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ABSTRACT

The attributes considered desirable and undesirable for men and women vary depending on the society in which they live. Both personality characteristics and physical standards are prescribed to men and women according to their cultures’ gender role ideology. Because gender and attractiveness are socially constructed, ideal body images depend on the society in which one lives. In Western culture, it is important for women to be physically attractive and thin. Western women cannot help but to be exposed to, and possibly influenced by, these values and beliefs.

Utilizing identity theory, I examined the relationship between gender role ideology and rates of eating disordered attitudes and behaviors, specifically femininity level in women. Five hundred and fifteen female and two hundred ninety eight male undergraduates at a large university in the southeast were sampled during the Fall 2008 semester. Participants completed questionnaires containing items from the Bem Sex Role Inventory (BSRI; Bem, 1974), three of the subsections of the Eating Disorders Inventory-3 (EDI-3; Garner, 2004), and a selection of demographic items.

The results show that, contrary to the hypothesis, levels of traditional femininity had no effect on Bulimia, Drive for Thinness, and the weight discrepancy variable. But it did have a weak negative effect on Body Dissatisfaction. This indicates that, either levels of traditional femininity are actually not positively related to the development of disordered eating, or the indicators used to measure them were not appropriate for the population under study.

Findings were that women and those with higher body mass reported more desire to lose weight than did men and those with lower mass bodies. Results suggest that gender might be more important than femininity levels in the development of eating disordered attitudes. Further, participants’ body mass and participants’ gender had more effect on the weight discrepancy
difference variable than they had on Bulimia, Body Dissatisfaction, and Drive for Thinness. These findings suggest that a subjective measure of a person’s own satisfaction with one’s body might be more useful than an objective, clinical measure of eating disordered attitudes and behaviors. Future research should also include a more current, relevant measure of gender role preferences including characteristics that are more important in a person’s level of culturally desired femininity.
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INTRODUCTION

Overview

It is argued, especially among feminist sociologists, that bodies are socially constructed in material and cultural worlds, meaning that they are both physical and symbolic (Lorber & Martin 2005). In order to determine if a body is “attractive,” it is necessary to examine the context in which it lives. Different body “types” are valued and seen as “beautiful” in different cultures, and at different times. A society praises and admires those who embody their ideals of beauty and femininity. Valued gender roles vary across cultures and throughout time and space, and women have gone to drastic measures to emulate the ideal of feminine beauty that pervades the culture in which they live. This beauty ideal can be difficult, if not impossible, for women to achieve, depending on the characteristics that the culture determines to be important in femininity.

In modern Western culture, it is important for a woman to be physically attractive and in order for her to be appealing, she must be thin (Wolf 2002). Women living in this culture cannot help but to be exposed to and possibly influenced by these values and beliefs. One way for women to meet these cultural standards of beauty is to participate in extreme dieting. In fact, an obsessive desire to be thin is undoubtedly related to the development of two eating disorders; anorexia and bulimia. Anorexia is an eating disorder in which the individual refuses to eat, starving herself/himself until she/he is below 85 percent of her/his healthy body weight (Westen 1999). Irreversible physiological complications and even death are likely to occur if starvation is severe enough. Bulimics participate in bingeing and purging, in which the person consumes excessive amounts of food and then either induces vomiting or uses laxatives in order to rid the body of the extra calories. The national chapter of Anorexia and Related Eating Disorders
(ANAD) estimates that a minimum of 20% of American women between the ages of 16 and 30 suffer from a major eating disorder (Nagel & Jones 1992). It has been reported that between .05% and 3.7% are sufferers of Anorexia and between 1.1% and 4.2% are sufferers of Bulimia (Taylor, C. B. et al. 2006). Often when women internalize modern Western extreme ideals of femininity and beauty, their attainment of it becomes very consuming, as thirty-three thousand female respondents to a Glamour survey reported that they would rather lose ten to fifteen pounds than achieve any other goal (Wolf 2002). Therefore, it is no surprise that so many Western women have adopted such dangerous behaviors like restricting food intake and performing other unhealthy eating habits.

Statement of the Problem

Using identity theory, this study examined the relationship between women’s self perceived levels of socially-desirable gender role characteristics, which are defined as perceived behavioral norms associated particularly with males or females, in a given social group or system (Bem 1981), and rates of eating disordered behaviors and attitudes. Data were collected on both females’ and males’ self perceived levels of culturally desirable gender role attributes, as well as on eating disorder attitudes and behaviors. All data were analyzed to determine if those who see themselves as very feminine, in terms of culturally-determined stereotypical characteristics, are more likely to develop eating disordered characteristics than those who report lower levels of stereotypically feminine characteristics.

Review of the Literature

Eating Disorders in the Modern West

Although anorexia and bulimia have existed for centuries, their prevalence is now at an all-time high, with an estimated eight million American sufferers (“Eating Disorders Statistics,”
The last time a very thin body was considered as ideal for women in Western culture was
the mid 1920’s and an epidemic of eating disorders emerged (Herzog et al. 1992). Anorexia and
bulimia have often been described as modern disorders that are the byproducts of modern
societal values (Brems, Fischer, & Johnson 1996). Women in Western cultures have become
increasingly preoccupied with dieting and obsessions over achieving extreme thinness.
Abnormal eating that is undertaken to fit the thin ideal of beauty is one cause of anorexia and
bulimia, and not necessarily, as some might assume, a manifestation of an underlying neurosis
(Wolf 2002). This extreme eating behavior can be explained by women’s desire to conform to
socially accepted gender roles: in order to be feminine, women are to be thin and beautiful.

Media and Feminine Portrayal

The media is a pervasive mode through which culturally desirable gender-role traits are
expressed. Women portrayed in magazine ads, television shows, and movies are the role models
of millions of women and these models have been consistently growing thinner for the past few
decades (Wolf 2002). The ideals they portray are becoming increasingly more difficult and more
dangerous to emulate. For example, the average model, dancer, or actress is thinner than 95
percent of the female population. In fact, since the 1970’s the average weight of Miss America
contestants has dropped more than 20 pounds while the average adult now weighs over 10
pounds more than she weighed a decade ago (Miller & Pumariega 2001). So, the discrepancy
between the ideal appearance of feminine beauty in our society and the actual appearances of
women is increasing, which fosters an environment in which women are likely to feel insecure
and inadequate.

Research repeatedly indicates that cultural norms and ideals of femininity impact
women’s beliefs about themselves and their behaviors (Wolf 2002). The ideal of femininity that
contributes to eating disorders is virtually inescapable in modern industrialized cultures. Nasser’s (1988) epidemiological research indicates that with the change in cultural norms related to feminine beauty, namely an increase in importance placed on thinness, the rates of anorexia and bulimia disorders have risen. For example, over the past few decades, data collected from content analyses of Playboy and other popular media indicate a shift to thinner standards. There has also been a huge increase in the number of diet articles in popular women’s magazines (Garner, Garfinkel, Schwartz, & Thompson 1980). In fact, a 1988 study found that between 1966 and 1986 the number of articles in popular magazines specifically endorsing weight loss increased by 11 times (Shealy 1998). Even simply reading beauty and fashion magazines increases the drive for thinness in women (Park 2005). Also, watching reality TV cosmetic surgery makeover programs has been shown to increase the internalization of the thin ideal and to lead to low self-esteem in young women, possibly contributing to eating disorders (Mazzeo, Trace, Mitchell, & Gow 2007).

Internalization of the Media’s Portrayal of the Thin Ideal

Further evidence of the power of internalization of the thin ideal expressed in the media is indicated by research findings reporting that exposure to thin-ideal magazines and sports magazines predict eating disorders, especially in older adolescent females (Harrison 2000). In a related study, Jung and Peterson (2007) interviewed school-age children to examine both their satisfaction/dissatisfaction with their bodies, as well as their media consumption and image perception patterns. Overall, the girls were dissatisfied with their current body sizes, and they desired to be slimmer. As for their patterns of media use, the girls generally showed a greater attraction toward, and recall of, images of beauty and appearance in all media venues. These results suggest that even in childhood females desire to be thinner than they actually are,
conforming to society’s preferred image of femininity. The proclivity toward beauty and appearance in preferred media indicates the importance they place on, and the interest they have in, matters and images that pertain to the stereotypical female gender role in Western culture. Media images such as these encourage women to judge themselves against the culturally admired feminine ideal, which most find difficult, if not impossible, to meet.

Social Benefits of Cultural Gender-Role Standards

According to Kilbourne (1994) the current emphasis on excessive thinness for women in media and advertising intentionally works to influence cultural ideals and consequent individual behavior. Actually, there is a lucrative market associated with eating disorders. It is theorized that they are culturally-induced diseases that benefit the economic and social institutions of the society (Hesse-Biber et al. 2006). The thin ideal promoted by the mass media in Western culture generates customers for the plastic surgery, diet-foods, advertising, and weight-loss companies. So, the influence of culture and media on women that creates dissatisfaction with their own bodies is seen as advantageous to certain people in the society. Not only do businesses and industries profit economically from women’s’ drive for thinness, but men seeking hyperfeminine women benefit as well.

