

Evaluating the Effects of Eating Disorder Memoirs on Readers' Eating Attitudes and Behaviors

Jennifer J. Thomas, BA^{1*}
 Abigail M. Judge, BA²
 Kelly D. Brownell, PhD¹
 Lenny R. Vartanian, PhD¹

ABSTRACT

Objective: More than 50 individuals have published eating disorder (ED) memoirs. The current study was the first to test whether memoirs affect readers' eating attitudes and behaviors, and whether they normalize and/or glamorize EDs.

Method: Fifty female undergraduates read an ED or control memoir. Before and afterward, participants completed the 26-item Eating Attitudes Test (EAT-26), the Eating Disorders Inventory (EDI) Drive for Thinness subscale, a measure of perceived ED symptom prevalence, and an Implicit Association Test (IAT) measuring associations between anorexia and glamour/danger.

Results: Participants in the ED condition did not demonstrate significant changes in the EAT-26, the EDI Drive for Thinness subscale, perceived symptom prevalence,

or IAT associations compared with controls. Before reading, the EAT-26 and EDI Drive for Thinness subscale correlated positively with perceived symptom prevalence and strength of the IAT association between anorexia and glamour.

Conclusion: ED memoirs appear to have little effect on undergraduates' eating attitudes and behaviors. Future research should investigate whether memoirs affect individuals with preexisting eating pathology, who may normalize and glamorize ED symptoms. © 2006 by Wiley Periodicals, Inc.

Keywords: eating disorder memoirs; eating attitudes; eating behaviors; normalization; glamorization

(*Int J Eat Disord* 2006; 39:418–425)

Introduction

The past two decades have witnessed a precipitous increase in the number of individuals with eating disorders who have published first-person accounts of their struggles. A recent search on WorldCat, a database of worldwide library holdings, revealed that >50 autobiographic books recounting the authors' experiences with anorexia nervosa and bulimia nervosa have been published (Figure 1). Nine such books have appeared in the last 2 years alone. Although these memoirs often contain dust jacket endorsements, forwards, and epilogues from well-known eating disorder specialists and advocacy organizations, the effects of these books on readers has yet to be empirically studied. Given that the

majority of lay women report obtaining information on eating disorders via books and magazines, and nearly 40% report that this knowledge has led them to alter their own eating habits,¹ eating disorder memoirists may be poised to exert considerable influence on consumers. In the absence of relevant data, however, the potential magnitude and direction of this influence remain equivocal.

Most memoirists cite altruistic motivations for writing their books. For example, Hornbacher² introduces her book, *Wasted: A Memoir of Anorexia and Bulimia*, by emphasizing that "I would do anything to keep people from going where I went. Writing this book was the only thing I could think of" (p 7). There are indeed several reasons to presume that memoirs could provide readers with therapeutic or preventative benefits. First, candid self-disclosure of abnormal eating behaviors could promote sympathetic understanding among individuals who have never suffered from disordered eating, and could also provide validation and hope for those with symptoms. In his work on group psychotherapy, Yalom proposes that because so many individuals with psychiatric disorders feel alone in their suffering, the promotion of universality through self-disclosure of symptoms may represent a powerful curative factor in group treatment.³

Accepted 18 June 2005

*Correspondence to: Jennifer J. Thomas, BA, Department of Psychology, Yale University, P.O. Box 208205, New Haven, CT 06520.
 E-mail: jennifer.thomas@yale.edu

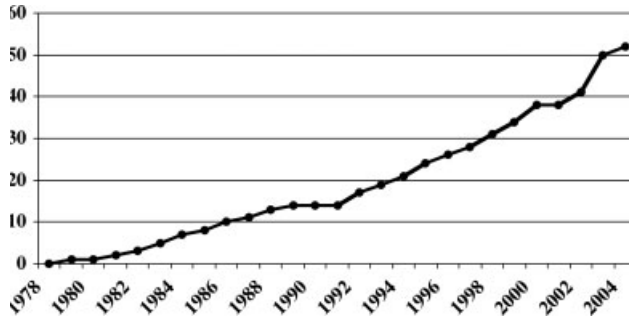
¹ Department of Psychology, Yale University, New Haven, Connecticut

² Department of Psychology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Published online 28 March 2006 in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/eat.20239

© 2006 Wiley Periodicals, Inc.

