence. This measure was adapted from Brownfain (1952) by Hesse-Biber et al. (1987). Subjects rated themselves on social and psychological well-being and ability traits after being asked the question: "Rate yourself on each of the following traits as you really think you are when compared with the average student of your own age. We want the most accurate estimate of how you see yourself." Possible responses for each of 27 traits were as follows: 5 (highest

10%); 4 (above average); 3 (average); 2 (below average); and 1 (below 10%). The GRQ is included in Appendix D.

Eating Disorder Inventory (EDI). The 64-item EDI (Garner & Olmsted, 1984) was used to assess cognitive, behavioural, and personality characteristics typically associated with eating disorders. The EDI is a popular screening and diagnostic measure because it has been demonstrated to possess above-average internal consistency, test-retest reliability, convergent and discriminant validity (Garner & Olmsted, 1984; Garner, Olmsted, & Polivy, 1983; Wear & Pratz, 1987). The EDI yields 8 subscale scores: Drive for Thinness, Body Dissatisfaction, Bulimia, Perfectionism, Ineffectiveness, Interpersonal Distrust, Interoceptive Awareness and Maturity Fears.

High scores on the Drive for Thinness scale indicate over-concern with dieting, preoccupation with weight, and an obsession with the extreme pursuit of thinness. Elevated scores on the Body Dissatisfaction scale indicate dissatisfaction with the shape and size of the body and body parts, and higher scores on the Bulimia scale reflect a stronger tendency to engage in episodes of uncontrolled binge eating followed by a strong desire to vomit. The Perfectionism scale assesses the extent to which individuals hold excessive personal expectations for achievement, and the Ineffectiveness scale measures feelings of incompetence and ineffectiveness which are related to self-esteem. High

scores on the Interpersonal Distrust scale reflect a sense of alienation and a general reluctance to form close interpersonal relations. High scores on the Interoceptive Awareness scale reflect a lack of confidence in recognizing and identifying emotions or visceral sensations of hunger or satiety. Finally, high scores on the Maturity Fears scale reflect wishes to retreat to the security of preadolescence.

Figure Ratings (FR). Subjects' perceptions of their actual and ideal shapes were measured by the Figure Rating method. The FR method was devised by Stunkard, Sorenson, and Schulsinger (1983) and modified for use in body image research by Fallon and Rozin (1985). The stimuli for this rating task consist of a series of nine line drawings of female figures which range ordinally from 1 (very thin body shape) to 9 (very large body shape). Subjects are asked to indicate which of the nine figures best represents their current body shape and the body shape they would prefer to have. Larger discrepancies between ratings of actual and ideal shapes reflect greater shape dissatisfaction (Fallon & Rozin, 1985).

Zellner, Harner, and Adler (1989) found that women who reported disturbed eating behaviour desired to lose weight and change their body shape. This desire to lose weight and change body shape was reflected in a large discrepancy between ratings of current body shape and ideal body shape as measured with the Figure Ratings. This measure of shape

perception was used because it was suitable for group testing situations.

Multidimensional Body-Self Relations Questionnaire (MBSRQ). Attitudinal aspects of body image were measured by the Multidimensional Body-Self Relations Questionnaire (MBSRQ), (Cash, 1988; Cash et al., 1986). The 69-item MBSRQ contains the 54-item short form (BSRQ-S) of the original 140-item BSRQ (Winstead & Cash, 1984), the 9-item Body Areas Satisfaction Scale (BASS), plus 6 weight-related items. The items were generated on the basis of conceptual, empirical, and psychometric criteria. The MBSRQ was developed from earlier versions and administered in July, 1985 through a nationwide readership survey of Psychology Today magazine (Cash et al., 1986).

The MBSRQ assesses body attitudes in three somatic domains: (1) physical aesthetics (Appearance), (2) physical competence (Fitness), and (3) biological integrity (Health). Moreover, a person's reaction to his/her image of his/her body has two psychological dimensions: (1) an affective dimension which reflects feelings about one's body (Evaluation), and (2) a cognitive/behavioural dimension which reflects beliefs about the normality of one's body (Orientation). Therefore, the MBSRQ yields scores on 6 subscales. They are as follows: Appearance Evaluation, Appearance Orientation, Fitness Evaluation, Fitness Orientation, Health Evaluation, and Health Orientation.

The survey published in Psychology Today received nearly 30,000 respondents. Cash et al. (1986) were able to randomly select a stratified sample of 2000 of these respondents to assess the reliability (internal consistency), validity, and factor structure of the MBSRQ, and to establish norms for various subgroups. There is good psychometric support for the MBSRQ; details are presented in Cash's unpublished manuscript (Cash, 1988).

