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Exploring the Causes and Consequences of Engaging in Fat Talk

Analisa Arroyo & Jake Harwood

Fat talk refers to the ritualistic conversations about one's own and others' bodies (e.g., "I'm so fat!" "No you're not, I'm the one who is fat!"). What we say about ourselves has implications for how we make sense of and evaluate ourselves and those around us; thus, the current research presents the results of two studies that sought to identify potential causes and consequences of fat talk. Mutually reinforcing effects were predicted between fat talk and both body image and mental health issues. In two studies, participants completed closed-ended scales reporting their use of fat talk, body satisfaction, perceived pressure to be thin, self-esteem, and depression. Across a three-week span, Study 1 found fat talk to predict lower body satisfaction and higher depression; fat talk also mediated the association between body weight concerns and mental health problems. Study 2 found, across a two-week span, fat talk to predict higher levels of depression and perceived sociocultural pressure to be thin. In addition, low body satisfaction predicted more fat talk. Results suggest that reducing the amount of fat talk weakens its connection to negative aspects of self-concept. Health campaigns, interpersonal strategies, and more positive forms of weight-related communication are discussed as possible ways to potentially reduce the negative effects of fat talk on both body image and mental health issues.

Keywords: Body Image; Health Communication; Objectification Theory; Self-esteem; Depression

Perceived sociocultural pressure to fit the idealized body type (thin, toned, muscular) is associated with negative affect (Stice & Bearman, 2001) and body-perception problems such as eating disorder symptomatology, a drive for thinness, and body dissatisfaction (Harrison & Hefner, 2006; Tiggemann, Polivy, & Hargreaves, 2009). Unfortunately, women see dissatisfaction with their bodies as normative because of

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pressures to be thin in our society (Rodin, Silberstein, & Striegel-Moore, 1984). In fact, 66% of adolescent girls are trying to lose weight (Neumark-Sztainer et al., 2002) and 50% of adult women have negative evaluations of how they look (Cash & Henry, 1995). This is also a concern for men; 75% of men report a discrepancy between their ideal and perceived bodies (Mishkind, Rodin, Silberstein, & Striegel-Moore, 2001). Thus, much current research explores the effects of ideal body images on both men and women (Harrison, Taylor, & Marske, 2006).

Perceived sociocultural pressure to fit the ideal body image is communicated to both males and females through messages sent from the media, family, and peers (Harrison et al., 2006; Tiggemann et al., 2009). Because interpersonal relationships are contexts where body weight ideals are manifested, the exploration of weight-related communication in interpersonal communication—*fat talk*—is essential in identifying and understanding people's negative and unhealthy beliefs, behaviors, and attitudes about their own and others' weight. The research reported here explores interpersonal transactions of the thin ideal by longitudinally assessing associations between fat talk, body concerns, and mental health. Specifically, this research (a) explores some of the causes and consequences in engaging in fat talk and (b) proposes fat talk as one mechanism through which body concerns affect mental health. In so doing, we examine a critical but underexplored relationship between interpersonal communication and both mental and physical health.

Objectification Theory

According to objectification theory (Fredrickson & Roberts, 1997), society's objectification of women causes self-objectification (i.e., women treat their bodies as objects that should be evaluated). Given current trends towards objectification of men's bodies (Grieve & Helmick, 2008; Wiseman & Moradi, 2010) and the indications of body dissatisfaction among men described earlier, objectification issues also apply to men. Self-objectification increases body shame and body dissatisfaction, each of which undermines mental health (e.g., resulting in increased depression: Grabe, Hyde, & Lindberg, 2007; Stice & Bearman, 2001).

Research has shown that depressive symptomatology is an outcome of an idealized body image and low body satisfaction (Thompson & Stice, 2001). After being teased about appearance (Keery, Boutelle, van den Berg & Thompson, 2005) or even after just being exposed to fashion models, women report higher levels of depression, anger, and body dissatisfaction (Cahill & Mussap, 2007). Chaiton et al. (2009) found that the pressure to be thin was uniquely related to depressive symptoms among adolescent girls, and body dissatisfaction was associated with depressive symptoms among adolescent boys. The relationship between body image and depression occurs among male *and* female adolescents (Adams, Katz, Beauchamp, Cohen, & Zavis, 1993) and men and women in early, middle, and late adulthood (Davison & McCabe, 2005). These studies show that messages about the ideal body image and self-objectification affect people's body image and lead to negative health outcomes such as depression.