FIGURE 1. Cumulative number of first-person eating disorder memoirs published by year (1978–2004).



Such validation could be especially helpful for individuals suffering from eating disorders, which are socially stigmatized^{4,5} and associated with poor emotional support.⁶

A second potential mechanism through which eating disorder memoirs could benefit readers is by highlighting the serious health consequences of such illnesses.^{2,7} Real-life accounts of similar others enduring the lifelong physical sequelae of self-starvation and self-induced vomiting could potentially increase feelings of vulnerability to negative health outcomes and thus serve as a deterrent. A retrospective study of treatment seeking in women with bulimia nervosa found that messages underscoring the medical consequences of eating disorders while simultaneously emphasizing the efficacy of current treatments were the most effective in persuading individuals to seek professional help.⁸

In contrast, several converging lines of evidence suggest that eating disorder memoirs could exert iatrogenic effects. For example, the symptoms of several psychiatric disorders, including depression⁹ and bulimia nervosa,^{10,11} have demonstrated social contagion. Prospective studies show that among self-selected student peer groups, bulimic symptoms converge over the academic year¹⁰ and diverge over the summer months¹¹ potentially due to symptom exposure and social norms. Given that some eating disorder symptoms, such as weight loss, are socially desirable, it is plausible that vulnerable readers might attempt to emulate the pathological behaviors that eating disorder memoirs so meticulously detail. Indeed, some individuals in samples of both outpatients with anorexia nervosa¹² and community women¹ have reported attempting self-induced vomiting after learning of the behavior from magazine articles about eating disorders. Similarly, posts on multiple proanorexia websites describe utilizing eating disorder memoirs as “triggers” or “thinspiration” to motivate extreme dietary restriction.^{13–15}

Surprising findings from an early eating disorder prevention program¹⁶ highlight the unfortunate potential for psychoeducational efforts to go awry in certain contexts. Specifically, a program that employed individuals who had recovered from anorexia nervosa and bulimia nervosa as presenters resulted in an unexpected increase in participants' eating disorder symptoms.¹⁶ Although these findings were later questioned on methodologic grounds,¹⁷ several theorists have hypothesized that the potentially iatrogenic effects of personalized eating disorder accounts may stem from the inadvertent glamorization or normalization of disordered eating behaviors.^{16,18,19}

At least two studies have provided preliminary support for symptom glamorization. In one study, after viewing an educational video about eating disorders, participants who were told the presenter had previously recovered from an eating disorder were more likely to report wanting to look like her than were those who were told the presenter was an eating disorder specialist (Schwartz et al., unpublished observations). Another study found that individuals who read popular magazine articles about bulimia nervosa later rated hypothetical individuals with the disorder as more attractive, successful, and in control than did individuals who read textbook presentations of the disorder.²⁰

In sum, it is possible to use existing data and theory to predict that memoirs could help or hurt those who read them. The purpose of the current study was to determine the impact of one such memoir on readers' eating attitudes and behaviors. To this end, participants were randomly assigned to read a memoir either on the topic of eating disorders or on a neutral topic, and eating disorder symptoms were measured before and after reading the memoir. Secondary aims were to evaluate whether reading an eating disorder memoir would promote the glamorization and/or normalization of eating disorder symptoms, and to determine the psychometric properties of new measures of these constructs created for the current study.

Method

Participants

Fifty-four female undergraduates participated in the study during the 2004–2005 academic year, including 34 students from a private northeastern university and 20 students from a public southeastern university. Participants ranged from 18 to 23 years of age ($M = 20.0$, $SD = 1.38$). The majority were White (59.3%), but a significant proportion self-identified as

Asian American/Pacific Islander (22.2%), Black (13.0%), Hispanic (3.7%), and other ethnicity (1.8%).