More recently, the construct validity of the MBSRQ was investigated by Keeton et al. (1990) who compared multiple measurement methods within and across perceptual and attitudinal modalities of body image. Keeton et al. (1990) found that MBSRQ Appearance Evaluation scale scores were related to other attitudinal measures of body image. Higher Appearance Evaluation scale scores were related to higher Body Parts Satisfaction Scale scores, and lower Subjective Units of Distress Scale scores. In addition, Appearance Evaluation was negatively correlated with global psychological adjustment and disordered eating behaviour.

### Procedure

Subjects were tested in groups of five in the Body Image Laboratory in the Department of Psychology by a male experimenter. The women completed written consent forms on arrival for the testing session. Each group tested was randomly assigned to one of the four video stimulus



conditions (Speaker A "normal weight", Speaker A "overweight", Speaker B "normal weight" or Speaker B "overweight"). The group members viewed the videotape and rated the competency of the speech delivered by the speaker. Next, subjects completed the self-report measures; order of presentation was counterbalanced across subjects.

Finally, weight and height were objectively assessed. Subjects were debriefed, thanked and asked not to discuss their participation with others. A description of the debriefing is included in Appendix E. Subjects were told that they could receive information about the results if they contacted the experimenter at a later time.

### Data Analyses

Preliminary data transformations. The 27-item competency measure used in the present study is intended to measure self-rated competency in three domains: academic, social and psychological. However, in previous research with this measure investigators have analyzed the scores on the measure item by item, rather than by domain (Brownfain, 1959, Hesse-Biber et al., 1987). Subscales which reflect the three domains have not been established or validated by empirical or rational methods. Item by item analysis of the competency measure was undesirable for purposes of the present study.

Although a principal components analysis might have been used to empirically identify meaningful groupings of items, the subject to item ratio was less than optimal. Therefore, the items were grouped rationally, according to the domain they appeared to reflect (academic, social or psychological). The rationally-constructed subscales are presented in Appendix F. Examination of the intercorrelations between the subscales indicated significant positive correlations between the Academic and Social subscales ( $r = .46$ ), and the Social and Psychological subscales ( $r = .56$ ). The correlation between the Academic and Psychological subscales was positive but not statistically significant ( $r = .13$ ).

## CHAPTER III

### RESULTS

#### Check on the Success of Random Assignment

Subjects assigned to the four stimulus conditions did not differ with respect to age, height, Body Mass Index (BMI), or weight (see Table 1). Thus, it appeared that the blocked random assignment procedure resulted in equivalent groups, at least with respect to the variables assessed.

#### Effects of Speakers' Weight on Subjects' Judgements of Speech Competency

Hypothesis 1. It was hypothesized that subjects would judge the competency of overweight speakers less positively than the competency of normal weight speakers. Preliminary analyses indicated that there were no significant differences in competency ratings between "normal weight" Speakers A and B [Speaker A Mean = 75.91, SD = 9.62; Speaker B Mean = 77.80, SD = 14.10;  $F(60) = 0.38$ ,  $p = .5369$ ], or "overweight" Speakers A and B [Speaker A Mean = 73.67, SD = 12.34; Speaker B Mean = 77.80, SD = 11.00;  $F(61) = 1.96$ ,  $p = .1663$ ]. Therefore, the two groups who rated "normal weight" speakers were combined, as were the two groups who made ratings of "overweight" speakers.

Table 1

Age, Height and Weight Characteristics of Women Randomly Assigned to each of the Four Stimulus Conditions.

	Stimulus Condition					
	Speaker A Normal Weight	Speaker A Over Weight	Speaker B Normal Weight	Speaker B Over Weight		
	<u>n</u> =32	<u>n</u> =33	<u>n</u> =30	<u>n</u> =30	<u>F</u>	<u>p</u>
<hr/>						
Age						
Mean	19.37	19.73	19.73	19.90	1.74	.16
SD	0.61	0.76	1.05	1.24		
Height (m/in)						
Mean	1.67	1.67	1.64	1.66	1.94	.13
SD	0.07	0.07	0.04	0.01		
Mean	65.78	65.78	64.59	65.38		
SD	2.76	2.76	1.58	0.39		
Weight (kg/lb)						
Mean	60.94	64.94	58.78	62.75	2.02	.11
SD	8.24	12.02	8.85	9.56		
Mean	134.37	143.19	129.61	138.36		
SD	18.17	26.50	19.51	21.07		
Body Mass Index						
Mean	21.92	23.19	21.98	22.74	1.00	.39
SD	2.97	4.00	3.54	3.29		