According to Lorber and Martin (2005), cultural values dictate that women are expected to be nurturing, emotionally giving, and willing to subordinate their own desires to please men. Therefore, it is culturally-preferred that their bodies be yielding and sexually attractive to men. According to Wolf (2002), beauty is a very important quality: women want to embody it and men want women who embody it. In order to be desired by men, and by society itself, many women feel they should be hyperfeminine. Paxton et al. (2005) used a multivariate model of predictors of body dissatisfaction to determine factors that contribute to girls’ dissatisfaction with
their bodies. Among the variables tested were beliefs about the importance of popularity with boys and beliefs about the importance of thinness for attractiveness. Participants, a group of 10th grade girls and boys, filled out questionnaires measuring these variables, and data were analyzed. Results show a relationship between level of importance placed on popularity with boys and negative feelings about appearance: the more importance the girls placed popularity with boys, the less satisfied they were with their bodies. Also, the more the girls believed that boys see thinness as important in a girl’s attractiveness, the more likely it was that they were dissatisfied with their own bodies. Though girls underestimated the body size that boys find most attractive, almost all of the boys surveyed indicated that slimness contributes to girls’ appeal (Paxton et al. 2005).

Portrayal of Gender-Role Standards Through Other Modes

Just as cultural standards of gender-role characteristics are conveyed to young women through the media, other modes are used to transmit these ideas. Sinton and Birch (2006) investigated several influences, including weight status, depression, parent, sibling, and peer and media influences, as predictors of appearance schemas (core beliefs and assumptions about the importance, meaning, and effects of appearance in one’s life). They found that girls’ appearance schema scores were related to perceptions of parental and sibling influence on weight concerns, appearance-related interactions with other girls, and awareness of media images. The girls’ appearance schemas were also associated with their levels of depression and body dissatisfaction. This is a high-risk situation because depression and body dissatisfaction are associated with eating disorders. For instance, women who are not satisfied with their body image might begin dieting in an effort to resemble the socially desirable body that Western culture values. This dieting could potentially lead to extreme restriction of food intake, resulting in anorexia. Also, it
has been shown that depression is more common among bulimics than non-eating disordered women (Hinz & Williamson 1987; Striegel-Moore et al. 1986).

Normative social influence occurs when the influence of others leads us to conform so that we will be accepted and liked by them (Akert et al. 1998), and cultural preferences in gender role characteristics are commonly transmitted through such peer pressure. This type of influence helps to explain women’s attempts to create the ideal body through dieting, and possibly through eating disorders like Anorexia and Bulimia (Gimlin 1994). Crandall (1998) conducted a study investigating the role of peer influence and the development of eating disorders in which he examined bulimic practices in two college sororities. He found that each sorority had its own social norm for binge eating. For instance, in one of the sororities, he found that the more a woman binged, the more popular she was. So, not only are women influenced by the media and other cultural avenues but they are also pressured to conform to the thin ideal by their own peers.

Some feminists argue that heterosexuality is compulsory and that people are taught society’s expectations of members of each gender by family and other significant others (Thompson 1996). It is maintained that women feel obligated to fulfill these stereotypically-heterosexual and feminine roles that culture prescribes them. In studying the transmission of social expectations of femininity, a group of women were interviewed and reported that these expectations were partly taught through messages that they learned about eating and about their bodies. Some participants recalled that the females in their childhood homes were given less food than the males, especially as teenagers. The reason behind this was that girls need to be thin in order to attract boys. As the girls aged, they were told to stop being athletic, to start wearing dresses, and to watch their weight. The girls were warned that if they did not diet and maintain a desirable weight, they would become “old maids” (Thompson 1996). Women who
adhere to the belief in a social obligation to display the characteristics appropriated by their
gender roles are likely to take measures to mirror the socially-valuable feminine image.
Unfortunately, for a woman to live up to cultural expectations of her gender role, it is important
that she be ultra-thin. Women who internalize this ideal are likely to be more apt to develop
eating disorders in order to control their weight.

Previous research has examined the relationship between parental gender role ideology
and prevalence of eating disorders in girls. For example, Silverstein, et. al (1998) found that
daughters with fathers who hold more traditional feminine gender role ideals for their daughters
have higher rates of eating disorder symptoms. Also, fathers who hold more traditional gender
role beliefs and place more value on traditional feminine traits in their daughters have been
shown to have daughters with higher rates of eating disorder symptoms.

Maintenance of Gender Norms

Many studies have explored the relationship between the maintenance of stereotypical
views of gender norms and roles, and eating disorders in adolescent females. Gershon, Anda;
Gowen, L. Kris; Compian, Laura; Hayward, Chris (2004) investigated this relationship and
found that females who adhered to gender-stereotyped roles in scripts of imaginary dates had far
greater concerns with their weight than did girls who endorsed non-gender-stereotyped views of
dating. This internalization of traditional feminine gender role expectations is further evidence
that females who place importance on maintaining stereotypical gender-related behaviors and
attitudes are more likely to develop concerns about their appearances.

Failure to Internalize Cultural Standards of Femininity

Research suggests that women who fail to internalize cultural gender role ideals do not
feel the pressure to maintain culturally-defined feminine body types. For example, studies
comparing heterosexual women, who often idolize the cultural definitions of feminine beauty, and homosexual women, whose views of beauty are most likely not influenced by collectively determined male preferences, conclude that lesbians are heavier, more satisfied with their bodies, and less likely to develop eating disorders than heterosexual females (Herzog, Bradburn, Yeh, & Warshaw 1992).

Identity Theory

Identity theory is a microsociological theory that links identities to the role relationships and role-related behavior of individuals. According to Stryker (1968), the self consists of a collection of identities, each of which is based on the occupation of a particular role, and each role has a set of associated meanings and expectations for the self. An individual’s role identities are said to influence her behavior, making her behave in a way that is expected of a person occupying her role (Stryker and Burke 2000).

There are two different brands of identity theory, each with its own emphasis and program of research (Stryker and Burke 2000). According to Peter Burke (1980), identity and behavior are linked through a common system of meaning. Once we identify the meaning of an identity for an individual, we can determine the meaning of the individual’s behaviors. For example, the gender identity of femininity includes being noncompetitive, having feelings easily hurt, and other traditionally feminine characteristics (Burke and Tully 1977). Each identity of a person contains its own set of dimensions to which one can respond. And the meanings associated with the particular dimensions of each identity are determined by the subpopulation to which it applies (Jan Stets 96). In measuring a person’s identity, the important thing is that the meanings attached to those identities influence the meanings implied by his/her corresponding behavior.
According to identity theory, women who adopt the stereotypical feminine gender role in Western culture will be influenced by the meanings and expectations of that particular role. Depending on how deeply these expectations are internalized, women will likely modify their behaviors so that they coincide with the behaviors expected of culturally determined, stereotypical females. If women attach great salience and importance to the traditional feminine gender role and its associated characteristics and behaviors, they will likely go to great measures to fit the role’s expectations. One such feminine gender role expectation is that a female should be “physically attractive.” In Western culture this means that, especially for a white middle-class woman, she will be thin. If a woman places a great deal of importance on her occupancy of the traditional feminine gender role then she will take great efforts to be thin and to fit the socially-desired feminine gender role. And in doing so, she might develop unhealthy eating habits, or even a dangerous eating disorder.

Gender-Role Discrepancy

Researchers sometimes adopt the self-discrepancy theory when studying eating disorders, which posits that a person will become distressed when there is a discrepancy between her actual self and the type of person she wants to be, or her ideal self (Akert, Aronson, & Wilson 1998). Distress is also induced when there is a discrepancy between her actual self and the type of person she believes she should be, or her ought self.

Following the self-discrepancy theory, Harrison (2001) studied the relationship between self-discrepancies in body image and development of eating disorders, prompted by exposure to thin-ideal media. Results indicate that exposure to thin-rewarded portrayal, which portrays thin characters as happy, attractive, and likeable, induced ideal discrepancies, while exposure to fat-punished portrayal, in which overweight characters are portrayed as less attractive and less
likeable, activated ought discrepancies. The activation of both types of discrepancies has been shown to increase negative affect, which is a common predictor of disordered eating.

Conflicting results have been found though, regarding differences between actual and culturally preferred gender role. In a study of 321 female college students, conflict between gender role ideology and self-perceived gender roles were shown to have little effect on responses to the Eating Disorder Inventory (Brems, Fischer, & Johnson 1996).