While previous work in communication has examined the effects of messages about the ideal body image, most work has focused on media images (Harrison, 2000a; Harrison & Hefner, 2006). Less work has examined the role of interpersonal processes in reinforcing the ideal body image; however, past research has shown that perceived pressure to fit the ideal body image is manifested through these interactions (McCabe & Ricciardelli, 2001). Interpersonal conversations about weight often feature elements that express and indicate self-objectification, such as self-criticism, desire to be thinner, and concerns about eating behaviors. These negative comments are collectively called *fat talk*. The next section elaborates on the fat talk construct.

Fat Talk: Manifesting an Idealized Body Image

Fat talk, a term coined by Nichter and Vuckovic (1994), is the ritualistic conversation that women have with each other about their own and others' bodies (e.g., "I'm so fat!" "No you're not, I'm the one who is fat!"). These types of conversations include comments about (1) what one's eating and exercise habits should be, (2) fears of becoming out of shape or overweight, (3) how one's eating and exercise habits compare to others, (4) other people's shape and appearance, (5) one's own weight, shape or diet, and (6) supplements, meal replacements, or muscle-building strategies (Nichter, 2000; Ousley, Cordero, & White, 2008).

Research indicates that women feel pressured to engage in fat talk, and that *men* also report being exposed to and participating in conversations about weight and appearance (Martz, Petroff, Curtin, & Bazzini, 2009). The majority of such talk is negative, focusing particularly on ways in which one's body fails to live up to one's own desires or societal expectations (Britton, Martz, Bazzini, Curtin, & LeaShomb, 2006). Given the negative focus of past research, the two studies reported here continue to look at people's negative comments. However, fat talk can serve more positive functions at times: the precise valence of the comments people make can depend on conversational context with women more likely to speak favorably about their bodies when other women are doing likewise (Tucker, Martz, Curtin, & Bazzini, 2007).

The work by anthropologists (Nichter) and psychologists (Martz, Stice, Durkin) provides insight as to who uses fat talk, when it is used, and around whom. Crucially, no communication scholars have studied this phenomenon, despite its clear connection to interpersonal processes. We can advance the understanding of fat talk by examining the causes and effects of fat talk, and the interpersonal dynamics of those causes and effects. A communication perspective frames fat talk as a dynamic and collaborative process wherein weight issues are negotiated between people. As will be clear from our hypotheses, we believe that fat talk both reflects psychological processes, and also contributes to those processes. In this sense, we view it as a constructive process: fat talk builds our ideas about the meaning of weight, and is a mechanism by which we come to terms with (and fall victim to) weight issues. The specific variables and theoretical framework in the current research are psychological in nature, but our focus is on the ways in which communication constructs *and* reinforces those psychological processes in dyadic interaction.

Study 1

Objectification theory suggests that self-objectification is associated with effects on two rather distinct sets of variables: (a) body weight concerns and (b) mental health problems (Grabe et al., 2007). For this reason, in the current work we examine weight-related cognitions (body satisfaction, perceived sociocultural pressure to be thin) and broader mental health constructs (self-esteem, depression). Our research conceptualizes fat talk as one way in which self-objectification is both manifested *and* constructed. When we engage in fat talk, it is a social extension and behavioral manifestation of self-objectification. Moreover, the interactive experience of being around, hearing, and participating in fat talk should contribute to the self-objectification process as individuals feel pressured to be a part of the discourse. This broad conceptual perspective leads to two distinct predictions concerning the causes and effects of fat talk, predictions we can examine simultaneously using a longitudinal design.

On one hand, body weight concerns and mental health issues might cause people to engage in fat talk as a way of expressing emotions concerning weight. Engaging in fat talk can be seen as a way to cope with negative body image and mental health concerns by seeking feedback from others. Fat talk allows us to obtain social validation and provides an outlet for negative emotions (Nichter, 2000): “fat talk uses weight as a reference point for feelings” (Gapinski, Brownell, & LaFrance, 2003, p. 278). Negative body perceptions may therefore be motivators for people to cope with and seek out feedback from others and fat talk may be a way for people to express their concerns. Fat talk, in this case, is the outcome of body weight and mental health concerns. Thus, we predict that negative self-perceptions will lead to an increased likelihood of engaging in fat talk:

- H1: Lower levels of body satisfaction and self-esteem, and higher levels of perceived sociocultural pressure to be thin and depression will predict engaging in fat talk.