Now it was possible to test the hypothesis that subjects who viewed videotaped speech presentations by "normal weight" speakers would give more favourable ratings of speech competency as compared to subjects who viewed videotaped speech presentations by "overweight" speakers. Results indicated that competency ratings for "normal weight" speakers did not differ from those assigned to "overweight" speakers [Normal Weight Mean = 76.82, SD = 11.94; Overweight Mean = 75.63, SD = 11.79;  $F(123) = 0.31$ ,  $p = .5767$ ]. Thus, hypothesis 1 was not supported.

#### Self-Ratings of Competence, Weight, and Body Image

Hypothesis 2. Pearson product-moment correlation coefficients between self-ratings of competence, weight, and body image variables were calculated to test the hypothesis that lower self-ratings of academic, social and psychological competence would be related to higher BMI, higher weight, more negative body image, feelings of ineffectiveness and increased desire for thinness. Table 2 displays the correlations between self-ratings of competence, weight characteristics, and body image variables.

First of all, neither weight nor BMI were significantly related to self-ratings of competence in any of the three domains. However, lower self-ratings of social competency

Table 2

Correlations Between Self-Ratings of Competency, Weight and Body Image Variables in the Total Sample (n=125).

	Academic Competence	Social Competence	Psychological Competence
Body Mass Index	-0.15	-0.15	-0.04
Current Weight	-0.16	-0.14	-0.05
EDI Drive for Thinness	-0.03	-0.18	0.02
EDI Body Dissatisfaction	-0.10	-0.32 ***	-0.13
EDI Ineffectiveness	-0.14	-0.39 ***	-0.24 *
FR Current	-0.13	-0.25 *	-0.12
FR Ideal	-0.17	-0.10	-0.04
FR Discrepancy	0.02	0.22 *	0.11
MBSRQ Appearance Evaluation	0.25 *	0.53 ***	0.28 **
MBSRQ Appearance Orientation	0.04	0.02	0.05
MBSRQ Fitness Evaluation	0.07	0.16	0.08
MBSRQ Fitness Orientation	0.28 **	0.29 **	0.18
MBSRQ Health Evaluation	-0.03	0.14	0.04
MBSRQ Health Orientation	0.21 *	0.27 **	0.25 *
MBSRQ Illness Orientation	0.04	0.18	0.19
MBSRQ Body Areas Satisfaction	0.18	0.43 ***	0.22 *

Note. With  $p < .001$ , for a family of 48 comparisons, adjusted  $p < .05$ .

\*  $p < .05$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$ ; (all two-tailed).

EDI - Eating Disorders Inventory

FR - Figure Ratings

MBSRQ - Multidimensional Body-Self Relations Questionnaire

were associated with higher EDI Body Dissatisfaction scale scores ( $r = -.32$ ), larger FR ratings of current shape and larger FR discrepancy scores ( $r_s = -.25$  and  $.22$ , respectively). Higher EDI Ineffectiveness scale scores were associated with lower self-ratings of competence in both social ( $r = -.39$ ) and psychological domains ( $r = -.24$ ).

In terms of body image as measured by the MBSRQ, higher Appearance Evaluation scale scores were significantly related to higher self-ratings of social, psychological and academic competence ( $r_s = .25$  to  $.53$ ). However, only self-ratings of social and psychological competence were associated with Body Areas Satisfaction (BASS) scores ( $r_s = .43$  and  $.22$ , respectively). Health Orientation scores were positively correlated with self-ratings of competence in all three domains ( $r_s = .21$  to  $.27$ ). However, Fitness Orientation scores were positively correlated with only academic and social competency self-ratings ( $r_s = .28$  and  $.29$ , respectively).

It should be noted that with  $p < .001$  adjusted for the number of comparisons made, the only correlations that remain statistically significant are the correlations between self-ratings of social competence and scores on the MBSRQ Appearance Evaluation, BASS, EDI Body dissatisfaction, and EDI Ineffectiveness scales ( $r_s = .53$ ,  $.43$ ,  $-.32$ , and  $-.39$  respectively).