Materials and Procedure

Due to the demand characteristics potentially inherent in a repeated measures design, the investigators disguised the true purpose of the experiment. Specifically, recruitment material advertised the study as the “National Consumer Reading Survey,” a market research investigation designed to ascertain the reading preferences of college women. Respondents to the study advertisement were invited to participate if they were native English speakers between the ages of 18 and 30 years. Participants were run individually. When a participant arrived for her first appointment, six recently published memoirs on a variety of topics were displayed in the laboratory, and she was told that she would be randomly assigned to read one. The participant was then asked to fill out a Time 1 survey packet that included questions on consumer preferences, reading habits, and psychological inventories on multiple life domains (e.g., interpersonal relationships, acculturation, spirituality) to disguise the embedded eating disorder questionnaires.

Included in the Time 1 survey packet were the true dependent measures of relevance to the current study, including the 26-item version of the Eating Attitudes Test (EAT-26)²¹ and a 5-item version of the Eating Disorders Inventory (EDI) Drive for Thinness subscale.²² Participants also completed two additional measures that were created specifically for the current study. The first measure, the Perceived Prevalence of Eating Disorder Symptoms Scale (PPEDSS), contained 9 items corresponding to criteria for anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (EDNOS) as outlined in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; Washington, DC: American Psychiatric Association; 1994).²³ The PPEDSS was constructed to ascertain whether eating disorder symptoms would be perceived to be more prevalent, or “normalized,” after reading the eating disorder memoir. For each item, participants were asked to “estimate the percentage of women your age who you think probably fit this description.” Sample items include the following: “are significantly underweight (e.g., less than 85% of expected body weight);” “intentionally induce vomiting in order to lose weight or prevent weight gain”; and “chew and spit out large amounts of food without swallowing it.” Responses to all 9 items were summed and then divided by 9 to obtain a final score ranging from 0 to 100, which represented the average percentage of same-gender peers perceived to engage in disordered attitudes and behaviors. The Chronbach alpha value for the PPEDSS among study participants was adequate (.82).

The second new measure, designed to measure the potential glamorization of eating disorders, was a com-

puter-based version of the Implicit Association Test (IAT).²⁴ The IAT is a performance-based assessment designed to measure automatic associations between concept categories. In the current study, the IAT was utilized to test whether participants more readily associated anorexia nervosa with “glamour” or with “danger.” Target words appearing in the center of the computer screen belonged to one of four conceptual categories: anorexia (emaciated, starve, fasting, bony), household (sofa, chair, clock, desk), glamorous (famous, stylish, elite, sophisticated), and dangerous (threatened, harmful, hazardous, fatal). The anorexia, household, and glamorous words were those frequently cited in a pilot study of 40 undergraduate and graduate students at both sites who were asked to list words associated with these categories. The dangerous words were adapted from a previous IAT study of individuals with specific phobia.²⁵ Household words were chosen as the anorexia contrast category due to presumably neutral implicit associations with this construct. As in previous IAT studies,²⁶ a neutral contrast category was selected to serve as a control so that reaction times could be assumed to reflect participants’ associations with the concept category of interest (in this case, anorexia nervosa). In one block of trials, participants were asked to press one key for anorexia words and glamorous words and a separate key for household words and dangerous words. In another block, the pairings were reversed such that participants were asked to press one key for anorexia words and dangerous words, and a separate key for household words and glamorous words. One half of the participants in each condition were randomly assigned to perform the anorexia/glamorous pairing first, whereas the other one half received the anorexia/dangerous pairing first. Faster reaction times to the anorexia/glamorous pairing were presumed to represent an implicit association between anorexia and glamour, whereas faster reaction times to the anorexia/dangerous pairing were presumed to indicate an implicit association between anorexia and danger. The IAT was scored according to the revised scoring algorithm described by Greenwald et al.²⁷ To decrease the salience of the anorexia IAT and to bolster the cover story, participants completed a second IAT on romantic relationships, which was not scored.

After completing all Time 1 measures, participants were told that they would be randomly assigned to read 1 of the 6 memoirs by picking a strip of paper out of a bowl. In actuality, all of the strips in the bowl contained the name of the book to which that participant had already been randomly assigned. Participants in the eating disorder condition were asked to read *Wasted: A Memoir of Anorexia and Bulimia*.² This book was selected by a quantitative method. Of all eating disorder memoirs identified by the investigators to have been published in the last 10 years, “Wasted” was stocked in the most libraries worldwide and was currently the best-selling eating

disorder memoir on 2 popular websites—amazon.com and barnesandnoble.com. Participants in the control condition were assigned to read *The Territory of Men: A Memoir*,²⁸ which was chosen for the control condition because it matched *Wasted* on multiple attributes of interest: It is also an autobiographic, female-narrated, recently published, coming-of-age narrative of similar length and readability (as determined by calculating Microsoft Word Flesch Readability scores for randomly selected pages in each text). Importantly, however, the book diverged from *Wasted* in that the protagonist does not present with any mental illness and thus makes very minimal mention of eating and weight.