Concurrently, doing fat talk may heighten body weight concerns and exacerbate mental health issues because it *makes* weight a salient issue; it is a means of self-objectification. Engaging in messages that promote the ideal body image has a negative impact on people’s self-perceptions (Stice, Shupak-Neuberg, Shaw, & Stein, 1994). Thus, talking about weight as Nichter (2000) describes (i.e., speaking about oneself negatively and seeking feedback from others) should perpetuate negative self-perceptions and enhance perceptions that thinness is culturally important (North & Swann, 2009). Given the largely negative tone of fat talk and assuming that weight becomes both more central and more negatively valenced as a result of fat talk, we predict that engaging in fat talk has negative consequences for self-esteem and depression. While self-esteem and depression are usually characterized as relatively stable states, there are intra-individual fluctuations in these variables. For example, Cahill and Mussap’s (2007) participants reported higher levels of depression after

being exposed to pictures of fashion models. Negative communicative interactions about body weight issues could have similar effects:

- H2: Engaging in fat talk will predict lower levels of body satisfaction and self-esteem, and higher levels of perceived sociocultural pressure to be thin and depression.

We also explore fat talk as a *mechanism* through which body weight concerns may lead to mental health problems. Fat talk involves expressing discontent with one's body and includes a number of topics indicating fear, wishing, jealousy, regret, and dissatisfaction (Ousley et al., 2008). Thus, the specific tone and content of fat talk messages perpetuate negative self-perceptions (e.g., "I'm so fat," "My ass is huge"), typically without providing coping or redress strategies. Beck's cognitive theory of depression (1974) states that such negative thoughts are predictive of the development of depression; as a result, we propose that dissatisfaction with one's weight manifests in a discourse that is centered on negative and distorted evaluations of one's self. Therefore, people with negative body weight concerns can perpetuate low self-esteem and depression by engaging in fat talk comments. Thus, fat talk may be a mechanism by which body concerns are translated into broader mental health problems:

- H3: The relationships between the body concern variables (i.e., body satisfaction, perceived sociocultural pressure to be thin) and (a) self-esteem and (b) depression will be mediated by fat talk.

Method

Participants and Procedure

College students are vulnerable to weight concerns because of specific factors such as a transition to a new environment, associated psychological distress, weight gain, and pressures about appearance (Hoffman, Policastro, Quick, & Lee, 2006; Maine & Bunnell, 2008). Because college students are an appropriate and important sample with which to explore the causes and consequences of engaging in fat talk, participants were recruited from undergraduate communication classes at a large Southwestern university in exchange for extra credit in their class ($N=57$). Participants' ages ranged from 18 to 26 ($M=20.63$, $SD=1.59$) and 58% were female. Participants were 77% White, 10% Latino, 1% African American, 9% Native American, and 1% Asian.

Across a three-week span, we administered six questionnaires by emailing participants directions and a link to an online questionnaire. Participants created a codeword that was used to link their responses. At Time 1, participants provided demographic information and completed closed-ended scales to report their use of fat talk, along with body weight concern and mental health variables. Times 2–5 were brief questionnaires and were used to assess the amount of fat talk used on a *daily* level. At Time 6, participants completed a longer questionnaire with the same

variables as Time 1 in order to assess changes over time. The measures are described below.

Time 1 and Time 6 Measures

Body weight concerns. We measured body satisfaction and perceived sociocultural pressure to be thin as potential causes and consequences of fat talk. Ten items from the Body Satisfaction Scale for Adolescents and Adults assessed *body satisfaction* (Mendelson, Mendelson, & White, 2001). Items (e.g., I'm satisfied with how I look) were measured on 5-point Likert scales (1 = *strongly disagree* to 5 = *strongly agree*); items were averaged, with high scores denoting high body satisfaction (Time 1: $M=3.19$, $SD=0.81$, $\alpha=.88$; Time 6: $M=3.22$, $SD=0.78$, $\alpha=.88$). To measure *perceived sociocultural pressure to be thin*, participants completed the Perceived Sociocultural Pressure Scale (Stice & Bearman, 2001). This 10-item scale (e.g., I've felt pressure from my friends to lose weight) was measured on a five-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*); items were averaged, with high scores denoting higher perceived pressure to be thin (Time 1: $M=2.50$, $SD=1.09$, $\alpha=.91$; Time 6: $M=2.58$, $SD=0.94$, $\alpha=.88$).

Mental health variables. We assessed self-esteem and depression as potential causes and consequences of fat talk. We utilized Rosenberg's (1989) *self-esteem* scale. These six items (e.g., I take a positive attitude toward myself) were measured on five-point Likert scales (1 = *strongly disagree* to 5 = *strongly agree*); items were averaged, with high scores denoting high self-esteem (Time 1: $M=3.99$, $SD=0.75$, $\alpha=.81$; Time 6: $M=3.96$, $SD=0.76$, $\alpha=.84$). We measured *depression* with the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). In response to how they felt in the last week, participants rated the 6 items (e.g., I felt depressed) on 4-point Likert scales (1 = *rarely or none of the time* to 4 = *all of the time*). Items were averaged, with high scores denoting higher levels of depression (Time 1: $M=2.08$, $SD=0.57$, $\alpha=.65$; Time 6: $M=1.97$, $SD=0.55$, $\alpha=.69$).