### Relations between Self-Ratings and Subjects' Judgements of Speakers' Speech Competency

Hypothesis 3. A standard multiple regression was performed using BMDP1R (Dixon, 1985) to test the hypothesis that subject's BMI, EDI Body dissatisfaction, self-ratings of competence and stimulus condition (normal weight vs. overweight speaker) would predict subject's ratings of the speaker's speech competency. The  $R$  for the regression was not significantly different from zero [ $F(6,118) = 0.97$ ,  $p = .4489$ ]. Subjects' ratings of the speaker's speech competency were not predicted by their BMI, EDI Body dissatisfaction, self-ratings of competence and stimulus condition. In subsequent regressions, FR discrepancy and MBSRQ Appearance Evaluation were substituted for EDI Body dissatisfaction as the body image variable. Neither variable improved the significance of the regression model. Thus, hypothesis 3 was not supported.

### Body Image Intercorrelations

Pearson product-moment correlation coefficients were calculated to assess the intercorrelations among body image measures. Table 3 displays the correlation matrix for the FR Discrepancy score (Ideal-Current Shape), EDI Body dissatisfaction, and MBSRQ scales. Larger FR discrepancies were related to greater EDI dissatisfaction, more negative self-evaluations on the MBSRQ Appearance Evaluation scale,



Table 3

Pearson Product-Moment Correlation Coefficient Matrix of Body-Image Measures

	FR discrepancy	EDI Body dissatisf	MBSRQ Appearance Evaluation	MBSRQ Appearance Orientation	MBSRQ Fitness Evaluation	MBSRQ Fitness Orientation	MBSRQ Health Evaluation	MBSRQ Health Orientation	MBSRQ Illness Orientation	Body Areas Satisfaction Scale
FR discrepancy	1.00									
EDI Body dissatisfaction	-0.61 ***	1.00								
Appearance Evaluation	0.52 ***	-0.64 ***	1.00							
Appearance Orientation	-0.13	0.26 **	-0.06	1.00						
Fitness Evaluation	0.05	-0.05	0.15	-0.03	1.00					
Fitness Orientation	0.14	-0.12	0.23 *	0.04	-0.08	1.00				
Health Evaluation	0.13	-0.25 *	0.30 **	0.08	0.06	0.20 *	1.00			
Health Orientation	0.11	-0.17	0.27 **	0.16	0.02	0.53 ***	0.39 ***	1.00		
Illness Orientation	0.09	-0.15	0.33 ***	0.18	0.04	0.03	0.05	0.46 ***	1.00	
Body Areas Satisfaction	0.56 ***	-0.78 ***	0.72 ***	-0.24 *	0.21 *	0.14	0.31 **	0.20 *	0.22 *	1.00

Note: With  $p < .001$ , for a family of 45 comparisons, adjusted  $p < .05$ \*  $p < .05$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$  (all two-tailed)

and more negative self-ratings of body areas on the BASS scale (absolute  $r_s = .52$  to  $.61$ ). EDI Body dissatisfaction scores were inversely correlated with MBSRQ Appearance Evaluation and BASS scores ( $r_s = -.64$  and  $-.78$ , respectively). In addition, EDI Body dissatisfaction scores were positively related to MBSRQ Appearance Orientation and inversely related to Health Evaluation scale scores ( $r_s = .26$  and  $-.25$ , respectively).

In terms of intercorrelations among MBSRQ scales, more positive self-evaluations on the Appearance Evaluation scale were related to higher self-ratings on the Fitness, Health and Illness Orientation scales ( $r_s = .23$ ,  $.27$ , and  $.33$ , respectively). In addition, more positive self-evaluations of appearance were related to higher self-ratings on the Health Evaluation scale and greater satisfaction with body areas on the BASS ( $r_s = .30$  and  $.72$ , respectively).

In addition to being related to Appearance Evaluation, more satisfaction with body areas (BASS) was related to higher self-evaluations on the Fitness and Health Evaluation scales ( $r_s = .21$  and  $.31$ , respectively), as well as higher self-ratings on the Health and Illness Orientation scales and lower self-ratings on the Appearance Orientation scale ( $r_s = .20$ ,  $.22$ , and  $-.24$ , respectively). In addition, higher self-ratings on the Health Orientation scale were related to more Illness Orientation and higher Health Evaluations ( $r_s = .46$  and  $.39$ , respectively). Finally,

higher self-ratings on the Fitness Orientation scale were related to higher self-ratings on the Health Orientation and Evaluation scales ( $r_s = .53$  and  $.20$ , respectively).