After taking approximately 1 week to read their assigned memoir, participants returned to the laboratory. The experimenter introduced the Time 2 questionnaire packet by explaining that work on consumer preferences sometimes requires randomly selecting individuals to complete the same questionnaires twice to test for the statistical properties of the research instruments. This explanation was provided to dissuade participants from guessing the true study purpose despite the second presentation of the dependent measures (EAT-26, EDI Drive for Thinness, PPEDSS). The questionnaire packet also included 10 factual questions about the plot of their assigned book (to verify that participants read the book), as well multiple distracter measures (e.g., attitudes toward the book, self-esteem, gender role beliefs). After completing the self-report measures, participants performed the IATs and were debriefed.

Participants from the northeastern university received \$25 for participating, whereas participants from the southeastern university were awarded credit toward their introductory psychology course. As additional compensation, participants at both sites were allowed to keep the book to which they were assigned. The study protocol was approved by the institutional review boards at both institutions.

Data Analysis

All statistical analyses were conducted with SPSS Version 11 for Macintosh computers. After calculation of Mahalanobis distances revealed no multivariate outliers and 1 missing data point was imputed from extant data, a repeated measures multivariate analysis of variance (MANOVA) was performed to detect potential changes in EAT-26 and EDI Drive for Thinness scores over time and any Time \times Condition interaction. Individual repeated measures analyses of variance (ANOVAs) were conducted to investigate temporal changes in perceived symptom prevalence and IAT associations, respectively. Finally, Pearson correlation coefficients and sequential linear regression were utilized to determine the relations be-

tween PPEDSS scores, IAT associations, and eating disorder symptomatology.

Results

Dependent Measures at Time 1

Because there were no significant mean differences between participants at the two sites on any of the four dependent measures, data from both sites were pooled for all analyses. At Time 1, mean EAT-26 ($M = 9.48$, $SD = 10.13$) and EDI Drive for Thinness ($M = 15.59$, $SD = 6.71$) scores were consistent with those previously reported for nonclinical samples.^{21,29} Eight participants scored above the clinical cutoff score of 20 on the EAT-26. The mean score on the PPEDSS was 27.42 ($SD = 11.58$), indicating that, on average, eating disorder symptoms were perceived to be relatively rare among same-age peers. Finally, the mean IAT score was -0.45 ($SD = 0.56$), indicating that, on average, participants exhibited faster reaction times when anorexia words were paired with dangerous words rather than glamorous words.

Adherence to Protocols

Of the 54 original participants, 4 did not return at Time 2. This attrition left 50 participants available for the repeated measures analyses, 25 in the control condition and 25 in the eating disorder condition. There were no significant differences between dropouts and completers on the EAT-26, EDI Drive for Thinness, PPEDSS, or IAT associations. The mean number of days between time points was 7.06 ($SD = 0.74$). On average, participants correctly answered 8.20 ($SD = 1.75$) of the 10 factual questions about their assigned memoir on the Time 2 questionnaire, suggesting that they did in fact read the books.

Change in Dependent Measures Over Time

Means and standard deviations for all dependent measures at both conditions and time points are presented in **Table 1**.