Daily Measure

Fat talk. Participants' frequency of fat talk use was measured at all 6 time points. Fat talk items were developed using Ousley et al.'s (2008) typology of fat talk conversations (see subheadings in Table 1), which was derived from "discussions by hundreds of [Southwestern USA] undergraduates about eating, exercise, and body-image issues" (p. 76). Although not limited to what one might say for each type of fat talk comment, three items were developed for each type (see Table 1), resulting in 18 items total. At Time 1, participants marked how frequently they or their friends said things *similar* to each of the statements on a 1–6 scale (1 = *rarely/never*, 2 = *less than once a month*, 3 = *monthly*, 4 = *weekly*, 5 = *daily*, 6 = *more than once a day*). Specific directions provided to respondents are provided in the table. These directions stress to the participants that they did not have to say the exact statement provided in the questionnaire, rather they were asked to think about whether or not

Table 1 Fat talk items.**What one's eating and exercise habits should be**

"I know I shouldn't eat this brownie."^a

"I need to work out more."

"I should watch what I eat."

Fears of becoming out of shape or overweight

"I'm so worried that I'm going to get fat!"^a

"I'm scared of what I will look like if I gain weight."

"I'd really hate to get fat."

How one's eating and exercise habits compare to others

"Amber [Mike] works out twice as long as I do. I wish I had her [his] stamina so that I could lose weight."

"If I ate like Jennifer [John] does, I would lose weight."

"I wish I could eat as healthy as some of my friends do."^a

Other people's shape and appearance

"Look how much weight she [he] has gained. She [he] looks terrible!"^a

"I wish I was as skinny [toned] as Amber [Will]."

"How does she [he] stay so thin?"

One's own weight, shape or diet

"I'm so fat"^a

"My ass is huge"

"I ate way too much yesterday"

Supplements, meal replacements, or muscle-building strategies

"I should try protein shakes to help lose weight"

"I should skip meals to help me lose weight"^a

"I'm going to try one of those weight loss pills"

Note: Participants were given the following directions: "Please tell us if ("how often" at Time 1) you or your friends said things SIMILAR TO each of the statements in the past two days (specific time not provided at Time 1). For example, with the statement "I know I shouldn't eat this brownie," other things that you say about food you should and should not eat would count as being similar to this statement." Brackets in items denote words used on the male questionnaire.^aItems used in Study 2

they said things similar to the presented items. At Times 2–6, answering either *yes* (1) or *no* (2), participants marked if they or their friends said things similar to each of the statements since they last filled out the survey. The yes/no items were used at Times 2–6 due to the limited time between each measurement and the need not to overtax respondents who were completing six questionnaires in a three-week period.

Three measures of fat talk were used in our analyses. First, Time 1 fat talk was calculated by averaging participants' responses ($M = 2.77$, $SD = 1.06$, $\alpha = .94$). Second, Times 2–5 fat talk were individually calculated by summing participants' responses, and then the daily sums were averaged to provide a daily fat talk measure for times 2–5 ($M = 8.50$, $SD = 5.28$, $\alpha = .91$). This daily measure was used in our mediation analysis. Given that we did not measure mental health or body concern issues in the daily measures, variation in fat talk within this period was not relevant to our hypotheses; therefore we did not use each daily measure individually as mediating variables. Third, Time 6 fat talk was calculated by summing participants' responses ($M = 8.09$, $SD = 6.18$, $\alpha = .94$). Our analyses did not reveal different outcomes for the different types of fat talk; thus, all fat talk items were combined to make a total fat talk item.

Table 2 Zero-order correlations of Study 1 variables.

	1	2	3	4	5	6	7	8	9	10	11	12
Time 1												
1. Fat Talk												
2. Body satisfaction	-.65**											
3. Pressure to be thin	.66**	-.58**										
4. Self-esteem	-.44**	.63**	-.42**									
5. Depression	.34**	-.42**	.32**	-.57**								
Time 6												
6. Fat talk	.65**	-.52**	.43**	-.41**	.30*							
7. Body satisfaction	-.66**	.85**	-.60**	.52**	-.44**	-.60**						
8. Pressure to be thin	.49**	-.39**	.60**	-.37**	.26	.41**	-.42**					
9. Self-esteem	-.48**	.58**	-.40**	.86**	-.57**	-.44**	.60**	-.40**				
10. Depression	.53**	-.39**	.45**	-.52**	.58**	.44**	-.57**	.40**	-.61**			
Mediator												
11. Fat talk daily	.64**	-.52**	.42**	-.50**	.36**	.85**	-.61**	.48**	-.55**	.47**		
Demographics												
12. BMI	-.04	-.11	.08	.08	-.01	-.18	.05	-.05	.17	.07	-.09	
13. Sex	-.41**	.19	-.37**	.03	.01	-.33*	.14	-.39**	.004	-.14	-.31*	.15

Note: Sex is coded as females = 1, males = 2. $N = 57$. ** $p < .01$, * $p < .05$.