## CHAPTER IV

### DISCUSSION

#### Effects of Speakers' Weight on Subjects' Judgements of Speech Competency

A primary purpose of this study was to assess the operations of a cultural stereotype around weight and competency. The present results did not support the hypothesis that overweight women would be rated as less competent than women of average body weight, and are inconsistent with Klienke and Staneski (1980) who found that large busted women were seen as less intelligent and competent compared to normal and small busted women. There are many possible reasons for these contradictory results; first of all, Klienke and Staneski (1980) utilized colour photographs of women sitting in chairs as compared to black and white videotapes of women reciting a speech from a standing position. Second, Klienke and Staneski (1980) manipulated only the bust size whereas the present study manipulated the entire body shape. Finally, subjects in the current study may have been more influenced by current media attention to issues of body image disturbance, eating disorders, and cultural stereotypes compared to those in the Klienke and Staneski (1980) study. It is possible that more knowledge about the negative effects of stereotypes around

weight and competency has resulted in less adherence to such stereotypes.

In the present study, there were no differences in ratings of speech competency assigned to "normal weight" and "overweight" speakers. These results suggest that a "weight and competency" cultural stereotype may not be as pervasive and/or maladaptive as expected. However, it is also possible that the stimuli and measures used to assess the current study's hypothesis were inadequate. For instance, there were numerous extraneous variables which may have confounded the impact of the video stimuli. This was evident from the results of the pilot study. The speakers' hair colour, facial features, clothing, voice tone, or speech rate may have influenced the subjects' ratings to a greater extent than the manipulation of body shape. The concept of a "weight and competency" stereotype is worthy of future research; however, the stimuli and measures used to assess stereotypes around weight and competency will need to be designed so that extraneous variables do not impact on subjects' judgements.

Future research using videotapes of speakers might be more successful if there is a larger discrepancy between body shapes. The videotapes in the present study were of "normal weight" and "overweight" body shapes. It was not possible to record videotapes of an "overweight" and "underweight" body shape simultaneously because there was

only one image-distorting camera. However, a larger discrepancy between the "normal weight" and "overweight" body shapes, in addition to using an ultra slim speaker might permit a more precise assessment of stereotypes around weight and competency. Also, the rating form asked only one question about the speaker's overall competency. Since the present study's results suggested a connection between self-ratings of social competency and negative body image, the inclusion of different types of competency in the rating form might produce interesting results. As an example, subjects might be asked to rate the social, psychological, and academic competence of the speaker. Under such conditions, the "overweight" speaker might be rated as less socially competent compared to a "normal weight" or "slim" speaker.

Another source of uncontrolled influence might have been a demand characteristic bias. Some subjects may have been actively interpreting the purposes of the videos and rating forms and their relations to the hypotheses. Subjects' ratings of the speaker's competency may have been biased if subjects concluded that their evaluations were supposed to be influenced by the speaker's body shape, especially in the overweight speaker condition.

### Self-Ratings of Competence, Body Image, and Weight

Another purpose of this study was to investigate the relations between self-ratings of competence, body image, weight, feelings of ineffectiveness, and desire for thinness. The results failed to support the hypothesis that current weight and BMI would be related to self-ratings of academic, social and psychological competence. However, women's attitudes towards their bodies were significantly related to self-ratings of competence, particularly in the social domain. It appears that women who are dissatisfied with their shape and/or appearance see a thin and beautiful body shape as a necessary component of successful social functioning. This could be construed as support for a cultural stereotype around body shape/size and competence (but only social competence).

The present results are consistent with the body image literature. For instance, the present results are similar to those of Keeton et al. (1990) who suggested that more negative self-evaluations of appearance were related to lower self-ratings of psychological adjustment. In addition, the present results support Hesse-Biber et al. (1987) who suggested that negative body image was related to impaired self-ratings of social competency (in particular, popularity, popularity with the opposite sex, physical attractiveness, assertiveness, and social self-confidence).

In summary, the present results suggest that body image, but not weight, is related to self-ratings of competence, particularly in the social domain. It appears that Canadian college women who are dissatisfied with their appearance, weight, and/or shape also feel less popular, assertive, and socially confident. In other words, women's self-evaluations of social functioning are not related to their objective weight but to subjective beliefs about the normality of their appearance and shape. Overall, the present results do not suggest that overweight women feel socially incompetent; rather, women who think that they are overweight and/or are unhappy with their appearance and shape tend to feel socially incompetent. The crucial factor is self-evaluation or cognitive appraisal. Therefore, education about the influence of cultural stereotypes and the role of cognitive appraisal should be a focus of treatment for people who exhibit body image disturbance.

