Age Differences in Eating Disordered Behavior and Its Correlates

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The eating disorders anorexia nervosa and bulimia nervosa currently threaten the physical and mental health of an alarming number of people today. Anorexia nervosa is characterized by maintenance of weight below 15% of normal for age and height, an intense fear of gaining weight, and eventual amenorrhea (American Psychiatric Association [APA], 2002). Bulimia nervosa is identified by a pattern of bingeing followed by compensation for the excessive caloric intake by vomiting, laxative use, fasting, or overexercising (APA). The prevalence of eating disorders has increased in recent years (Kitsantas, Gilligan, & Kamanta, 2003). Precise estimates of incidence and prevalence vary but tend to range from about 3% to 10% of women 15–29 years of age (Polivy & Herman, 2002) and about 2.4% for men (Espina, Ortego, Ochoa, Aleman, & Juaniz, 2002). Concern over body shape is even more prevalent, with research indicating 32% of women and 8.9% of men being affected (Espina et al., 2002).

Virtually all conceptualizations of eating disorders, including the criteria in the DSM-IV-TR (American Psychiatric Association, 2002), make reference to body image (Polivy & Herman, 2002). Body image has been characteristically defined as self-appraisals and emotional experiences about one’s physical appearance (Braitman & Ramanaiah, 1999) and body dissatisfaction has been defined as negative feelings about the body (Polivy & Herman, 2002).

Factors Related to Disordered Eating and Body Dissatisfaction

Eating disorders are serious and can be life threatening. Medical risks include electrolyte imbalances, cardiac arrhythmias, and the female athlete triad (Petrie & Rogers, 2001; Thompson, 1996). The female athlete triad is defined as a combination of an eating disorder, osteoporosis, and amenorrhea all at the same time. Therefore, it is imperative that researchers investigate factors that may contribute to body image dissatisfaction and eating disordered behavior. The present work explored the relation between eating disorders and several well-documented factors including mass media, self-esteem, perfectionism, negative affect, anxiety, self-focus, and age.

Mass Media

In recent years, a great deal of research has examined the influence of exposure to media images on the development of eating disorders. Evidence has
shown that media may play a powerful role in the formation of eating and body image disturbances (Thompson & Heinberg, 1999). The Western thin-ideal and the body dissatisfaction associated with it have been shown to be important risk factors for eating pathology (Twamley, 1999). In a sample of undergraduate women, one study found that how often individuals view media, particularly media believed to promote thinness, predicts body dissatisfaction and disordered-eating symptomatology (Harrison & Cantor, 1997). Hawkins, Richards, Granley, and Stein (2004) found that for women, media exposure predicted disordered eating symptomatology, drive for thinness, and body dissatisfaction. For men, media use predicted approval of personal thinness, dieting, and select attitudes in favor of thinness and dieting for women. Also, men exposed to ideal image advertisements became significantly more depressed and had higher levels of muscle dissatisfaction than men exposed to neutral ads (Agliata & Tantleff-Dunn, 2004). Exposure to certain media appears to be associated with a subsequent increase in eating disordered symptomatology. Exposure to thin-ideal media image may contribute to the development of eating disorders by causing body dissatisfaction, negative moods, low self-esteem and eating disorder symptoms in women (Hawkins et al., 2004).

Self-Esteem

In addition to the influence of media exposure, self-esteem appears to play a large role in the development of eating disordered behaviors. Self-esteem was found to predict body satisfaction in both men and women (Green & Pritchard, 2003). Furthermore in nonclinical samples, self-esteem negatively correlates to disordered eating symptoms (Granillo, Jones-Rodriguez, & Carvajal, 2005) and a decrease in self-esteem contributes to poorer body image (Abell & Richards, 1996; Gleason, Alexander, & Somers, 2000) and bulimic symptoms (Vohs, Bardone, Joiner, Abramson, & Heatherton, 1999). Finally, cross-sectional research has shown that the most important variables in emergent bulimic symptoms included body dissatisfaction, self-esteem, depression, and dieting. In addition, all these symptoms play a role in eating disorder through various pathways (Mora-Giral, Raich-Escursell, Segues, Torras-Claraso, & Huon, 2004).