In a study investigating the effects of gender-role discrepancy in females, Johnson and Petrie (1995) revealed that women without gender-role discrepancy reported fewer anorectic and bulimic symptoms, less concern with body shape, and higher self-esteem. These findings suggest the negative results that are likely to occur when females try to fill the ideal “hyperfeminine” gender roles desired and valued in Western culture.

Utilizing a grounded-theory approach, Fraze (2001) investigated why, in the presence of thin ideal mass media, some women develop eating disorders and some do not. Twelve eating-disordered women and 10 non-eating disordered women, who had sisters with eating disorders, were interviewed. Data showed that the disordered eating behaviors in some women resulted from chronic dieting with the goal of becoming thin. These women reported low self-esteem and experienced difficulties due to messages advocating the thin ideal from the mass media, family members, and other people in their lives. The non-eating disordered women experienced these problems as well, but less severely. This is likely because these women were protected by buffers, such as more self-acceptance. So, without a strong sense of self-worth, independent of appearance, sociocultural factors to be culturally-“beautiful” and feminine may influence women’s unhealthy eating habits.
Cantelon et al. (1986) administered the Bem Sex Role Inventory and a gender role satisfaction questionnaire to 30 eating disordered women and 21 female controls. Responses suggest that when there is conflict between actual gender role and ideal gender role, anorexic and bulimic patients see this conflict as being related to their illness. According to a feminist perspective, women suffering from anorexia and bulimia over-identify with the traditional female role. In Western society, women are urged to adopt traditional gender characteristics, which include dependency and lack of assertiveness (Bruch, 1973, 1978; Boskind-Lodahl 1976).

Gender-Role Internalization in Eating Disordered Women

The sufferer of anorexia often lacks a self-defined identity, and she is very sensitive to the needs and desires of others. Her identity is determined from the outside. The disorder is characterized by a crisis of the female body and a quest for identity. It is a kind of “performed gender” that is initially applauded by society (Spitzack 1993) because the characteristic food restriction of the disorder enables the woman to mirror the stereotypically “beautiful” image of females in Western culture. So, without a strong sense of self and assurance of who she is and her place in the world, the eating-disordered woman might refuse to eat and to maintain a healthy weight in order to gain control over feelings of helplessness that pervade her life (Cantelon, Leichner, & Harper 1986).

The dangers of the cultural pressures on women to adhere to social norms of traditional femininity are obvious. Results from a study examining gender-role identifications in patients with anorexia indicate that these patients were more feminine gender-typed than the non-eating disordered control group (Weeda-Mannak, Arondeus, & Takens 1990). Fraenkel et al. (1989) found that both anorexics and bulimics possess “hyperfeminine” identifications. Results from another study comparing the femininity and masculinity scores on the Bem Sex Role Inventory
of anorexics and non-eating disordered women indicate that, though they did not differ on scores of femininity the anorexic participants scored significantly lower on masculinity items than did the non-eating disordered women (Katz & Sitnick 1984).

Data gathered from semi-structured interviews with both anorexic and bulimic patients, as well as with non-eating disordered control groups, show that females with eating disorders are less critical of the socially-desired thin ideal than are non-eating disordered females (Murray 1999). Similarly, Szymanski and Chrisler (1990) found a higher endorsement of stereotypically feminine qualities among women with bulimia, as compared to non-eating disordered women. Also, data suggest a significant relationship between the anorexic’s level of criticism of the thin ideal and the duration of her disorder. This might imply that it is necessary (but not sufficient) for a women with anorexia to develop a critical stance against cultural standards of feminine weight and body shape in order for her to recover. Further, research suggests that this critical view might be the factor preventing non-eating disordered women from developing the disorder (Murray 1999).

Although much research indicates a relationship between levels of femininity and development of eating disorders in women, not all evidence supports this correlation. For instance, while studying eating disordered symptoms and levels of femininity among women, Timko, et. al (1987) found no relationship between the two variables, while Sitnick & Katz (1984) reported finding equal levels of endorsed femininity among women without and with eating disorders.

Conclusion

I designed my research to further investigate the relationship between gender role identification and eating disorders. Specifically, I am focusing on the relationship between
women’s levels of self-perceived, culturally-defined femininity and prevalence of eating disorders; namely anorexia and bulimia. I am examining the possibility that women who place importance on achieving the stereotypically feminine characteristics prescribed by society will engage in unhealthy behaviors in order to achieve the thin ideal, which is seen as an important component of the stereotypical feminine gender role in Western culture.

Previous research on gender role identity and development of eating disorders has provided mixed results, as there has been no consistent positive or negative correlation found between the two variables. Further, some have argued that either gender-role typing, masculine or feminine, is related to eating disorders (Thornton et al. 1991), while some adhere to the hypothesis that eating disordered attitudes and behaviors are particularly characteristic of “hyperfeminine” women (Steiger et al. 1989). Still others posit that women high in masculinity are more likely to develop eating problems (Silverstein, Carpman, Perlick, & Perdue 1999).

Since past research has not been successful in determining the link between gender role orientation and eating disorders, I propose to examine the relationship further. But unlike other studies, I am only interested in certain attitudes and behaviors, namely bulimic behaviors, drive for thinness, and body dissatisfaction. I have also included a fourth dependent variable; discrepancy between actual and desired weight of the participants. Because of locale, my focus is on white, college-aged, middle-class women who comprise a substantial portion of the eating-disordered population in Western culture. I hypothesize that the women who see themselves as more stereotypically feminine will have higher rates of body dissatisfaction, drives for thinness, bulimic behaviors, and larger discrepancies between actual and preferred body weights.
METHODS

Participants

Participants were 515 female and 298 male undergraduate students at a large southeastern university. Students were randomly selected to participate through cluster sampling, in which a complete list of all undergraduate courses taught at the University of Wilmington during the Fall 2008 semester was used to randomly select 40 courses (2% of the courses offered that semester). Instead of sampling each participant individually, cluster sampling was used in order to save time and produce a higher response rate. Although this method can be very convenient and cost-efficient, it produced a less precise sample than would both simple and stratified random sampling. But since my sampling method used only one stage of sampling, the sampling error was relatively low. And in this case, where the sample size is 30 classes and reasonably representative of the population, it is a more efficient method of random sampling.

The final number of courses sampled was 30. As participation was completely voluntary, students in each class were told that they did not have to complete the survey. Also, students were asked not to take the survey if they had already done so in another class. After receiving instructions from the researcher the students who chose to participate completed the self-administered survey which took approximately 10 minutes. Participants represented students of all schools within the university of undergraduate study Arts & Humanities (N=169), Social Sciences (N=160), Physical Sciences (N=154), Business (N=70), Education (N=81), and Nursing & Health Sciences (100). The average age of the sample is 20.3 years old (SD= 8 months), and the majority of the sample is White (88.6%).
Instrumentation

Bem Sex Role Inventory (BSRI; Bem, 1974).

The BSRI was developed to measure gender role identification. Its original form contains sixty adjectives, 20 of which are socially desirable “masculine” personality characteristics (e.g., independent, forceful), 20 of which are socially desirable “feminine” personality characteristics (e.g., compassionate, gentle), and 20 of which are “neutral” characteristics (e.g., truthful, conceited). The short form, which contains 30 items (ten from each subscale) was used in the current study in order to decrease the amount of time needed to complete the survey. For each of the thirty characteristics, participants used a 7-point scale to rate how well each describes them. Possible responses range from never or almost never true (1) to always or almost always true (7). The 10 items in the femininity subsection are personality characteristics that are seen as more socially desirable for a woman than a man. Items in the masculinity subsection are personality characteristics that are seen as more socially desirable for a man than for a woman. The primary purpose of the third (androgyny) subsection is to provide a neutral context for the other two subscales, as it contains items that are neutral with respect to gender. Scores for each subsection are derived by averaging the ratings given to each item in the subsections. Internal consistency and test-retest reliability for each subsection have been found to be high (Hepp et al., 2005; Bem, 1974). Although this inventory is somewhat dated and “sex role” has been widely replaced with “gender role”, it is still a helpful, standard measure.

The Eating Disorders Inventory-3 (EDI-3; Garner, 2004).

The EDI-3, a revision of the original EDI (EDI; Garner, Olmsted, & Polivy, 1983) and the EDI-2 (EDI-2; Garner, 1991), is a 91-item self-report measure of psychological and behavioral symptoms commonly associated with anorexia and bulimia. Respondents use a 6-
point, forced-choice scale to indicate whether each item applies *Always, Usually, Often, Sometimes, Rarely*, or *Never*, and each item is given a score from 0 to 4. The most extreme responses in the pathological and symptomatic direction are given a score of 4, the immediately adjacent responses are scored as 3, the next responses are given a score of 2, the next is given a 1, and the two responses furthest from the most extreme symptomatic and pathological responses both receive a score of 0. In order to compute the respondents’ scores for each scale, the scores from all of the items of each scale are totaled.