A 2×2 (Time \times Condition) MANOVA on the 2 measures of eating pathology revealed a trend-level main effect for time, $F(2, 47) = 2.86$, $p = .067$, such that both groups' EAT-26 and EDI Drive for Thinness scores decreased from Time 1 to Time 2. However, there was no main effect for condition, $F(2, 47) = 0.87$, $p = .427$, and no significant Time \times Condition interaction, $F(2, 47) = 0.20$, $p = .818$, indicating that, compared with the control memoir, the eating disorder memoir had no significant impact

TABLE 1. Dependent measures by memoir condition at Time 1 and Time 2

	Time 1 <i>M</i> (<i>SD</i>)	Time 2 <i>M</i> (<i>SD</i>)
EAT-26		
ED	11.56 (12.22)	9.28 (9.48)
Control	7.80 (7.84)	6.52 (5.64)
Drive for Thinness		
ED	16.96 (7.28)	16.16 (6.83)
Control	14.80 (6.14)	14.26 (5.74)
PPEDSS		
ED	29.10 (14.20)	26.76 (12.74)
Control	26.49 (8.21)	23.00 (8.61)
IAT <i>D</i> effect		
ED	-0.19 (0.59)	-0.36 (0.70)
Control	-0.66 (0.43)	-0.50 (0.53)

Note: *M* = mean; *SD* = standard deviation; EAT-26 = 26-item Eating Attitudes Test; ED = eating disorder; IAT = Implicit Association Test; PPEDSS = Perceived Prevalence of Eating Disorder Symptoms Scale.

on participants' eating attitudes and behaviors. To address the issue of whether nonsignificant differences in overall EAT-26 scores resulted from large changes in positive and negative directions canceling each other out, we calculated the number of participants in each condition whose EAT-26 change score from Time 1 to Time 2 exceeded the absolute value of 1 Time 1 pooled *SD* unit ($SD = 10.13$). It was determined that, in the eating disorder condition, 1 participant's score increased by >1 *SD* unit, 3 decreased, and 21 stayed the same. In the control condition, 1 increased and 24 stayed the same.

A 2×2 (Time \times Condition) ANOVA on perceived symptom prevalence demonstrated a main effect for time, $F(1, 48) = 7.25$, $p = .010$, indicating that both groups of participants scored lower on the PPEDSS at Time 2 compared with Time 1. Again, there was no Time \times Condition interaction, $F(1, 48) = 0.28$, $p = .599$, indicating that the eating disorder memoir had little effect on participants' perceived prevalence of eating disorder symptoms among women their age.

Finally, a 2×2 (Time \times Condition) ANOVA on IAT scores revealed no main effect for time, $F(1, 48) = 0.02$, $p = .902$. However, there was a trend-level Time \times Condition interaction, $F(1, 48) = 3.77$, $p = .058$. Participants in the eating disorders condition (but not participants in the control condition) showed a slight increase in the strength of their associations between anorexia and danger between Time 1 and Time 2, although this increase did not reach statistical significance in an analysis of simple effects ($F = 2.13$, $p = .151$).

Deception Check

Of the 50 participants who completed the entire study protocol, 18.0% ($n = 9$) guessed that the pur-

pose of the study was to observe potential changes over time in ≥ 1 of the 4 dependent measures. None of these 9 participants hypothesized the direction of the potential change. Eliminating these individuals from the repeated measures analyses did not significantly alter the observed pattern of results, although the trend-level Time \times Condition interaction in IAT scores dropped out, $F(1, 39) = 1.79$, $p = .189$.

Relationships among Eating Pathology, Perceived Symptom Prevalence, and IAT Glamour

At Time 1, scores on the PPEDSS correlated positively and significantly with the EDI Drive for Thinness subscale ($r = .49$, $p < .001$) and EAT-26 ($r = .29$, $p = .033$) scores. The more eating disorder symptoms participants endorsed, the higher their estimates for the prevalence of eating disorder symptoms among women their age. IAT scores also correlated positively and significantly with EAT-26 scores ($r = .29$, $p = .037$) and exhibited a trend-level positive correlation with the EDI Drive for Thinness subscale ($r = .26$, $p = .060$). Therefore, at higher levels of eating pathology, individuals exhibited stronger associations between anorexia and glamour, and relatively weaker associations between anorexia and danger.