Perfectionism

Perfectionism was linked to eating disturbances in several studies. It was shown that disordered eating attitudes increased with perfectionism (Hopkinson & Lock, 2004). Research indicates that perfectionism is associated with body dissatisfaction and shows that stress can trigger abnormal eating and even eating disorders in individuals with perfectionistic personalities (Ruggiero, Levi, Giuna, & Sassaroli, 2003). In a case study, perfectionism contributed to the maintenance of a person’s eating disorder, and on this basis it was predicted that reducing clinical perfectionism would improve eating disorder psychopathology. As predicted, eating disorder psychopathology was improved after reducing clinical perfectionism (Shafran, Lee, & Fairburn, 2004). Finally, women who were high in perfectionism and who considered themselves overweight were more likely to experience bulimic symptoms (Vohs et al., 1999).

Negative Affect/Mood

Numerous studies have examined the contribution of positive and negative affectivity to disordered eating and body dissatisfaction. Presnell, Bearman, and Stice (2004) found that negative affectivity predicted increases in body dissatisfaction. The results of a 3- to 4-year prospective study demonstrated that negative affect/attitudes at the beginning of the study strongly predicted later disordered eating (Leon, Fulkerson, Perry, Keel, & Klump, 1999). Kitsantas et al. (2003) examined the self-regulatory and subjective well-being of students diagnosed with eating disorders, at-risk students, and individuals without eating disorders. They found that students with eating disorders scored significantly lower on the life satisfaction and positive affect scales than did those students at risk of eating disorders or students without eating disorders. Also, both the groups with eating disorders and the at-risk students scored significantly higher on negative affect than did the groups without eating disorders.

Anxiety

The link between eating disorders and mood disorders has been well-documented in the literature, and research has begun to consider anxiety as a potential precursor to the development of eating disorders. Specifically, certain features of social anxiety may play an important role in the development and maintenance of eating disorders. Clinical groups report higher levels of social anxiety than do nonclinical groups, and social anxiety is associated with higher levels of bulimic symptomatology (Hinrichsen, Wright, Waller, & Meyer, 2003). In another study, individuals with anorexia nervosa and bulimia nervosa were examined to establish the rate of anxiety disorders in that population. Results indicated that approximately two-thirds of the individuals with eating disorders had at least one anxiety disorder, and a majority reported experiencing the anxiety symptoms before they developed the eating disorder. Even those people who had...
an eating disorder but no anxiety disorder tended to be anxious, perfectionistic, and harm avoidant (Kaye, Bulik, Thorton, Barbarich, & Masters, 2004).

**Self-Focus**

There is no research specifically on self-focus as a risk factor for eating disordered behavior. However, self-focus has been shown to be related to several risk factors of eating disorders, suggesting self-focus may play a role in eating disordered behavior. Self-focused attention refers to the direction of attentional resources towards one’s own thoughts and feelings rather than towards objects in the external environment (Carver & Scheier, 1981). Self-focus has been shown to lead to perfectionism and anxiety (Ingram, 1990), which are two well-documented risk factors for disordered eating. Ingram found that people with clinical levels of social anxiety appear to have a heightened level of self-focus. The relation between mood and self-focus has also been examined. Research in which mood states are induced shows that self-focus increases with negative mood and decreases with positive mood (Green, Sedikides, Saltzberg, Wood, & Foranzo, 2003). Because many known risk factors of eating disorders are linked to self-focus, we found it important that self-focus be examined to determine its relation with disordered eating.

**Age**

The vast majority of eating disorder literature focuses on adolescents and traditional college-age students. Research conducted on adults is sparse. One study, however, did examine some risk factors in adults and found that media influence had a strong relation to body image dissatisfaction in adult women, and self-esteem predicted body dissatisfaction in both adult men and women (Green & Pritchard, 2003). Another study examined the differences between adolescents and adults in clinical presentation of eating disorders and found that adolescents (age 9-19) were more likely than adults (age 20-46) to have lower global severity scores, greater denial, and less desire for help. Adolescents in this study also displayed more weight loss, lower original and maximum weights, history of fasting, and elimination of junk food from their diets (Fisher, Schneider, Burns, Symons, & Mandel, 2001). It has also been shown that adolescents are more responsive to fashion magazines and report higher body dissatisfaction after viewing fashion magazines than do adults (Shaw, 1995).