Results and Discussion

Zero order correlations of all study variables can be found in Table 2. Fat talk is significantly associated with body satisfaction, perceived pressure to be thin, self-esteem, and depression at both Time 1 and Time 6 in the predicted directions.

H1 and H2 were contrasting hypotheses put forth to distinguish whether fat talk was a cause or an outcome (or both) of body concerns and mental health issues. We used standard multiple regression analyses to test these two hypotheses. The predictor variables were from Time 1 and the outcome variables were from Time 6. For H1, fat talk was the outcome variable and the mental health and body image variables were the predictor variables; for H2, the mental health and body image variables were the outcome variables and fat talk was the predictor variable.¹ In order to assess the effects of the predictor on *change* in the outcome variable, analyses controlled for Time 1 scores of the outcome variables (e.g., fat talk at Time 1 was used as a control when fat talk at Time 6 was the outcome variable; for an example of this technique, see Vezzali, Giovannini, & Capozza, 2010). Sex and BMI ($M = 22.78$; $SD = 4.03$) were examined as potential moderators in all analyses, but no significant interaction effects emerged for either variable; these results are not reported. Sex and BMI, however, were used as covariates in all of the following analyses.

H1 posed fat talk as the outcome of body weight and mental health issues. As shown in Table 3, there was no support for this hypothesis. Our data do not support the prediction that engaging in fat talk is an outcome of mental health or body weight concerns.

H2 posed fat talk as the predictor of body weight and mental health concerns. As shown in Table 3, there was partial support for this hypothesis. Fat talk significantly predicted decreased levels of body satisfaction and higher levels of depression. Our data do not support the prediction that engaging in fat talk increases perceived sociocultural pressure to be thin or decreases self-esteem, at least in the short term.

Table 3 Study 1: fat talk as a cause or outcome of body concerns and mental-health issues.

	<i>B</i>	<i>SE B</i>	β	<i>sr</i> ²	<i>R</i> ²
H1: Fat talk as outcome (DV)					
Body satisfaction	−1.31	1.09	−.17	.02	.45
Pressure to be thin	−.56	.84	−.10	.00	.44
Self-esteem	−.95	1.05	−.12	.01	.44
Depression	.89	1.14	.09	.01	.44
H2: Fat talk as predictor (IV)					
Body satisfaction	−.15	.07	−.22*	.02	.75
Pressure to be thin	.07	.14	.08	.00	.39
Self-esteem	−.03	.06	−.05	.00	.73
Depression	.18	.06	.37**	.10	.45

Note: All analyses control sex and BMI, as well as for the DV at Time 1 in order to assess change over time. R^2 values include variance accounted for by the Time 1 DV measure, which is in all cases significant. $N = 57$. ** $p < .01$, * $p < .05$.

H3 predicted that body concerns would lead to mental health problems over time, with fat talk as a mechanism explaining this relationship. To test our hypothesis, we used bootstrapped tests of indirect effects (Preacher & Hayes, 2008). The models used 5,000 bootstrapped resamples that generated 95% bias corrected and adjusted confidence intervals (Bca CI); CI's not including zero demonstrate a statistically significant indirect effect. These models included the *daily* (Times 2–5) measure of fat talk as a mediator between Time 1 body concerns and Time 6 mental health measures, thus retaining appropriate time-ordering for the mediated pathways. Results from our mediated models are shown in Figure 1. This hypothesis was fully