The perceived prevalence of symptoms and IAT scores were not significantly correlated with one another ($r = .10$, $p = .492$). Furthermore, each appeared to account for unique proportions of the variance in eating pathology. Specifically, in a sequential linear regression on EAT-26 scores, IAT scores explained 8.1% of the variance at the first step ($R = .29$, standardized $\beta = .29$, $p = .037$), and perceived prevalence of symptoms explained an additional 7.0% of the variance at the second step ($R = .39$, standardized $\beta = .27$, $p = .046$), yielding a total of 15.1% of the variance in EAT-26 scores explained by the 2 measures combined. Similarly, in a sequential linear regression on EDI Drive for Thinness scores, IAT scores explained 6.6% of the variance at the first step ($R = .26$, standardized $\beta = .26$, $p = .060$), and perceived symptom prevalence explained an additional 21.7% of the variance at the second step ($R = .53$, standardized $\beta = .47$, $p < .001$), yielding a total of 28.3% of the variance in EDI Drive for Thinness explained by the 2 measures combined.

Conclusion

The current study provided the first exploration of the effects of eating disorder memoirs on readers'

eating attitudes and behaviors. Our results suggest that eating disorder memoirs have little impact overall, and that this neutral net effect is not attributable to memoirs significantly helping some individuals and harming others. The finding that such memoirs are relatively inert contrasts with theories that predict either beneficial or iatrogenic effects. This finding also dovetails with evidence from the criminology literature that cautionary tales do not necessarily guarantee behavioral improvements. According to a recent meta-analysis, “Scared Straight” and other programs in which juvenile delinquents visit prison facilities to interact with current inmates do not actually lead to decreases in participants’ subsequent criminal behavior.³⁰ One potential explanation for the lack of positive impact of reading the eating disorder memoir may be a saturation effect. Specifically, contemporary college women may already be quite knowledgeable about eating disorders, thus rendering their preexisting eating attitudes and behaviors relatively resistant to change after reading just one book.

The results also failed to support the alternative hypothesis of iatrogenic increases in eating disorder symptoms, contrasting with preliminary evidence from proanorexia websites^{13–15} and a previous qualitative study of outpatients with anorexia¹² that personal narratives can be triggering. One potential explanation for the incongruence between anecdotal evidence and the current result is that the potential for iatrogenesis is limited to vulnerable populations. Readers who vary in their underlying predispositions for disordered eating may also differ with regard to the salience, encoding, and retrieval of memoir information. The result of a previous study in which women who endorsed high levels of bulimic symptoms attended significantly more to body size than did control women when making similarity ratings among photographs³¹ lends plausibility to this view. It is possible, for example, that a vulnerable individual could read an eating disorder memoir and later recall and employ the author’s preferred weight loss methods, whereas a relatively less vulnerable individual would find more poignancy in the author’s struggle toward recovery and thus not be moved to attempt disordered behaviors. Unfortunately, due to the small number ($n = 8$) of individuals in this sample who scored above the clinical cutoff score on the EAT-26, it was not possible to test for such differences in this particular investigation.

Although the current study found eating disorder memoirs to exhibit no effect on readers’ eating attitudes and behaviors, the null results should be interpreted with caution due to factors unique to this particular investigation. First, it is possible that

participants evinced changes in constructs not directly measured by the assessments employed, or that changes eventually surfaced only after the 1-week follow-up period. Second, we did not assess participants’ exposure to alternate sources of personal eating disorder accounts, either before or during the current experiment. However, potential exposure to such alternate sources would be expected to balance out across the two conditions due to random assignment. A third caveat is that participants at one site (but not the other) consisted exclusively of introductory psychology students, who may perceive disordered eating differently from nonpsychology students. Notably, a reanalysis of the data utilizing site as a proxy for psychology student status revealed that participants’ eating attitudes and behaviors did not change significantly after reading the eating disorder memoir in either case. Finally, a larger sample size may have yielded greater statistical power. However, the effect size observed for the Time \times Condition interaction ($\eta^2 = .009$) indicates that memoir condition accounted for $< 1.0\%$ of the variance in eating pathology at Time 2 and falls short of that characterized as “small” by Cohen’s standards ($\eta^2 = .01$).³² Therefore, our results suggest that if memoirs have any effect on readers’ eating attitudes and behaviors, this effect is of little practical importance.