**Present Study**

Though these studies are very beneficial, in all of them age is only categorized as child, adolescent, or adult. Currently, there are no documented studies that break age down in a more sensitive manner, such as by decade. Thus, the goal of this study was to break down age by decade and identify possible risk factors leading different groups to develop disordered eating. Two issues were investigated. First, are there significant differences in the level of eating disorders between different decades? Second, do different age groups have different factors contributing to disordered eating?

**Method**

**Participants**

Participants of this study were 272 undergraduates (67% female) at a large western state university. Approximately 90% of participants were White. They were all students of Introductory Psychology and received course credit for their participation in this study. The ages ranged from 17 to 68 (\( M = 22.17, SD = 7.14 \)).

**Measures**

Body image dissatisfaction. Body image was assessed using the Body Shape Questionnaire (Cooper, Taylor, Cooper, & Fairburn, 1987; see Cooper et al. for discussion on validity and reliability) which contained various questions on how participants feel about certain aspects of their body (e.g., “Have you pinched areas of your body to see how much fat is?”). Responses were rated on a 6-point scale (1 = never, 6 = always), with higher scores indicating greater body dissatisfaction (Cronbach’s α = .94).

**Disordered Eating.** Eating disturbances were assessed using questions from the Eating Attitudes Test (EAT-26) related to a preoccupation with food, eating, and weight (Garner & Garfinkel, 1979; Cronbach’s α = .94). Twenty-six questions (e.g., “I am terrified about being overweight”) were scored on a 6-point Likert scale (1 = never, 6 = always). The EAT-26 was used in the present study because of its wide use and accuracy in self-reported testing for nonclinical populations (Mintz & O’Halloran, 2000).

**Mass Media.** The influence of societal pressures on body image was assessed by the Mass Media Influence Subscale of the Socialization Factors Questionnaire (Passino, Grant, & Vartanian, 2000). This 10-item scale inquires about the influence of magazine, TV, and models on individuals’ perceptions of themselves (e.g., “I feel bad about my own body after seeing attractive models in magazines and on TV.”). Participants responded on a 5-point scale (1 = strongly agree, 5 = strongly disagree). Questions were averaged to create a mass media influence scale (Cronbach’s α = .88).

**RESULTS**

Age Differences in Eating Disordered Behavior

One issue investigated was whether different age groups display significant differences in the level of eating disorders. A 2 (gender) x 5 (age) x 3 (risk for eating disorders) ANOVA was conducted to determine if the level of eating disorders was significantly different by age or gender. The ages were divided into three age groups: children (age 11-13), adolescents (age 14-17), and adults (age 18-68) (Green & Pritchard, 2003). The risk for eating disorders was assessed using questions from the Eating Attitudes Test (EAT-26) related to a preoccupation with food, eating, and weight (Garner & Garfinkel, 1979; Cronbach’s α = .94). Twenty-six questions (e.g., “I am terrified about being overweight”) were scored on a 6-point Likert scale (1 = never, 6 = always). The EAT-26 was used in the present study because of its wide use and accuracy in self-reported testing for nonclinical populations (Mintz & O’Halloran, 2000).

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In the present study, there were no significant differences in the level of eating disorders between different age groups. However, there were significant differences between different decades. First, there were significant differences in the level of eating disorders between different decades. Second, there were significant differences between different age groups. Currently, there are no documented studies that break age down in a more sensitive manner, such as by decade. Thus, the goal of this study was to break down age by decade and identify possible risk factors leading different groups to develop disordered eating. Two issues were investigated. First, are there significant differences in the level of eating disorders between different decades? Second, do different age groups have different factors contributing to disordered eating?
Self-Esteem. Levels of self-esteem were measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965), which has been shown to be both valid and reliable.