The EDI-3 is divided into twelve primary scales, three of which are eating-disorder-specific and nine of which are general psychological scales that are very relevant to, but not specific to, eating disorders. The present study utilizes items from the three scales specific to eating disorder risk, which deal with attitudes and behaviors concerning eating, weight, and body shape. These three scales are the Drive for Thinness Scale (DT- assesses an extreme desire to be thinner, concern for dieting, and an intense fear of gaining weight; 7 items), Bulimia Scale (B- assesses the tendency to think about and participate in bingeing and purging; 8 items), and the Body Dissatisfaction Scale (BD- assesses discontentment with the overall shape and size of regions of the body that are of special concern to those with eating disorders- i.e., stomach, hips, thighs, buttocks; 10 items).

These three subscales of the EDI-3 have both excellent reliability (in the high .80s to low .90s for the 3 Eating Disorder Risk scales), as well as excellent test-retest stability (r=.95 for the DT scale, r=.94 for the B scale, r=.95 for the BD scale) (Garner, 2004).

Procedure

After verbally giving informed consent, each participant was given a questionnaire to complete. Appearing first on the questionnaire is a section of the 30 items from the short form of
the BSRI, which is followed by the 25 items from the Bulimia (B), Body Dissatisfaction (BD), and Drive for Thinness (DT) subscales of the EDI-3. The final section of the survey is the biographical data portion which is where participants provide information about other demographic variables of interest including gender, race, and age. Participants are also asked to provide their weight and height (in order to calculate body mass index (BMI)), as well as their parents’ educational level. These control variables will be used during data analysis, in order to determine the independent impact of perceived traditional femininity on the development of eating disorders.

Statistical Analysis

Statistical analysis was performed using SPSS.

Pearson’s correlations were calculated on participants’ scores on the independent and dependent variables, and scores are reported on Table 2. I also ran four separate OLS regression models using data from both the male and female participants, and results are shown on Tables 3 and 4. The dependent variables of the models were levels of bulimic behavior (B), levels of drive for thinness (DT), levels of body dissatisfaction (BD), and discrepancy between current and desired weight (weight discrepancy- WD), and the focal independent variable was perceived levels of femininity.

Ethical Issues

The questionnaires, which passed the University of North Carolina at Wilmington’s Institutional Review Board, were kept anonymous. When not being analyzed, the surveys were locked in a private filing cabinet, and the participants were also informed that, immediately following data analysis, all surveys would be destroyed. Any questions or concerns regarding the study were also addressed at that time, and my name and contact information was given to
participants in case they had questions/concerns and wanted to contact me at a later time. Participants were also directed to resources if they felt they might have, or be at risk for developing, an eating disorder or unhealthy attitudes concerning body image or eating.

RESULTS

Findings

Table 1 shows the descriptive statistics of the respondents included in all four models of the analysis. Of the 813 total participants, 515 (63.3%) were women and 298 were men. A little less than 90 percent of the sample (88.6%) were White, and the rest of the participants reported that they were either Black, Asian, Native American, Other Race, or Mixed Race. The average age of participants was 20.30 years (female average age was 19.74 yrs. and male average age was 21.25 yrs).

[Table 1 about here]

As indicated on Table 1, the average body mass index (BMI) of the female participants (22.78) was slightly lower than that of the male participants (24.33), meaning that the females were, on average, slightly leaner than the male participants. Neither the males nor the females averaged BMIs indicated existence of disordered eating - BMI critical value for women 18 years and over is 18 to 18.50 and it is between 18.50 and 19.50 for men over 18 years (EDI-3 Referral Form 2004). Also, the females, on average, preferred to be 11.51 pounds lighter than they actually were and the men indicated that they wished to be only 2.75 pounds lighter than they were. This shows that although the women in the sample actually had lower BMIs than the men, they wanted to lose more weight than the men did, suggesting that females were further from their ideal weight. This is consistent with previous research on the difference between men and women’s attitudes about their weight and body satisfaction. Wolf (2002) reported that only one
in ten men are “strongly dissatisfied” with their bodies, whereas one third of women are “strongly dissatisfied” with theirs. She also states that women think they have a weight problem if they are 15 pounds overweight, but men do not think they are overweight until they are thirty-five pounds above the average weight range.

The SES of the participants (which were crudely measured by their parents’ levels of education) was relatively high. Table 1 shows that almost half of the participants (42.6 %) indicated that both of their parents/guardians earned at least a bachelor’s degree, and a little over a fourth of the sample (27.9%) reported that one of their parents/guardians earned at least a BA. College graduates generally have higher paying jobs so it is reasonable to assume that the current sample is composed of participants with relatively high socioeconomic statuses which has been shown to be positively correlated with development of eating disorders (Wang et al. 2005).

As shown on Table 1, the average femininity score of the participants was 5.47 (and 5.66 for women and 5.14 for men). These scores are comparable to the norms reported by Bem (1978, 1981), in which she found that the average score on the femininity scale for all participants was 5.50: 5.57 for females, and 5.19 for male participants.

The participants’ average score on the Body Dissatisfaction measure of the Eating Disorders Inventory-3 was 11.47 (Table 1). The mean score for females was 14.19 and the mean score for men was 6.75. According to the scoring sheet found in the EDI-3 (Eating Disorders Inventory-3), the male participants, on average, had low levels of body dissatisfaction, whereas the sample combined, as well as the female participants taken separately, averaged moderate body dissatisfaction. The average score on the Bulimia scale for all participants was 3.66: 4.04 for female participants, and 3.02 for male participants. None of these means meet requirement for diagnosis of an eating disorder for people ages 18 and older (BSRI-3 Referral Form 2004),
which is unexpected, as reports indicate that up to 20% of American women suffer from a major eating disorder (Nagel & Jones 1992). Also, the mean scores on the Drive For Thinness variable for all participants (7.17), female participants (9.14), and male participants (3.76) were all too low to meet criteria for diagnosis of a disorder.

Table 2 also shows that traditional femininity is correlated (though only moderately, Pearson’s r = .277, p = .000) with gender. According to Burke’s identity theory, the responses of the participants, as they rated their own levels of traditional femininity, help locate their identity meanings (Jan Stets 96). This positive correlation found among the participants suggests that the gender identity of femininity means more to a woman’s self than it does to a man’s sense of self.

But contrary to what was expected, femininity had either weak correlations, if significant, or no correlations with the measures of eating disorder attitudes and behaviors (see Table 2). Drive For Thinness was the only variable significantly correlated with levels of femininity and this correlation is relatively small (Pearson’s r = .094, p = .007). Neither the Bulimia score nor the Body Dissatisfaction score were significantly correlated with the participants’ levels of femininity (Pearson’s r = -.016, p = .657, Pearson’s r = .030, p = .398 respectively). Femininity was weakly correlated with BMI (Pearson’s r = -.088, p = .013), suggesting that heavier people tend to have less traditional views of femininity. This is consistent with the hypothesis that more traditionally feminine people are more likely to be concerned with their appearances and take measures to be “attractive”.

Scores on the measure for Drive For Thinness were moderately to highly correlated with differences between participants’ weight discrepancy (Pearson’s r = .419, p = .000), as the more weight the participants wanted to lose, the higher the drive for thinness. Drive For Thinness is
also significantly correlated with participants’ BMI (Pearson’s $r = .133$, $p = .000$), meaning that as the participants’ BMIs increased, so did their drives for thinness.

As presented on Table 2, the BMI’s of the male participants were higher than the BMI’s of the females in the study, meaning that the women were leaner than the men. But, even though they were less massive than the men, the weight discrepancy of the women was higher than it was for the men (Pearson’s $r = .254$, $p = .000$).

Table 2 also shows that Bulimia is positively and significantly correlated with participants’ BMI (Pearson’s $r = .124$, $p = .000$) and weight discrepancy (Pearson’s $r = .287$, $p = .000$). This means that, as the participants’ BMI increased, and as the discrepancy between their actual and preferred weight increased, they were more likely to practice bulimic behaviors.

Like the two other measures of disordered attitudes and behavior scores on the Body Dissatisfaction variable were significantly correlated with participants’ BMI (Pearson’s $r = .313$, $p = .000$). Also indicated on Table 2, participants’ levels of Body Dissatisfaction were correlated with scores on the weight discrepancy variable (Pearson’s $r = .589$, $p = .000$). So, those who weigh more than they would prefer to weigh are undoubtedly less satisfied with their bodies.