Another important finding from the current study was that participants’ own level of eating pathology correlated positively and significantly with their perceived prevalence of symptoms among other women their age. This result converges with a previous finding that highly symptomatic women were more likely than those with few symptoms to view bulimic symptoms as common and acceptable among others,³³ and extends those findings to the symptoms of EDNOS and anorexia nervosa. This pattern might reflect a false consensus effect, a phenomenon in which individuals tend to overestimate the extent to which their own characteristics and opinions are shared by others, and which is believed to stem, in part, from the relatively greater cognitive accessibility of one’s own attitudes and behaviors.³⁴ Given evidence of similar levels of bulimic symptoms within peer groups,¹⁰ it is also possible that when a high-symptom individual attempts to assess the commonality of eating pathology in general, examples of her own high-symptom friends most easily come to mind and subsequently inflate her estimate. Another potential explanation for the relative congruence between participants’ level of eating pathology and perceived symptom prevalence is that individuals who view their own disordered eat-

ing behaviors as shameful or aberrant may experience cognitive dissonance, which in turn leads them to reframe symptoms as somewhat less pathological. In the domain of substance abuse, multiple interventions have attempted to decrease alcohol use by alerting undergraduates to actual levels of normative usage on their particular campuses.³⁵ Our findings suggest that it might be worthwhile to test the effectiveness of similar interventions in the field of eating disorder prevention.

Finally, participants' level of eating pathology correlated positively and significantly with the strength of their implicit association between anorexia and glamour. Although several theorists^{17–19} have expressed concern that media portrayals of eating disorders glamorize and sensationalize symptoms, this study is the first to demonstrate that the glamorization of eating disorders is associated with eating pathology. It is therefore possible that, as others have suggested,¹⁸ media accounts that depict “sufferers” as holding coveted forms of social capital, including beauty, fame, and wealth, conflate psychopathology with desirable attributes, and potentially encourage vulnerable individuals to engage in disordered eating as a way to emulate high status icons. Alternatively, it is equally plausible that individuals who engage in disordered eating behaviors may come to view their own actions not only as more normative (as suggested above) but also as more positive or glamorous, which could also account for the observed IAT effects. Future longitudinal work would be needed to confirm either hypothesis, and the anorexia/glamour IAT represents a promising new dependent variable for upcoming studies of media influences on disordered eating. This IAT may be a particularly helpful contribution because there are no extant measures of the glamorization of eating pathology, and research participants may be unlikely to acknowledge such associations when explicitly queried.

In sum, the findings of the current study suggest that eating disorder memoirs may be ineffective at achieving their preventive aims. Given anecdotal evidence that such books may be harmful to even a few readers, further evaluation of the effects of these memoirs, particularly among individuals with preexisting (or individuals at risk for) eating pathology, is warranted before they are promoted for use in treatment, prevention, and educational settings. Findings also indicate that women who endorse high levels of eating pathology both normalize and glamorize eating disorder symptoms. Interventions aimed at decreasing the perceived allure and com-

monality of these disorders may prove fruitful additions to future prevention efforts.