Interpretations of the present results suggest a wide range of future research questions. Previous research indicates that self-esteem and social anxiety are intricately related to body image disturbance (Cash & Brown, 1987; Rosen, Gross, & Vara, 1987). It is reasonable to assume that successful social interactions help to increase feelings of popularity, assertiveness, attractiveness, confidence as well as self-esteem. It would be interesting to measure the amount of social involvement in addition to



body image, self-ratings of competence, and self-esteem. Women who are dissatisfied with their attractiveness and shape may avoid social activities and interactions. Such avoidance may mediate body image disturbance, evaluations of social competence, and self-esteem.

Correlations between MBSRQ scale scores and self-ratings of competence suggest that creating a healthy lifestyle and engaging in physical exercise is also related to feeling competent. The items of the MBSRQ Health and Fitness Orientation scales reflect concerns about proper eating behaviour, regular physical exercise, and awareness of fitness and diet issues. These results suggest that creating a healthy lifestyle is a necessary component of perceived self-competence. Thus, empirical evidence supports the old adage "a healthy body is a healthy mind!".

Finally, lower self-ratings of academic, social and psychological competence were expected to relate to feelings of ineffectiveness and a strong desire for thinness among women in the current sample. In this study, weight loss preoccupation and a desire for thinness were related to low self-ratings of social competence, but these relationships were not statistically significant. However, self-ratings of social and psychological competence were significantly related to feelings of ineffectiveness. This finding is hardly surprising; it is logical that women who reported lower ratings of social and psychological competence would

also report feelings of ineffectiveness. Feeling effective is a defining feature of self-efficacy which is sometimes considered to be a component of self-esteem (Zimbardo, 1987). In summary, the significant correlations between EDI Ineffectiveness and self-ratings of social and psychological competence lend some construct validity to the self-rating form used in the present study.

#### Relations between Self-Ratings and Subjects' Judgements of Speakers' Speech Competency

In the current sample, weight, shape satisfaction and self-ratings of competence did not play an influential role in determining women's evaluations of the models' speech competency. That is, being overweight or feeling incompetent or being dissatisfied with shape did not have a significant influence on college women's evaluations of others. The lack of support for this hypothesis suggests that a cultural stereotype around weight and competency may not impact upon women's evaluations of others. That is, a woman who is dissatisfied with her shape and who feels socially incompetent will not necessarily project her internalized "weight and competency" stereotype onto others.

#### Body Image Intercorrelations

The significant intercorrelations among FR discrepancy, MBSRQ Appearance Evaluation, BASS, and EDI Body

dissatisfaction indicate a substantial convergence among these attitudinal measures of body image. The present results are consistent with the views of Cash and Brown (1987) and the results of Keeton et al. (1990) who note that attitudinal measures of body image tend to be moderately to highly intercorrelated.

Except for the Appearance Evaluation and BASS scales, MBSRQ scales were not correlated with the other body image measures employed in this study (FR current and discrepancy scores, EDI Body dissatisfaction). This is unsurprising because the other six MBSRQ scales were not designed to measure affective reactions to one's physical appearance and/or body shape. In fact, Cash and his colleagues have described the MBSRQ as an advance in the measurement of body image because it measures attitudes and behaviours oriented toward health, fitness and illness, in addition to body-size and appearance. Perhaps future research will use different measures which can validate the other MBSRQ scales. For example, a demonstration of proper eating habits, regular physical exercise, and substantial knowledge of fitness, illness and diet issues could be utilized as criteria to validate the Health, Fitness, and Illness Orientation scales of the MBSRQ.

APPENDIX A

SPEECH

- thank you for letting me speak to you today
- I would like to talk to you about the chemical companies that continue to regularly spill toxins into the St. Clair River
- when a dark monster was discovered prowling the depths of the St. Clair River in 1985 it became clear that the industries of the Chemical Valley of Sarnia were up to no good
- the "Blob" as it became known was the alleged result of a spill of dry cleaning solvents into the St. Clair River
- After this happened, the media and government disclosed horror stories daily and we learned that the Chemical Valley had been releasing hundreds of pounds of chemicals into the river on a daily basis with permission from the government
- in addition, they had been accidentally spilling about double that amount
- these disclosures resulted in public pressure on the government to do something
- impressive thick reports were ordered by the government
- promises were made; laws were drafted
- the sabres of enforcement and prosecution were rattled mightily

#### HOWEVER

- in just over three years following the Blob discovery there have been hundreds of "reported" spills of chemicals
- an average of 2 spills per week !
- these spills were from chemical companies which are on their "best behaviour"
- some of the spills were large, some small
- some were very toxic, others less so
- some were recovered in whole or in part, others not at all

- not all data have been made available but the following is known:

- 1) some of the spills are unknown
- 2) some involve oil
- 3) some involve untreated wastewater
- 4) even gasoline and diesel fuel

SO NOW WHAT?