Regarding the correlations between participants’ gender and levels of Drive For Thinness, levels of bulimia, and levels of Body Dissatisfaction, female participants scored higher than did the men on all three of these measures of eating disorder attitudes and behaviors. The correlation between gender and Drive For Thinness (Pearson’s $r = .369$, $p = .000$) indicates a higher concern to lose weight among the women than among the men, given that women were coded as 1 and men as 0. Bulimic attitudes and behaviors are also reported to be more likely among the female participants than among the male participants (Pearson’s $r = .127$, $p = .000$). Again, the correlation between gender and Body Dissatisfaction is positive and significant (Pearson’s $r = .396$, $p = .000$),
meaning that female participants were less satisfied with their bodies than were the male participants.

As shown on Table 2, the variable measuring weight discrepancy of participants was positively and significantly correlated with participants’ gender. In other words, the discrepancy between actual weight and desired weight of the female participants was greater than the discrepancy among the male participants. This is unsurprising, considering the societal pressure on women to lose weight and be ultra thin. The gender variable was also significantly related to the BMI variable, but negatively. This indicates that female participants average leaner BMIs than the males. That the males in the study were more massive, yet had less desire to lose weight than the women, shows the importance of ultra thinness for women, yet not for men.

[Table 3 about here]

Table 3 shows the results from multiple regression of bulimia, body dissatisfaction, and drive for thinness on selected independent variables. In Model 1, Bulimia is regressed on levels of femininity, gender, race, age, difference between actual and desired weight, BMI, and parents’ education. The variables shown as significant predictors of bulimia were difference between participants’ actual and desired weight ($\beta=0.409$, $p=0.000$) and participants’ BMI ($\beta=-0.146$, $p=0.009$).

The strong significant effect of the weight discrepancy variable indicates that the participants who wished to lose more weight were more likely to report bulimic attitudes and behaviors. This is possibly because many people resort to such restrictive eating practices in order to lose weight, which can potentially lead to the development of dangerous eating disorders.

The negative significant effect of BMI on Bulimia means that controlling for other variables, particularly the discrepancy between actual and desired weight, the less massive participants reported more bulimic symptoms and attitudes. This negative effect is interesting, as
purging isn’t very effective at riding oneself of calories, which is why most bulimics end up gaining weight over time (Belmonte 2008). Vomiting immediately after eating will only eliminate 50% of the calories consumed at best and laxatives and diuretics are even less effective. Laxatives get rid of only 10% of the calories eaten, and diuretics do nothing at all (Belmonte 2008).

Since the two variables (BMI and the discrepancy) were expected to have the same direction of effect on Bulimia but did not, multicollinearity was tested to help explain the opposite signs. Tolerance scores (.397 for Discrepancy variable, .447 for BMI variable) show that the opposite signs are not likely due to multicollinearity. This may suggest that the objective state (BMI) and the subjective evaluation (weight discrepancy) of one’s body affect one’s attitudes and behaviors differently. It appears that the participants’ own evaluations of their bodies and of their weight has more impact on their levels of satisfaction with themselves, as well as on their eating disorder behaviors.

The negative effect of BMI on bulimic behaviors suggests that the more massive participants were, the less likely to partake in bulimic behaviors, suggesting that they are more satisfied with their current body sizes. On the other hand, the participants with the greater discrepancies between their actual and desired weights were more likely to engage in bulimic practices, suggesting that it is not as important what one actually weighs, but what one believes one should weigh. The participants with the greater weight discrepancies are likely more sensitive to cultural standards of beauty and attractiveness.

Contrary to the hypothesis, femininity was shown to be a non-significant predictor of Bulimia ($\beta = -.050$, $p=.159$). As shown on Table 3, Model 2 displays the regression of Bulimia from Model 1, plus the addition of an interaction variable between participants’ gender and
levels of traditional femininity. This interaction variable was added to test if the effect of femininity on Bulimia is conditional on participants’ gender. As displayed on Table 3, the interaction variable has a positive, significant effect on levels of bulimic attitudes and behaviors ($\beta = .593$, $p = .007$), meaning that traditional femininity has a stronger effect on bulimia for women than it does for men. This implies that, following Burke’s identity theory, the self-meanings associated with the gender identity of femininity in women are more highly associated with bulimic attitudes and behaviors. Results possibly suggest that those traditionally feminine qualities that comprise the culturally-preferred gender identity of femininity are predictors of attitudes and behaviors that contribute to dangerous eating disorders. Because these behaviors, which are often adopted by women to try to control weight, are predicted by women’s levels of traditional femininity, it is suggested that the characteristics that higher levels of traditional femininity in women are associated with the desire to be thin and to conform to the cultural ideal of feminine beauty.

Model 3 includes the regression of Body Dissatisfaction on levels of femininity, gender, race, age, weight discrepancy, BMI, and parents’ education (Table 3). As displayed, both participants’ gender and the weight discrepancy variable were shown to be positive and significant predictors of participants’ levels of dissatisfaction with their bodies. As hypothesized the female participants reported greater levels of dissatisfaction with their bodies than did the men ($\beta = .277$, $p = .000$). Also unsurprisingly, greater discrepancy between participants’ actual and desired weight predicted greater levels of body dissatisfaction ($\beta = .532$, $p = .000$).

Like Model 1, femininity had a negative effect on the Body Dissatisfaction variable (Table 3). An interaction variable between gender and femininity was added to Model 3 in order to test if femininity levels were more influential on women’s body dissatisfaction than on men’s
body dissatisfaction (Model 4). Results indicate that the effect of the interaction variable on 

*Body Dissatisfaction* is approaching significance ($\beta=.315$, $p=.076$), suggesting that gender role identity affects men and women differently in terms of development of eating disordered attitudes and behaviors.

*As shown on Table 3, Drive for Thinness was regressed on levels of femininity, gender, race, age, weight discrepancy, BMI, and parents’ education* (Model 5). As shown, participants’ drives for thinness were predicted by gender ($\beta=.201$, $p=.000$), the variable measuring weight discrepancy ($\beta=.502$, $p=.000$), and BMI ($\beta=-.145$, $p=.004$) of the participants in Model 5.

Again, females were more likely to have higher drives for thinness than were the men. Extant research on cultural norms and ideals of femininity impact women’s beliefs about themselves and their behaviors. The ideal of femininity that contributes to women’s obsession with appearance and thinness pervades modern industrialized cultures.

As expected, participants with higher discrepancies between actual and desired weights were more likely to have higher drives for thinness ($\beta=.502$, $p=.000$). Similar to Model 1 of Table 3 however, BMI was again shown to have a significant and negative effect on drives for thinness ($\beta=-.145$, $p=.004$). This means that the lower the participants’ BMIs, the higher their drives for thinness. A possible explanation for this is that the lower BMI participants enjoy their less massive bodies, therefore giving them drive for thinness. Since they are closer than the high BMI participants to the social and other benefits of being lean, they develop the desire to maintain their leaner bodies.

Like Models 1 and 3, femininity had an unexpected negative, though insignificant effect on participants’ drives for thinness ($\beta=-.007$, $p=.831$). Since it is possible that the insignificant effect of traditional femininity on eating disordered attitudes and behaviors is because it is only
influential among women, not men, an interaction variable between gender and femininity was added to the analysis in Model 6 (Table 3). As indicated on Table 3, the interaction variable is not a significant predictor of Drive for Thinness ($\beta = .193$, $p=.328$), meaning that the interaction of levels of traditional femininity and participants’ gender had no effect on the participants’ drives for thinness. These results are similar to those found by other researchers. For example, Timko, et. al (1987) found no relationship between femininity and development of eating disorders.

Model 7 includes the post hoc analysis in which the weight discrepancy variable was included as a dependent variable, and it was regressed on levels of femininity, gender, race, age, BMI, and parents’ education. This variable is an indicator of body dissatisfaction, because it is a subjective evaluation of the discrepancy between actual and ideal state. The indicators of bulimia, body dissatisfaction, and drive for thinness, which are from the Eating Disorder Inventory-3 (a clinical tool used to diagnose eating disorders for treatment) are arguably only measuring behaviors and attitudes serious enough to be considered for psychological diagnosis. And because the participants might not be satisfied with their bodies, and they might have the propensity to engage in dangerous dieting behaviors, but they might not have these qualities to the degree to warrant psychological treatment, this inventory is possibly not a reliable measure for the current study. In other words, because the participants do not score very highly on the measures for Bulimia, Body Dissatisfaction, and Drive for Thinness does not mean that they are satisfied with their bodies or that they feel that they look the way society would prefer they look. It simply means that they do not have a severe, diagnosable eating disorder. The measure of participants’ discrepancies between actual and preferred weight, however, is a subjective indicator of the participants’ perceived state of their bodies, which is a more direct measure of
how the participants view their own bodies and how satisfied they are with the size of their bodies.

[Table 4 about here]

As presented on Table 4, participants’ gender ($\beta=.404, p=.000$) and BMI ($\beta=.744, p=.000$) were found to be significant predictors of discrepancy between actual and ideal weight. As expected, women were more likely than men to report larger weight discrepancies. This is congruent with past research findings, where it was found that slightly over half of high school girls surveyed were unhappy with their bodies and, by age 18, 78% of females were dissatisfied (Wolf 2002).