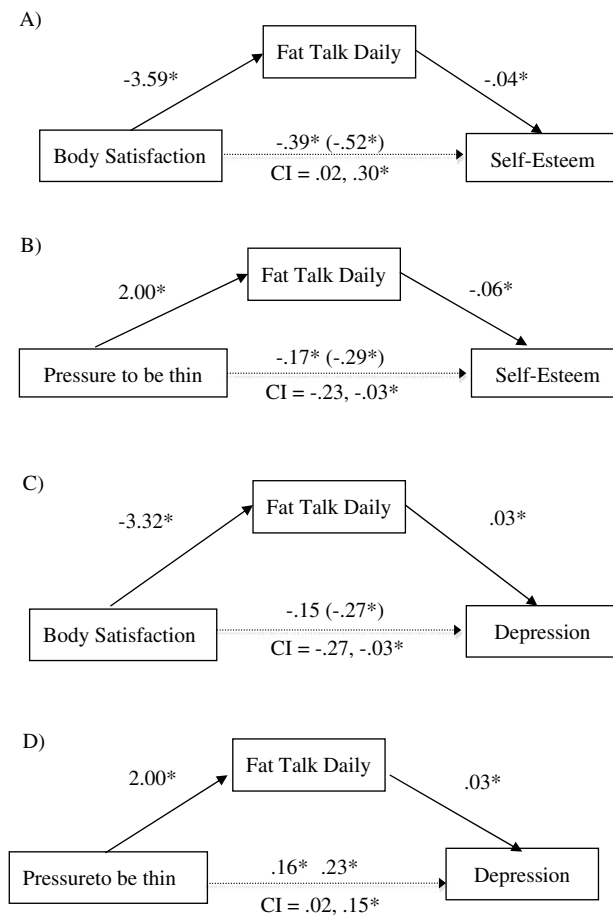


Figure 1. Mediating role of fat talk daily on the relationship between T1 body concerns and T6 mental-health issues (Study 1). Path coefficients are derived from Hayes' (2009) INDIRECT SPSS macro. A statistically significant confidence interval (CI) indicates that the indirect effect differs significantly from zero, and hence that there is statistically significant mediation. The value in the parentheses indicates the total effect of the independent variable on the dependent variable. Sex and BMI were included as control variables. * $p < .05$

supported. The findings support the idea that fat talk is a mechanism whereby negative weight-related cognitions are translated into broader and more chronic mental health concerns.

Results from Study 1 revealed that fat talk significantly predicted body satisfaction and depression, but fat talk was not an outcome of the mental health or body concern variables. These results show that what we say about ourselves influences our self-related cognitions: communication shapes our perceptions of self. We also found support for fat talk as a mechanism through which body weight concerns lead to mental health problems.

Study 2

A second study was performed with three goals: to replicate the effects of Study 1, to address limitations in the first study, and to extend our understanding of the interpersonal dynamics of fat talk. Because of the small sample size, Study 1's estimates are not as precise as with a larger sample and the study suffered from low power. Study 1 also suffered from some inconsistent measurement of constructs over time. The fact that the Study 1 did not support the prediction that body weight concerns and mental health problems predict fat talk might be because fat talk at Time 1 was measured on an interval scale and fat talk at Time 6 was a binary measure. Because Time 1 was used as a control and Time 6 had reduced variance due to our measurement choice, we had very little residual variance to explain in the Time 6 fat talk. Hence, Study 2 used a larger sample and consistent measurement over time.

Study 2 also sought to build on Study 1 by distinguishing between *saying* and *hearing* fat talk comments. The first study combined both in a single measure, and hence we do not know whether the effects observed are primarily a function of intrapersonal or interpersonal processes. Does articulating weight concerns affect one's own body image (and vice versa), or is it others' weight-related talk that is more important? Study 2 makes the same predictions as Study 1, such that fat talk is both the predictor of (H1) and outcome of (H2) body weight concerns and mental health problems, and does so with regard to self and others' fat talk. It is somewhat unlikely that one's own body weight concerns or mental health issues would *cause* fat talk by a partner. However, such effects are not unthinkable; for instance, depressed people might seek out conversational partners who are inclined towards such talk.

Method

Participants and Procedure

Participants ($N = 111$) were recruited from undergraduate communication classes at a large Southwestern university in exchange for extra credit in their class. Participants' ages ranged from 18 to 43 ($M = 21.31$, $SD = 3.55$) and 77% were female. The participants were 77% White, 14% Latino, 4% Native American, and 5% other responses. Across a two-week span, we administered two questionnaires by

Table 4 Zero-order correlations of Study 2 variables

	1	2	3	4	5	6	7	8	9	10	11	12	13
Time 1													
1. Saying fat talk													
2. Hearing fat talk	.59**												
3. Body satisfaction	-.53**	-.18											
4. Pressure to be thin	.47**	.34**	-.54**										
5. Self-esteem	-.28**	-.11	.55**	-.31									
6. Depression	.16	.10	-.20	.12	-.39**								
Time 2													
7. Saying fat talk	.71**	.49**	-.53**	.38**	-.30**	.15							
8. Hearing fat talk	.53**	.75**	-.20*	.33*	-.13	.08	.66**						
9. Body satisfaction	-.47**	-.13	-.86**	-.45**	-.63**	-.24*	-.57**						
10. Pressure to be thin	.51**	.36**	-.57**	.82**	-.34**	.10	.55**	.45**	-.55**				
11. Self-esteem	-.21**	-.11	.44**	-.26**	.76**	-.46**	-.31**	-.14	.55**	-.33**			
12. Depression	.25**	.12	-.36**	.20*	-.39**	.58**	.28**	.16	-.45**	.30**	-.49**		
Demographics													
13. BMI	.02	-.06	-.31**	.17	-.16	-.01	.05	-.01	-.25	.09	-.07	.04	
14. Sex	-.31**	-.24**	.27	-.42	.14	-.18	-.40**	-.29*	.27**	-.44**	.22*	-.15	.14