- The chemical Valley continues to pollute our waters...the waters which we drink, bathe, and cool with and the water from which many catch fish

- in October, Polysar had a major spill of diethylbenzene resulting in the fourth recent closure of downstream water intake systems

In summary,

- we can add somethings to what the Chemical Valley spills into the St. Cl. R:

- 1) water from other rivers
- 3) tonnes of pesticides annually from the farmers
- 4) acid rain and toxic fallout

- we can take this and add untreated raw sewage, road runoff, and recreational and commercial watercraft spills

- we can pour this chemical cocktail over some grossly contaminated sediments and you have what we in the Windsor area call "water"

IS THERE ANY HOPE?

- these spills must end now!

- Lake St. Clair can no longer serve as an industrial toilet....not if we continue to depend on its waters for fishing, drinking, bathing, swimming, and life

APPENDIX B

SPEECH RATING FORM

A) Speech Content

1) How interesting was the subject material?

1. Not at all interesting
2. Somewhat interesting
3. Moderately interesting
4. Extremely interesting

2) How convincing was the speaker's argument?

1. Not at all convincing
2. Somewhat convincing
3. Moderately convincing
4. Extremely convincing

B) Speech Presentation

Please rate the speaker on each of the following items listed, using the following scale:

- A) Poor, really interfered with a smooth presentation
- B) Problematic, interfered somewhat with a smooth presentation
- C) Pretty good, interfered very little with a smooth presentation
- D) Excellent, did not interfere at all with a smooth presentation

1. Voice clarity

A      B      C      D

2. Rate of speech (eg. too fast or too slow)

A      B      C      D

3. Apparent confidence of the speaker

A      B      C      D

4. Nonverbal behaviours (eg. hand movements, gestures, facial expressions)

A      B      C      D



D) Overall Ratings

1) On a scale of 0 to 100, where 0=not at all competent and 100=extremely competent, how would you rate the overall competence of this speaker?

\_\_\_\_\_ / 100

2) On a scale of 0 to 100, where 0=no chance and 100=sure winner, in your opinion, what is the likelihood that this speaker could win a speaking contest?

\_\_\_\_\_ / 100

## APPENDIX C

### CONSENT FORM

## Participant Information and Consent Form

### BODY-IMAGE RESEARCH

This research is concerned with the relationships among body-image, self-concept, and certain sociocultural expectancies. If you agree to participate in this research, you will attend a group testing session with a male researcher in the Department of Psychology. During the 50 to 60 minute session, you will be asked to watch and make judgements on videotaped presentations and to complete several short questionnaires about your experiences and views of yourself. Most people find these tasks interesting and enjoyable. There are no "right" or "wrong" answers to any of the questions which you will be asked; we'd simply like you to report your judgements and experiences as honestly as you are able. You will receive credit for towards your final grade in your Introductory Psychology Course as compensation for your time. The researcher will provide you with more details about the research before you leave.

### Consent to Participate

I have read the above description and agree to participate in the research procedures as outlined. I understand that my responses will be held in confidence, identified only by a research code number, and that I may withdraw from the study at any time, at my request. I also understand that I may register any complaints which I might have about this research with Dr. Robert Orr, Chair, Department of Psychology, University of Windsor. I am aware that, at my request, a summary of the results of this research will be made available to me when the study has been completed.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

**APPENDIX D****GENERAL RESEARCH QUESTIONNAIRE**

This questionnaire includes TWO SECTIONS. Please respond to every question item in each section. Apart from a few factual questions in Section A, most of the questions on this form have to do with your thoughts and feelings about different aspects of your life. There are no right or wrong answers to such questions; we are simply interested in learning a little about how you honestly think and feel about things. Your answers will be held in confidence.