Table 4 also shows that the higher the participants’ BMIs, the more weight they wanted to lose (Model 7). These results might be expected, considering the social importance of body weight and body image in American culture. It shows that, as people deviate from the acceptable weight range, they are less likely to be complacent with themselves. And evidence suggests that many Americans’ senses of self-satisfaction depend on their appearances and their weight in particular.

As shown on Table 4, participants’ levels of femininity had no significant effect on the weight discrepancy variable ($\beta=.025, p=.273$). The lack of significant positive effect of levels of traditional femininity on the participants’ discrepancies between actual and ideal weight is similar to Pettinati, et. al’s findings (1987) in which eating disordered participants did not differ with regard to actual self-descriptions of their own levels of femininity.

As we did with Models 1, 3, and 5, we added an interaction variable between gender and femininity to the analysis (Model 8). This interaction variable, however, is not a significant predictor of weight discrepancy of participants ($\beta=-.001, p=.992$), implying that the interaction
between traditional femininity and gender has no noticeable effect on participants’ weight discrepancies.

While traditional femininity had a significant effect on bulimic behaviors, once the interaction term between gender and femininity was introduced, it had no significant impact on Drive for Thinness, and only a marginally significant effect on Body Dissatisfaction. This lack of a significant effect of traditional levels of femininity on all of the measures of eating disorders is possibly because traditional feminine personality traits and characteristics are not enough, by themselves, to induce feelings of overweight or dissatisfaction with one’s body in most women. It is possible that the importance a woman places on appearance is as important as her other traditionally feminine characteristics, in terms of how likely she will be to develop eating disorders. In fact, in terms of the levels of femininity as measured by the BRSI, participants in the current study are actually more traditionally feminine (5.66 on BSRI) than were the participants in Bem’s 1970 study (5.57 on BSRI). This possibly suggests that, in the modern world in which we are inundated with imagery at all times and appearance is very important to a woman’s social desirability, the importance a woman places on attractiveness might interact with her level of traditional femininity to predict eating disordered symptoms.
Table 1

Individual Characteristics of Respondents (%)

<table>
<thead>
<tr>
<th>Variable</th>
<th>All</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>813 (100)</td>
<td>515 (63.3)</td>
<td>298 (36.7)</td>
</tr>
<tr>
<td>Average Age in Years</td>
<td>20.30</td>
<td>19.74</td>
<td>21.25</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>717 (88.6)</td>
<td>451 (87.7)</td>
<td>266 (90.2)</td>
</tr>
<tr>
<td>Black</td>
<td>38 (4.7)</td>
<td>26 (5.1)</td>
<td>12 (4.1)</td>
</tr>
<tr>
<td>Other or Mixed Races</td>
<td>54 (6.7)</td>
<td>37 (7.2)</td>
<td>17 (5.8)</td>
</tr>
<tr>
<td>Major Discipline of Study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arts &amp; Humanities/Social Sciences</td>
<td>329 (44.8)</td>
<td>208 (43.9)</td>
<td>121 (46.5)</td>
</tr>
<tr>
<td>Physical Sciences</td>
<td>154 (21.0)</td>
<td>90 (19.0)</td>
<td>64 (24.6)</td>
</tr>
<tr>
<td>Business/Education/Nursing &amp; Health</td>
<td>251 (34.2)</td>
<td>176 (37.1)</td>
<td>75 (28.8)</td>
</tr>
<tr>
<td>Sciences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undecided/Missing</td>
<td>86 (10.5)</td>
<td>41 (8.0)</td>
<td>38 (12.8)</td>
</tr>
<tr>
<td>Grade Point Average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3.0</td>
<td>161 (20.7)</td>
<td>82 (16.8)</td>
<td>79 (27.4)</td>
</tr>
<tr>
<td>3.0-3.5</td>
<td>385 (49.5)</td>
<td>250 (51.1)</td>
<td>135 (46.9)</td>
</tr>
<tr>
<td>3.6-4.0</td>
<td>231 (29.7)</td>
<td>157 (32.1)</td>
<td>74 (25.7)</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>771 (94.8)</td>
<td>495 (96.1)</td>
<td>275 (92.6)</td>
</tr>
<tr>
<td>Married/Engaged</td>
<td>42 (5.2)</td>
<td>20 (3.9)</td>
<td>22 (7.4)</td>
</tr>
<tr>
<td>Average Body Mass Index (BMI)</td>
<td>23.35</td>
<td>22.78</td>
<td>24.33</td>
</tr>
<tr>
<td>Weight Discrepancy: Average Difference Between Current Weight and Desired Weight in pounds</td>
<td>8.30</td>
<td>11.51</td>
<td>2.75</td>
</tr>
<tr>
<td>Parents’ Educational Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Parents Earned at Least a BA Degree</td>
<td>349 (42.6)</td>
<td>215 (41.7)</td>
<td>134 (45)</td>
</tr>
<tr>
<td>Only One Parent Has At Least a BA Degree</td>
<td>229 (27.9)</td>
<td>148 (28.7)</td>
<td>81 (27.2)</td>
</tr>
<tr>
<td>Neither Parent Has At Least a BA Degree</td>
<td>216 (26.3)</td>
<td>141 (27.4)</td>
<td>74 (25.7)</td>
</tr>
<tr>
<td>Missing</td>
<td>26 (3.2)</td>
<td>11 (2.1)</td>
<td>9 (2.1)</td>
</tr>
<tr>
<td>Average Femininity Composite Score</td>
<td>5.47</td>
<td>5.66</td>
<td>5.14</td>
</tr>
<tr>
<td>Average Masculinity Composite Score</td>
<td>4.92</td>
<td>4.85</td>
<td>5.05</td>
</tr>
<tr>
<td>Avg. Drive For Thinness Composite Score</td>
<td>7.17</td>
<td>9.14</td>
<td>3.76</td>
</tr>
<tr>
<td>Average Bulimia Composite Score</td>
<td>3.66</td>
<td>4.04</td>
<td>3.02</td>
</tr>
<tr>
<td>Average Body Dissatisfaction Composite Score</td>
<td>11.47</td>
<td>14.19</td>
<td>6.75</td>
</tr>
<tr>
<td></td>
<td>DT (p)</td>
<td>B (p)</td>
<td>BD (p)</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------</td>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>DT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>.535**</td>
<td>(.000)</td>
<td></td>
</tr>
<tr>
<td>BD</td>
<td>.705</td>
<td>(.000)</td>
<td>.490**</td>
</tr>
<tr>
<td>Femininity</td>
<td>.094**</td>
<td>(.007)</td>
<td>-0.016</td>
</tr>
<tr>
<td>Gender</td>
<td>.369**</td>
<td>(.000)</td>
<td>.127**</td>
</tr>
<tr>
<td>Race</td>
<td>-.012</td>
<td>(.728)</td>
<td>.068</td>
</tr>
<tr>
<td>Age</td>
<td>-.053</td>
<td>(.130)</td>
<td>.027</td>
</tr>
<tr>
<td>Weight Discrepancy</td>
<td>.419**</td>
<td>(.000)</td>
<td>.287**</td>
</tr>
<tr>
<td>BMI</td>
<td>.133**</td>
<td>(.000)</td>
<td>.124**</td>
</tr>
<tr>
<td>Parents’ Educ</td>
<td>.021</td>
<td>(.556)</td>
<td>.031</td>
</tr>
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</table>

N=813
DT=Drive For Thinness
B=Bulimia
BD=Body Dissatisfaction
Weight Difference=Difference between current and desired weight in lbs
BMI=Body Mass Index
Parents’ Educ=Parents'/guardians’ combined educational level
<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
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<tbody>
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<td>Bulimia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>1.93 (1.09, 3.77)</td>
<td>.915 (1.09, 2.77)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(B, se B)</td>
<td>.053 (7.48, 2.42)</td>
<td></td>
<td>.025 (2.32, 1.18)</td>
<td>.018 (1.40, .506)</td>
<td>.015 (1.48, .506)</td>
<td>.017 (1.04, .53)</td>
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<td>Gender coded as:</td>
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<td>Female = 1, Male = 0</td>
<td>Female = 1, Male = 0</td>
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<tr>
<td>Race</td>
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<td>1=White and 0=Others</td>
<td>1=White and 0=Others</td>
<td>1=White and 0=Others</td>
<td>1=White and 0=Others</td>
</tr>
<tr>
<td>BMI</td>
<td>-.146** (-.141, .054)</td>
<td>.143** (.295, .026)</td>
<td>.532** (.295, .025)</td>
<td>.532** (.295, .025)</td>
<td>.502** (.218, .022)</td>
<td>.502** (.218, .022)</td>
</tr>
<tr>
<td>Parents' Educa</td>
<td>.057 (.453, .271)</td>
<td>.060 (.474, .270)</td>
<td>.014 (.247, .506)</td>
<td>.015 (.272, .506)</td>
<td>.052 (.736, .441)</td>
<td>.053 (.748, .442)</td>
</tr>
<tr>
<td>Interaction</td>
<td>.593** (.829, .306)</td>
<td>.315 (1.017, .572)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Gender X Femininity)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>R-Squared</td>
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<td>.117</td>
<td>.416</td>
<td>.419</td>
<td>.277</td>
<td>.278</td>
</tr>
</tbody>
</table>