Note: Sex is coded as females = 1, males = 2. $N = 111$. ** $p < .01$, * $p < .05$.

emailing participants directions and a link to an online questionnaire. Participants created a codeword that was used to link their responses. At both time points respondents completed closed-ended scales to report their use of fat talk, body weight concerns, and mental health. At Time 1, participants also provided demographic information. The measures are described below (see Table 4 for correlation matrix of Study 2 variables).

Measures

Body weight concerns and mental health variables. Body satisfaction (Time 1: $M = 2.88$, $SD = 0.87$, $\alpha = .83$; Time 2: $M = 3.03$, $SD = 0.68$, $\alpha = .90$), perceived sociocultural pressure to be thin (Time 1: $M = 2.56$, $SD = .90$, $\alpha = .84$; Time 2: $M = 2.61$, $SD = 0.99$, $\alpha = .80$), depression (Time 1: $M = 1.86$, $SD = .52$, $\alpha = .69$; Time 2: $M = 1.90$, $SD = 0.57$, $\alpha = .74$), and self-esteem (Time 1: $M = 4.05$, $SD = .66$, $\alpha = .76$; Time 2: $M = 3.98$, $SD = 0.70$, $\alpha = .80$) were measured with the same scales used in Study 1.

Fat talk. As in Study 1, participants rated their frequency of fat talk, however only six items were used in Study 2. Only one item from each of the six types of fat talk (e.g., what one's eating and exercise habits should be, fears of becoming out of shape or overweight, etc.) was used because Study 1 did not reveal any differential effects of the various dimensions of fat talk (items used in Study 2 are marked in Table 1). These six items were completed twice at each time point – once for how frequently participants *say* fat talk comments in the past week (e.g., How often did you say anything like 'I'm so fat;' Time 1: $M = 2.38$, $SD = 1.09$, $\alpha = .78$; Time 2: $M = 2.27$, $SD = 1.06$, $\alpha = .84$) and once for how frequently participants *hear* fat talk comments in the past week (e.g., How often did you hear someone else say anything like 'I'm so fat;' Time 1: $M = 2.88$, $SD = 1.32$, $\alpha = .88$; Time 2: $M = 2.71$, $SD = .34$, $\alpha = .92$). Items were averaged, with higher scores denoting saying and hearing fat talk comments more frequently.

Results and Discussion

Study 2 used the same statistical methods as Study 1. Standard multiple regression analyses were used, where the predictor variables were from Time 1 and the outcome variables were from Time 2. All analyses controlled for Time 1 scores of the outcome variables in order to assess the effects of the predictor on change in the outcome variable. Sex and BMI ($M = 23.32$; $SD = 4.80$) were used as covariates in all analyses.

H1 posed fat talk as the outcome of body weight and mental health issues. As shown in Table 5, there was partial support for this hypothesis. Low body satisfaction significantly predicted *saying* more fat talk comments, and low self-esteem trended toward significantly predicting producing more fat talk. No variables predicted *hearing* fat talk comments. These results show that individuals' negative concerns for their bodies are communicatively manifested in the negative comments they make about their own bodies. These results emerge from separate regression analyses for

Table 5 Study 2: fat talk as a cause or outcome of body concerns and mental-health issues

	<i>B</i>	<i>SE B</i>	β	<i>sr</i> ²	<i>R</i> ²
H1: Fat talk as outcome (DV)					
Saying fat talk					
Body satisfaction	-.27	.10	-.22*	.03	.56
Pressure to be thin	.02	.10	.02	.00	.53
Self-esteem	-.19	.11	-.12#	.01	.54
Depression	.14	.14	.07	.00	.53
Hearing fat talk					
Body satisfaction	-.07	.11	-.05	.00	.58
Pressure to be thin	.07	.11	.05	.00	.58
Self-esteem	-.13	.13	-.06	.00	.59
Depression	.07	.17	.02	.00	.58
H2: Fat talk as predictor (IV)					
Saying fat talk					
Body satisfaction	-.01	.04	-.02	.00	.75
Pressure to be thin	.16	.06	.17**	.02	.72
Self-esteem	.02	.04	.03	.00	.59
Depression	.10	.04	.20*	.03	.38
Hearing fat talk					
Body satisfaction	.01	.03	.02	.00	.75
Pressure to be thin	.08	.04	.10#	.01	.70
Self-esteem	-.02	.03	-.04	.00	.59
Depression	.03	.04	.08	.01	.35