This scale uses a variety of questions assessing personal feelings about oneself as well as positive and negative emotions (e.g., “I feel I have a number of good qualities.”). Responses were measured on a 4-point scale (1 = strongly agree, 4 = strongly disagree, \(\alpha = .89\)).

Perfectionism. Perfectionistic tendencies were assessed by asking participants various questions about their performance levels in activities such as school and the influence of the expectations of others (e.g., family, teachers, parents; “Only outstanding performance is good enough in my family.”). Responses were rated on a 6-point scale (1 = never, 6 = always). This measure is a subscale of the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983) and demonstrated adequate reliability in this sample (\(\alpha = .87\)).

Mood. To measure psychological adaptation, students responded to a 30-item short version of the Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1981). This measure has been used successfully with adolescent populations (Lira, White, & Finch, 1977). The POMS is divided into six 5-item subscales and assesses tension, depression, anger, vigor, confusion, and fatigue. Responses were measured on a 5-point scale (1 = not at all, 5 = extremely). Responses were summed for each subscale, with higher scores indicating more of that symptom. In addition, we created an overall negative affect score (see McNair et al. for scoring information, as well as reliability and validity).

Anxiety. The State-Trait Anxiety Inventory (STAI) measures anxiety in adults (Spielberger, Gorsuch, & Lushene, 1969). It is a self-report assessment device that includes separate measures of state and trait anxiety. We were only interested in “trait anxiety” (via the T-Anxiety scale) which is more general and long-standing anxiety than the temporary condition of “state anxiety.” The T-Anxiety scale consists of 20 statements that assess how respondents feel “generally” (\(\alpha = .92\)) and were rated on a 4-point scale (1 = almost never, 4 = almost always).

Self-Focus. Self-focus was measured using a self-focus temperament scale (Spievak, Kerr, & Callahan, 2005). Twenty-six items were rated on a five-point scale (1 = extremely uncharacteristic, 5 = extremely characteristic) as to how well they described the participants (e.g., “I think about myself a lot”). Items were summed with higher scores indicating higher levels of self-focus (\(\alpha = .89\)).

Procedures
All participants were given the survey in a classroom environment and were allowed 50 minutes to complete the survey.

Results
We first examined age differences in eating disorders and body dissatisfaction in our population using an analysis of variance (ANOVA). As displayed in Table 1, there were statistically significant age differences in disordered eating and in body dissatisfaction. An LSD post hoc analysis revealed that participants in their teens reported higher disordered eating than participants in their 20s (\(MD = 2.45, SE = .97\)), whereas participants in their 40s or older reported higher disordered eating symptomology than participants in their 20s (\(MD = -5.73, SE = 2.13\)). We did not find significant differences between the teens and the 30s group (\(MD = 1.16, SE = 2.03\)), the teens and the 40s and older group (\(MD = -3.28, SE = 2.09\)), the 20s and the 30s groups (\(MD = -1.16, SE = 2.08\)), or between the 30s and the 40s and older groups (\(MD = -4.44, SE = 2.78\)). For body dissatisfaction, participants in the teens were more dissatisfied than those in their 20s (\(MD = -3.30, SE = .12\)), participants in their 30s were more dissatisfied than those in their 20s (\(MD = -.74, SE = .26\)), and the 40s and older participants were also

| Table 1: Means and Standard Deviations of Disordered Eating and Body Dissatisfaction by Age (N) |
|---------------------------------|-----------------|-----------------|-----------------|------------------|------------------|
|                                | Teens (178)     | 20s (119)       | 30s (18)        | 40s (17)         | F                |
| BSQ                            | 2.77 (1.03)     | 2.47 (1.06)     | 3.21 (0.79)     | 3.06 (1.05)      | 4.35**           |
| EAT-26                         | 8.60 (8.9)      | 6.15 (6.74)     | 7.44 (9.09)     | 11.88 (8.77)     | 3.56*            |

*Note: *p < .05, **p < .01
more dissatisfied than the 20s group (MD = -.59, SE = .27). There were no significant differences found between the teens and the 30s group (MD = -.45, SE = .26), the teens and the 40s and older participants (MD = -.29, SE = .26), or between the 30s and the 40s and older groups (MD = .15, SE = .35).