#### SECTION A

1. Age: \_\_\_\_\_
2. Marital status (circle your response):
  - a. Single, never married
  - b. Married (including common-law)
  - c. Separated/Divorced
  - d. Widowed
3. How many children do you have? \_\_\_\_\_
4. What is your CURRENT weight (lbs or kg)? \_\_\_\_\_
5. What is your height (ft & in or cms)? \_\_\_\_\_
6. What do you consider to be your IDEAL weight (lbs or kg)?  
\_\_\_\_\_
7. Have you ever been diagnosed or treated by a professional for any of the following problems? (check yes or no for each one):

a. Anorexia Nervosa	YES _____	NO _____
b. Bulimia or Bulimia Nervosa	YES _____	NO _____
c. Obesity	YES _____	NO _____

## GENERAL RESEARCH QUESTIONNAIRE PAGE TWO

## SECTION B

Rate yourself on each of the following traits as you really think you are when compared to the average student your age. Please give the most accurate estimate of how you see yourself.

5 = I'm in the highest ten percent  
 4 = I'm above average  
 3 = I'm average  
 2 = I'm below average  
 1 = I'm in the lowest ten percent

1. Academic ability	1	2	3	4	5
2. Assertiveness	1	2	3	4	5
3. Athletic ability	1	2	3	4	5
4. Artistic ability	1	2	3	4	5
5. Cheerfulness	1	2	3	4	5
6. Defensiveness	1	2	3	4	5
7. Drive to achieve	1	2	3	4	5
8. Emotional maturity	1	2	3	4	5
9. Flexibility	1	2	3	4	5
10. Leadership ability	1	2	3	4	5
11. Mathematical ability	1	2	3	4	5
12. Mechanical ability	1	2	3	4	5
13. Originality	1	2	3	4	5
14. Physical attractiveness	1	2	3	4	5
15. Popularity	1	2	3	4	5

## GENERAL RESEARCH QUESTIONNAIRE PAGE THREE

## SECTION B CONTINUED

Rate yourself on each of the following traits as you really think you are when compared to the average student your age. Please give the most accurate estimate of how you see yourself.

5 = I'm in the highest ten percent  
 4 = I'm above average  
 3 = I'm average  
 2 = I'm below average  
 1 = I'm in the lowest ten percent

16. Popularity with the opposite sex	1	2	3	4	5
17. Public speaking ability	1	2	3	4	5
18. Self-acceptance	1	2	3	4	5
19. Intellectual self-confidence	1	2	3	4	5
20. Social self-confidence	1	2	3	4	5
21. Self-understanding	1	2	3	4	5
22. Sensitivity	1	2	3	4	5
23. Sincerity	1	2	3	4	5
24. Stubbornness	1	2	3	4	5
25. Trustfulness	1	2	3	4	5
26. Understanding of others	1	2	3	4	5
27. Writing ability	1	2	3	4	5

APPENDIX E

DEBRIEFING



Thank you for participating in this study. This study addresses the extent to which women's eating behaviour and body-image have been influenced by sociocultural pressures to be thin and successful in vocational life. It is hypothesized that certain women may internalize these cultural expectations to be thin, competent, and successful into a thin is competent stereotype where being thin is one component of being competent. It is hypothesized that women, who adhere to a thin is competent stereotype will report more eating disordered behaviour, more disturbed body-image, and less competence in academic, social, and psychological functioning.

Remember, your answers to all of the questionnaires will be kept confidential. Also, you may obtain a copy of the results when the study is completed, if you ask for them. I would also like to remind you not to discuss this research project with your fellow classmates.

**APPENDIX F****SELF-RATED COMPETENCY:  
RATIONALLY CONSTRUCTED  
SCALES**

Scale	Item
Academic Competence	1. Academic ability 3. Athletic ability 4. Artistic ability 10. Leadership ability 11. Mathematical ability 12. Mechanical ability 17. Public speaking ability 27. Writing ability
Social Competence	2. Assertiveness 14. Physical attractiveness 15. Popularity 16. Popularity with opposite sex 20. Social self-confidence 26. Understanding of others
Psychological Competence	5. Cheerfulness 6. Defensiveness 7. Drive to achieve 8. Emotional maturity 9. Flexibility 13. Originality 18. Self-acceptance 19. Intellectual self-confidence 20. Self-understanding 22. Sensitivity 23. Sincerity 24. Stubbornness 25. Trustfulness

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## VITA AUCTORIS

Stuart Gibson was born and raised in Edmonton, Alberta. After graduating from Bonnie Doon Composite High School in 1981, Stuart entered the Faculty of Business at the University of Alberta.

After just one course in macroeconomics, Stuart decided to enter the world of science in 1982. In 1986, Stuart received a Bachelor of Science with a Specialization in Psychology.

After working for two years as a Psychological Assistant at Alberta Hospital, Stuart decided to enter the fray of academia once again. In 1988, Stuart moved to Windsor, Ontario and began his graduate education in the Clinical Psychology Doctoral Programme.