*sig. at < .05  **sig. at < .01

a Difference between current and desired weight in lbs

a Body Mass Index

a Parents'/guardians' combined educational level

Gender coded as: 1=Female and 0=Male

Race coded as: 1=White and 0=Others

Parents' Educ coded as: 1=Both parents have at least a BA and 0=Others

TABLE 3. Regression to Predict Bulimia, Body Dissatisfaction, and Drive for Thinness
<table>
<thead>
<tr>
<th></th>
<th>Model 7</th>
<th>Model 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight Discrepancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta (B, se B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=771</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>(-78.941, 3.461)</td>
<td>(-76.577, 2.766)</td>
</tr>
<tr>
<td>Femininity</td>
<td>.025 (.443, .403)</td>
<td>.025 (.447, .600)</td>
</tr>
<tr>
<td>Gender</td>
<td>.404** (13.702, .785)</td>
<td>.405** (13.745, 4.419)</td>
</tr>
<tr>
<td>Race</td>
<td>.000 (-.036, 3.143)</td>
<td>.000 (-.037, 3.146)</td>
</tr>
<tr>
<td>Age</td>
<td>.071** (.303, .098)</td>
<td>.071** (.303, .098)</td>
</tr>
<tr>
<td>BMI&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.744** (2.995, .092)</td>
<td>.744** (2.995, .092)</td>
</tr>
<tr>
<td>Parents’ Educ&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.002 (.052, .717)</td>
<td>.002 (.052, .718)</td>
</tr>
<tr>
<td>Interaction</td>
<td></td>
<td>-.001 (-.008, .809)</td>
</tr>
<tr>
<td></td>
<td>(Gender X Femininity)</td>
<td></td>
</tr>
<tr>
<td>R-Squared:</td>
<td>.640</td>
<td>.640</td>
</tr>
</tbody>
</table>

*sig. at < .05
**sig. at < .01
<sup>a</sup> Body Mass Index
<sup>b</sup> Parents’/guardians’ combined educational level
Gender coded as: 1=Female and 0=Male
Race coded as: 1=White and 0=Others
Parents’ Educ coded as: 1=Both parents have at lease a BA and 0=Others
DISCUSSION AND CONCLUSION

This study explored the relationship between gender role ideology and development of eating disordered behaviors and attitudes in college-aged women. Participants included 813 undergraduates at a large southeastern university (515 females, 298 males). Individuals were selected via cluster sampling, as 40 classes (4% of the total courses offered) were chosen randomly from all undergraduate courses offered at UNCW during the Fall 2008 semester. The participants’ levels of femininity were measured by responses on the short form of the Bem Sex Role Inventory, which includes 30 items measuring levels of femininity, masculinity, and androgyny. Eating disordered behaviors and attitudes were measured by responses on three sections of the Eating Disorders Inventory-3. These subsections indicate levels of bulimic behaviors, drives for thinness, and body dissatisfaction. Scores from all three sections were taken to obtain individuals’ values for the three dependent variables.

Physical attractiveness is an unearned factor that affects a person’s social value in America. From birth, “attractive” people are treated better and viewed more positively than less “attractive” people (Etcoff 1999). “Good looks” actually provide material and social benefits not as readily available to those with less desirable appearances. Though physical appearance is important in society’s views of both men and women, it is much more central in the evaluation of women. Because “looks” play such a crucial role in determining the social worth of women, “looks” are commodified and women are seen as objects (Schur 1984). For many Western women, becoming an attractive object for society to see is thought of as an important role obligation.

The ideal feminine beauty, especially for white women, portrayed by Western culture is a very thin, young body. The discrepancy between the ideal appearance of American and the
actual their bodies is increasing, and this fosters an environment in which women are likely to feel inadequate and insecure (Wolf 2002). When a woman feels she does not meet the standards of feminine beauty, and she is not fulfilling the role obligation of being an “attractive” woman, she is likely to feel failure and feel that she is somehow deficient (Schur 1984). These feelings of inadequacy often induce thoughts of body dissatisfaction and drive for thinness, which often lead to eating disordered behaviors and unhealthy attitudes. So, the more importance placed on meeting cultural standards of femininity, the more likely a woman will go to extreme measures in order to fulfill cultural standards of feminine beauty, including the thin ideal.

As shown on Tables 3 and 4, participants’ gender had significant effects on their levels of Body Dissatisfaction, Drive for Thinness, and the variable measuring Weight Discrepancy. This suggests that women were more likely than men to report higher levels of body dissatisfaction, higher drives for thinness, and greater discrepancies between actual and desired weights, but this relationship was not found for the dependent variable for bulimic attitudes/behaviors. The positive significant relationship between gender and these three dependent variables is consistent with the importance placed on appearance, attractiveness, and thinness in modern-day America.

It is possible that the levels of femininity of the participants had no significant effect on the some measures of eating disordered attitudes and behaviors (except for with the interaction variable between gender and femininity) because the relationship between gender role ideology and eating disorders is more complex than the current study assumes. I believe that a third factor measuring importance of attractiveness or sexuality of participants needs to be considered in the interaction. Though I do think that levels of traditional femininity are correlated with eating disordered thoughts and behaviors, I think that the relationship between the two is possibly mediated by the importance a person places on meeting the culturally preferred standards of
physical attractiveness. Maybe simply being very feminine, in terms of culturally desired characteristics, is not a predictor of unhealthy eating attitudes.

All traditionally feminine women do not necessarily place importance on being ultra thin in order to meet the culturally popular standards of attractiveness. So, it would be hypothesized that those women with high levels of stereotypical femininity as well as high levels of importance placed on conforming to society’s preferred image of female attractiveness would be more likely to report higher levels of eating disordered thoughts and behaviors.

Another possible explanation of the lack of relationship between the participants’ levels of femininity and the three original measures of the dependent variable (bulimic behaviors, body dissatisfaction, and drive for thinness) is that they might be too stringent. Because the EDI-3 was developed as a psychological diagnostic tool, it is likely to measure only very high levels of these dangerous behaviors and attitudes, which would exclude participants with less severe, but nonetheless real, symptoms. Also, eating disorders and related symptoms are discussed much more in the media and in the education system than they were in the past. This attention to and awareness of the disorder might make the respondents more hesitant to admit that they actually do suffer from some of the symptoms associated with the disorder, as there is a sort of stigmatization attached to the practicing such behaviors.

Although it was not one of the original dependent variables, the weight discrepancy measure was included in the analyses as a dependent variable because it is likely a more useful measure of body dissatisfaction and eating disordered attitudes and thoughts for the population under study. It is believed that this indicator would be more able to measure more subtle, less extreme dissatisfactions with one’s appearance.
Interestingly, the BMI of the participants had a slight negative effect on all three of the original indicators of eating disordered attitudes and behaviors. In other words, the less massive participants indicated higher levels of bulimic behaviors, more body dissatisfaction, and higher drives for thinness. As discussed earlier, this is possibly due to satisfaction of the lower BMI participants with their leaner bodies. It is possible that they enjoy the benefits, both social and physical, of having relatively lower BMIs, so they concern themselves with maintaining their smaller bodies.

Further, cultural views about the body are more than aesthetic; they are also moral judgments. When a person’s body does not fit social conventions regarding appearance and weight, that person may be viewed as lacking in self-control and self-respect (Lorber and Martin 2005). Because they are less valued and seen as less moral than conventionally “attractive” people, overweight Americans and Whites in particular, are more likely to feel less secure and less satisfied with themselves, which helps explain the desire of the participants with the higher BMIs to lose much weight.

Another explanation for the lack drive for thinness in the higher BMI participants is that they are possibly partaking in cognitive dissonance reduction. According to Leon Festinger (1957, 1962), developer of the cognitive dissonance theory, people are likely to change their attitudes or beliefs about something when they have multiple thoughts which are logically inconsistent. When a person has objects of thought or behaviors which are dissonant with one another, they experience cognitive dissonance, which leads to a type of psychological tension similar to anxiety. When the person experiences these uncomfortable feelings, they are motivated to change the thoughts, attitudes, or perceptions of information that caused them tension (Westen 1999). So, it is possible that the participants with the higher BMIs felt anxiety
resulting from the discrepancy between their high levels of body mass and the culturally-desired body image, and decided to reject the thinner body ideal preferred by society. By rejecting the thin ideal that pervades Western culture, they eliminate the dissonance between their actual higher BMIs and the lower BMI image valued in society. Without the dissonance and its accompanying anxiety, these participants may have less drive for thinness, which possibly explains the lack of correlation between high BMIs and drive for thinness.