To examine whether the relation between our risk factors and disordered eating and body dissatisfaction would be the same for the different age groups, we ran Pearson’s correlations for each age group, between each age group, and the EAT-26 and BSQ. These correlations are shown in Table 2. There was a significant negative correlation between body dissatisfaction and self-esteem in all age groups. Media was very strongly positively correlated to both body dissatisfaction and disordered eating in the teens and 20s groups, but correlated only to disordered eating in the 30s group and body dissatisfaction in the 40s and older group.

A significant negative correlation between disordered eating and self-esteem was found for the teens and participants in their 30s, but not for participants in their 20s or 40s and older group. Perfectionism was significantly positively correlated to body dissatisfaction for participants in their teens and participants in their 40s and older, but not for participants in their 20s or 30s. Perfectionism was significantly positively correlated to disordered eating for all age groups. Significant positive correlations were found between mood and both body dissatisfaction and disordered eating in the teens and 20s groups. Conversely, there were no significant correlations between mood and either body dissatisfaction or disordered eating for participants in their 30s or 40s and older.

Anxiety was also found to be positively correlated to both body dissatisfaction and disordered eating for the teens, those in their 20s and participants in their 40s and older, and correlated with disordered eating and not body dissatisfaction for participants in their 30s. Lastly, self-focus was positively correlated to disordered eating but not body dissatisfaction for the teens. Self-focus was also positively correlated to both body dissatisfaction and disordered eating for participants in their 20s, and it was also found to be correlated with body dissatisfaction and not disordered eating for the 30s group. There were no significant correlations between self-focus and the 40s and older group for either body dissatisfaction or disordered eating.

**Discussion**

Due to a paucity of literature on disordered eating and body image dissatisfaction in discrete age groups, the goals of this study were to break down age by decade and identify possible risk factors correlated to disordered eating and body dissatisfaction in the different age groups. The main issues investigated were whether there are significant differences in the level of eating disorders between different decades and whether different age groups have different factors contributing to disordered eating.

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<td>Correlations Between Risk Factors and Disordered Eating and Body Dissatisfaction</td>
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Note: *p < .05, **p < .01
Our results on the prevalence of eating disorders for age groups were somewhat surprising. Our results showed that body dissatisfaction is actually highest for persons in their 30s, and lowest for persons in their 20s. Statistically, participants in their 20s scored significantly lower on the BSQ than did participants in any of the other three age groups. As for disordered eating, participants in their 40s scored the highest. As with body dissatisfaction, participants in their 20s scored the lowest. Much of the literature on disordered eating and body dissatisfaction focuses on adolescents and teens because they are at a higher risk (Fisher et al., 2001). Our findings, however, indicated that other groups may be just as vulnerable as younger groups because body dissatisfaction and disordered eating were actually higher in the older groups in our study. Also, our research showed that participants in their 20s were less susceptible to both disordered eating and body dissatisfaction indicating that something about being in this age group may lessen these disturbances. Below we will discuss possible reasons for these differences.

Mass Media

Consistent with the literature (Hawkins et al., 2004; Thompson & Heinberg, 1999), we found that media strongly correlated to both body dissatisfaction and disordered eating in the teens and 20s group, but only correlated with disordered eating in the 30s group and body dissatisfaction in the 40s and older group. These data showed a correlation between media exposure and body dissatisfaction and disordered eating in all age groups, although the two younger age groups displayed higher correlations than did the older age groups. Previous research shows adolescents to be more responsive to fashion magazines and reporting higher body dissatisfaction than adults after viewing such materials (Shaw, 1995). Our results suggest that this decrease in the negative relationship between media viewing and disordered eating and body image may decrease throughout adulthood as well.