References

1. Murray S, Touyz S, Beaumont P. Knowledge about eating disorders in the community. *Int J Eat Disord* 1990;9:87.
2. Hornbacher M. *Wasted: A Memoir of Anorexia and Bulimia*. New York: Harper Collins; 1998.
3. Yalom ID. *The Theory and Practice of Group Psychotherapy*. 4th ed. New York: Basic Books; 1995.
4. Crisp AH, Gelder MG, Rix S, et al. Stigmatisation of people with mental illnesses. *Br J Psychiatry* 2000;177:4.
5. Fleming J, Szmukler GI. Attitudes of medical professionals towards patients with eating disorders. *Aust N Z J Psychiatry* 1992;26:436.
6. Rorty M., Yager J, Buckwalter JG, et al. Social support, social adjustment, and recovery status in bulimia nervosa. *Int J Eat Disord* 1999;26:1.
7. Hendricks J, Hendricks G. *Slim to none: A Journey through the Wasteland of Anorexia Treatment*. New York: McGraw-Hill; 2003.
8. Smalec JL, Klingle RS. Bulimia interventions via interpersonal influence: the role of threat and efficacy in persuading bulimics to seek help. *J Behav Med* 2000;23:37.
9. Joiner TE. Contagious depression: existence, specificity to depressed symptoms, and the role of reassurance seeking. *J Pers Soc Psychol* 1994;67:287.
10. Crandall CS. Social contagion of binge eating. *J Pers Soc Psychol* 1988;55:588.
11. Zalta AK, Keel PK. Peer influence on bulimic symptoms in college students. *J Abnorm Psychol*, in press.
12. Thomsen SR, McCoy KJ, Williams M. Internalizing the impossible: anorexic outpatients' experiences with women's beauty and fashion magazines. *Eat Disord* 2001;9:49.
13. Anonymous. Ana(ANorexiA) tips. Available from URL: <http://anorexicpride.blog.com/> [Accessed March 8, 2005].
14. Anonymous. Celebrity stats. Available from URL: <http://www.wasted.fanpage.com/custom2.html> [Accessed March 8, 2005].
15. Anonymous. Things to do instead of eating. Available from URL: <http://www.angelfire.com/crazy2/totalcontrol/noteat.html> [Accessed January 27, 2005].
16. Mann T, Nolen-Hoeksema S, Burgard D, et al. Are two interventions worse than none? Joint primary and secondary prevention of eating disorders in college females. *Health Psychol* 1997;16:215.
17. Stice E, Shaw H. Eating disorder prevention programs: a meta-analytic review. *Psych Bull* 2004;130:206.
18. Garner DM. Iatrogenesis in anorexia nervosa and bulimia nervosa. *Int J Eat Disord* 1985;4:701.
19. O'Dea J. School-based interventions to prevent eating problems: first do no harm. *Eat Disord* 2000;8:123.
20. Schulze EA, Gray JJ. The effects of popular and textbook presentations of bulimia nervosa on attitudes towards bulimia nervosa and individuals with bulimia nervosa. *Br Rev Bulimia Anorexia Nervosa* 1990;4:83.
21. Garner DM, Olmsted MP, Bohr Y, et al. The Eating Attitudes Test: psychometric features and clinical correlates. *Psychol Med* 1982;12:871.
22. Garner DM, Olmsted MP, Polivy J. Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *Int J Eat Disord* 1983;2:15.
23. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994.

24. Greenwald AG, McGhee DE, Schwartz JLK. Measuring individual differences in implicit cognition: The Implicit Association Test. *J Pers Soc Psychol* 1998;74:1464.
25. Teachman BA, Aiden GP, Woody SR. Implicit associations for fear-relevant stimuli among individuals with snake and spider fears. *J Abnorm Psychol* 2001;110:226.
26. Field M, Mogg K, Bradley BP. Cognitive bias and drug craving in recreational cannabis users. *Drug Alcohol Depend* 2004;74:105.
27. Greenwald AG, Nosek BA, Banaji MR. Understanding and using the Implicit Association Test: I. An improved scoring algorithm. *J Pers Soc Psychol* 2003;85:197.
28. Fraser J. *The Territory of Men: A Memoir*. New York: Random House; 2002.
29. Heatherton TF, Nichols P, Mahamedi F, et al. Body weight, dieting, and eating disorder symptoms among college students, 1982 to 1992. *Am J Psychiatry* 1995;152:1623.
30. Petrosino A, Turpin-Petrosino C, Buehler J. Scared Straight and other juvenile awareness programs for preventing juvenile delinquency: a systematic review of the randomized experimental evidence. *Ann Am Acad Pol Soc Sci* 2003; 589:41.
31. Viken RJ, Treat TA, Nosofsky RM, et al. Modeling individual differences in perceptual and attentional processes related to bulimic symptoms. *J Abnorm Psychol* 2002;111:598.
32. Cohen J. *Statistical Power Analysis for the Behavioral Sciences*. 2nd ed. Hillsdale, NJ: Earlbaum; 1988.
33. Vander Wal JS, Thelen MH. Attitudes toward bulimic behaviors in two generations: the role of knowledge, body mass, gender, and bulimic symptomatology. *Addict Behav* 1997;22: 491.
34. Gross SR, Miller N. The “golden section” and bias in perceptions of social consensus. *Pers Soc Psychol Rev* 1997;1:241.
35. Perkins HW, editor. *The Social Norms Approach to Preventing School and College Age Substance Abuse: A Handbook for Educators, Counselors, and Clinicians*. San Francisco: Jossey-Bass; 2003.