The BMI variable had a positive significant effect on the fourth indicator of eating disordered attitude; weight discrepancy. This means that the participants with more massive bodies reported the desire to lose more weight than did the participants with less massive bodies. This is in agreement with past findings, as research indicates that overweight people are responded to negatively, and overweight is seen as deviant in our culture (Etcoff 70-1).

Though levels of culturally preferred femininity did not have any real effect on development of eating disordered behaviors and attitudes in the population under study, except for with the interaction variable (between gender and femininity), findings imply that it is important for women, and for men to a lesser extent, to reject the ultra thin cultural standards of beauty of the modern West. Images of extremely thin actresses, models, and other popular figures saturate the popular media in the West. Findings suggest that women judge themselves against these unrealistic ideals and place importance on meeting their standards. So, findings suggest that women do place importance on meeting the cultural standards of beauty far more than do men.

If, as suggested above, the participants with the higher BMIs did actually fail to accept the cultural standard of attractiveness, then the findings also suggest the importance of rejecting the socially-preferred image of attractiveness. It is important for young women, (and men) not to
internalize the ultra thin ideal as an important image to strive to mirror because this would likely lead to eating disorders. Since the participants with the higher BMIs were less likely than were the participants with the lower BMIs to have diagnosable symptoms of restrictive eating disorders, findings suggest that a rejection of cultural standards of attractiveness is important in avoiding developing dangerous eating disorders. Even though the higher BMI participants indicated greater weight discrepancies, they did not indicate that they were partaking in disordered behaviors in order to reduce their body masses. So, it is possible that the more massive participants did, in fact wish to lose weight, but not to the extent that they would develop symptoms of restrictive-type eating disorders.

Findings suggest the importance of changing the culturally-preferred ideals of attractiveness, especially for women. These standards are extremely difficult and dangerous to meet. It is very likely that once the images of beauty that pervade society resemble more realistic, healthy standards, the prevalence of eating disorders and related attitudes and thoughts would decline drastically. It is also important for society to no longer place huge importance on appearance in the measure of a person’s worth and social success. Since images of beauty are so pervasive and powerful, they are extremely effective triggers of insecurities and feelings worthlessness in women (and in men to a lesser extent). If these images were not so widely used and not so central to most aspects of society, appearance would be less important and other more merit-based qualities would be more important in determining a person’s sense of value and esteem. This would likely eliminate much of the development of drives for thinness and body dissatisfaction in Western societies.

Though this study has very important implications, it does have limitations. First, the population under study included undergraduates enrolled in a university where the majority of
the students are middle-class, white, and approximately 20 years of age. Therefore, results should only be generalized to populations with similar demographics.

Another limitation is that the sample was arrived at through random cluster sampling, and natural clusters such as the ones in my study, often vary considerably in the number of cases they contain. This was the case with my clusters, as some of the classes sampled had less than ten students, and some had close to one hundred. This may cause over-sampling of students enrolled in certain classes, while under-representing students enrolled in others. So, certain “types” of students may be less represented in the study.

Further research on the topic might include an added dimension to the analysis, such as a measure of importance of attractiveness or importance of sexuality of the participants in order to determine the interaction between traditional feminine characteristics and importance placed on appearance, and development of eating disordered attitudes and behaviors.

Also, future research could include a model including androgyny. Extant research has found that androgyny is important to consider in relating gender roles to various psychological and other attributes. For instance, Silverstein, et al (1990) found that women who exhibit nontraditional gender identity or gender conflict were more likely than other women to report certain eating disordered behaviors. So, future research on gender roles and eating disordered symptoms and behaviors could be enhanced by measuring androgyny of participants.

Another improvement could be a more appropriate, less clinical measure of eating disordered attitudes and behaviors. Since only a small minority actually do meet criteria for a diagnosable eating disorder, it might be better to operationalize the dependent variable with some type of bodily satisfaction survey or drive for thinness survey. This way, levels of bodily dissatisfaction could be correlated with levels of femininity. This would likely be a more
insightful measure of the dependent variable, as it would not exclude those with body insecurities that are not severe enough to qualify for treatment.
SOURCES


http://www.state.sc.us/dmh/anorexia/statistics.htm


Appendix A. Eating Attitudes Survey
Eating Attitudes Survey

This questionnaire is part of a study testing the relationship between health attitudes and personality characteristics. Please take your time and respond as accurately as possible. The information you provide in this survey is completely confidential and your participation is voluntary. Thank you very much for taking part in this study. Your participation is very important and very much appreciated. If you are interested in hearing about the results of this study, feel free to contact me at emr9582@uncw.edu.

Part I.
Directions:
For the following items, please indicate if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). To indicate your response, circle the appropriate letter.

1. I eat sweets and carbohydrates without feeling nervous. A U O S R N
2. I think that my stomach is too big. A U O S R N
3. I eat when I am upset. A U O S R N
4. I stuff myself with food. A U O S R N
5. I think about dieting. A U O S R N
6. I think that my thighs are too large. A U O S R N
7. I feel extremely guilty after overeating. A U O S R N
8. I think that my stomach is just the right size. A U O S R N
9. I am terrified of gaining weight. A U O S R N
10. I feel satisfied with the shape of my body. A U O S R N
11. I exaggerate or magnify the importance of weight. A U O S R N
12. I have gone on eating binges where I felt that I could not stop. A U O S R N
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>I like the shape of my buttocks.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>14.</td>
<td>I am preoccupied with the desire to be thinner.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>15.</td>
<td>I think about bingeing (overeating).</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>16.</td>
<td>I think my hips are too big.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>17.</td>
<td>I eat moderately in front of others and stuff myself when they’re gone.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>18.</td>
<td>I feel bloated after eating a normal meal.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>19.</td>
<td>If I gain a pound, I worry that I will keep gaining.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>20.</td>
<td>I have the thought of trying to vomit in order to lose weight.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>21.</td>
<td>I think that my thighs are just the right size.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>22.</td>
<td>I think my buttocks are too large.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>23.</td>
<td>I eat or drink in secrecy.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>24.</td>
<td>I think that my hips are just the right size.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
</tr>
<tr>
<td>25.</td>
<td>When I am upset, I worry that I will start eating.</td>
<td><strong>A</strong></td>
<td><strong>U</strong></td>
<td><strong>O</strong></td>
<td><strong>S</strong></td>
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</tbody>
</table>
Part II.
Directions:
The following items are personality characteristics that we would like you to use to describe yourself. Please indicate, on a scale from 1 to 7, how true of you each of these characteristics is. To indicate your response, write the appropriate number in the space provided.

Please use this scale to respond to each item:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tr>
<td>1</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
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<td></td>
<td></td>
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<tr>
<td>7</td>
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</tr>
</tbody>
</table>

1. Defend my own beliefs
2. Affectionate
3. Conscientious
4. Independent
5. Sympathetic
6. Moody
7. Assertive
8. Sensitive to needs of others
9. Reliable
10. Strong personality
11. Understanding
12. Jealous
13. Forceful
14. Compassionate
15. Truthful
16. Have leadership abilities
17. Eager to soothe hurt feelings
18. Secretive
19. Willing to take risks
20. Warm
21. Adaptable
22. Dominant
23. Tender
24. Conceited
25. Willing to take a stand
26. Love children
27. Tactful
28. Aggressive
29. Gentle
30. Conventional
Part III.

Directions:
For the following items, please respond appropriately in the spaces provided or circle your correct response. Please write N/A in the spaces where the question is not applicable to you.


4. GPA:  <2.0     2.0-2.4     2.5-2.9     3.0-3.5     3.6-4.0


8. County/State where you attended high school: _____________________________________

9. Number of brothers/step-brothers:________       10. Number of sisters/step-sisters:________

11. Your birth-mother is: married to your birth-father     remarried     single     deceased

12. Your birth-father is: married to your birth-mother     remarried     single     deceased

13. Your Relationship Status:    Single      Married       Engaged      Dating Multiple People       Have a Boyfriend/Girlfriend

14. Are you Hispanic/Latina?:             Yes                       No

15. Race:                 Black                          Asian                           White                      Native American                   Other____________

16. Parent/Guardian #1 Occupation: ____________       17. Parent/Guardian #2 Occupation:_______________

18. Parent/Guardian #1 Educational Level: <High School        High School/GED        Junior College        BA        Graduate Degree

19. Parent/Guardian #2 Educational Level: <High School        High School/GED        Junior College        BA        Graduate Degree