Self-Esteem

Similar to previous studies (Green & Pritchard, 2003), we found a significant negative correlation between body dissatisfaction and self-esteem in all age groups. Previous studies have also shown that low self-esteem is positively correlated with disordered eating (Granillo et al., 2005). Our data, however, only found this correlation for participants in their teens and participants in their 30s. Because self-esteem predicted body image dissatisfaction in all age groups and only predicted disordered eating for two of the age groups, it appears that self-esteem is a stronger predictor of body dissatisfaction than it is for disordered eating. We hypothesize that people with low self-esteem almost always have high body dissatisfaction, but only some of these people with low self-esteem develop disordered eating, and this may relate to their age.

Perfectionism

Research indicates that perfectionism is associated with body dissatisfaction (Ruggiero et al., 2003) and our data partially supports this conclusion. We found perfectionism was significantly positively correlated to body dissatisfaction for participants in their teens and participants in their 40s and older, but not for participants in their 20s or 30s. This may have to do with the fact that perfectionism seems to peak in teens (Amanat, 1994) and in middle aged adults (Christain, 1969). Previous studies have also shown that disordered eating attitudes increased with perfectionism (Hopkinson & Lock, 2004). Our data support these findings in all of the age groups. Our findings on perfectionism indicate that participants with disordered eating are very perfectionistic, but not all participants with body dissatisfaction are highly perfectionistic. Therefore, people who are highly perfectionistic may develop disordered eating but not necessarily have body dissatisfaction. It may be their drive for perfection and control causing the eating disorder rather than being dissatisfied with their bodies.

Negative Affect/Mood

Previous research indicates that negative affect is a risk factor for both body dissatisfaction (Presnell et al., 2004) and disordered eating (Leon et al., 1999). Our data support these findings, but only for the teens and the 20s group. Conversely, we did not find associations between mood and body dissatisfaction or disordered eating for participants in their 30s or 40s and older. These findings suggest that negative affect is a stronger risk factor for body dissatisfaction and disordered eating in younger age groups and may not be a risk factor for people in older age groups. The literature shows that negative affect increases with age and positive affect decreases with age (Pinquart, 2001). This pattern of results may make negative affect less predictive of disordered eating and body dissatisfaction in the older age groups as more people are affected.

Anxiety

Our study confirmed research showing a correlation between anxiety symptoms and disordered eating (Kaye et al., 2004). We found anxiety was positively correlated with both body dissatisfaction and disordered eating for the teens, participants in their 20s
and participants in their 40s and older. Anxiety was correlated with disordered eating but not body dissatisfaction for participants in their 30s. These results indicate anxiety is related to disordered eating and body dissatisfaction regardless of age.

**Self-Focus**

To date, there is no research on self-focus as a risk factor for disordered eating. Our findings show self-focus was positively correlated with disordered eating, but not body dissatisfaction for the teens. Self-focus was also positively correlated with both body dissatisfaction and disordered eating for participants in their 20s and was also positively correlated to body dissatisfaction and not disordered eating for the 30s group. There were no significant findings for self-focus and the 40s and older group for either body dissatisfaction or disordered eating. These results indicate that participants in their 20s with high self-focus may also be at a high risk for both disordered eating and body dissatisfaction. Although participants in their 20s were at the lowest risk for disordered eating and body dissatisfaction, those participants who did have disordered eating and body dissatisfaction also had the highest levels of self-focus. It appears that self-focus plays a unique role in the development of symptoms of eating disorders and body dissatisfaction.

**Limitations**

This study examined disordered eating and body image dissatisfaction in very discrete age categories and found several promising results. This study, however, is not without limitations. One possible shortcoming of our research is the small sample size in the 30s and 40s age groups. This small sample size was due to the research being conducted at a university in which most students are of traditional college age. Another drawback of our study is that all participants are college students enrolled in an introduction to psychology course. Finally, the questionnaire was quite lengthy and all participants received the questions in the same order, which may have lead to participant fatigue toward the end of the survey. All of these factors limit the generalizability of our findings.

**Conclusion**

Our prospective findings provide additional information on the risk factors for both disordered eating and body dissatisfaction. We add to the literature by investigating differences in risk factors for different decades. Our findings warrant further study of age differences in risk factors of disordered eating and body dissatisfaction. Future studies should examine these variables utilizing more participants in the 30s and 40s age groups.

**References**


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