Note: All analyses control sex and BMI, as well as for the DV at Time 1 in order to assess change over time. *R*² values include variance accounted for by the Time 1 DV measure which is in all cases significant. Separate standard multiple regressions were run for each of the predictor variables. *N* = 111. ***p* < .01, **p* < .05, #*p* < .10.

each of the predictor variables. When all four of the predictors are entered simultaneously, body satisfaction emerges as the only significant predictor of saying fat talk ($\beta = -.21$, $p < .05$, $sr^2 = .02$); again, no variables predict hearing fat talk.

H2 posed fat talk as a predictor of body weight and mental health concerns. As shown in Table 5, there was partial support for this hypothesis. *Saying* fat talk comments significantly predicted higher levels of depression and more perceived pressure to be thin. *Hearing* fat talk comments trended toward significantly predicting perceived pressure to be thin, suggesting that being exposed to others' comments may perpetuate the ideal body image. Thus, verbally expressing discontent with one's own body has negative effects for one's own mental health and body image; results also suggest less conclusively that others' fat talk may perpetuate sociocultural pressure to be thin.

Study 2 revealed that people with lower body satisfaction make more negative comments about their weight, and, in turn, making more fat talk comments increases levels of depression and perceived sociocultural pressure to be thin. Verbalizing discontent with one's body and weight is a stronger predictor of negative body concerns and mental health problems than hearing fat talk comments, with the latter associated with only one marginally significant effect.

General Discussion

The goal of the current research was to explore the causes and consequences of engaging in fat talk, particularly in terms of body concern and mental health issues. Study 1 found that fat talk explains significant variance in body dissatisfaction and Study 2 finds that saying fat talk predicts perceived pressure to be thin. Both studies also show that fat talk significantly predicts changes in depression across time. Study 2 also shows that fat talk occurs as a result of negative body cognitions; people who are less satisfied with their bodies tend to engage in more fat talk conversations. Finally, Study 1 demonstrates that fat talk mediates the connection between negative body cognitions and mental health issues. Overall, our results demonstrate a variety of dynamic connections between fat talk, concerns about one's body, and negative mental health issues. What follows is a theoretical discussion of specific findings, practical applications, and some future directions.

Results from this study allow us to better understand the degree to which interpersonal and intrapersonal processes are connected in this context and more generally. Specifically, although fat talk is an interpersonal process, its negative effects appear stronger at the intra-individual level. Using a general measure of both saying and hearing fat talk, Study 1 found that none of the intrapersonal variables predicted fat talk. However, Study 2 used separate measures of saying and hearing fat talk and found that body satisfaction did predict *saying* fat talk (but not *hearing* those comments). These results demonstrate that one's own body weight concerns or mental health issues do not appear to *cause* a partner to engage in fat talk comments. More surprising, Study 2 also revealed that *saying* fat talk was associated with depression and perceived pressure to be thin, but *hearing* was not. This suggests that, in this context at least, peer communication is less influential in shaping one's mental state than one's own communication.

Broadly, these results suggest that expressing weight-related concerns matters: Above and beyond cognitive concerns and being involved in other people's conversations about the topic, *doing* fat talk has negative effects. These findings complement symbolic interactionist and social constructionist views of mental health (e.g., Goffman, 1963), but come closer to self-labeling perspectives (e.g., Moses, 2009). These perspectives suggest that labeling *self* as stigmatized constitutes a fundamentally different process from being so-labeled by others; in our case, the enactment of fat talk could be construed as a specific manifestation of the dynamics of this self-labeling process. Naturally, further work is required to distinguish more precisely the mechanisms whereby talking is more influential than hearing in this context. One potentially fruitful avenue would be examining the association between doing fat talk and internalization of fat-related identities, attitudes, and stigmas.

We must also highlight the importance of examining bidirectional links between fat talk and various outcomes, which is consistent with Slater's (2007) focus on reinforcing spirals in communication. There is a tendency in much of social science to understand causality as a unidirectional process, in part fed by the focus on experiments as the best tests of causality. However, Slater shows that many causal relationships are bidirectional

and mutually reinforcing. These mutually reinforcing spirals do not necessarily lead to an inevitable downward trajectory towards increasing depression and more fat talk. All of the effects explain only limited variance, and so other variables may reduce the volume of fat talk or improve mental health, thus reversing the spiral. Nonetheless, we have uncovered a subtle tendency towards mutually reinforcing negative cognitions and behaviors. More broadly, and again in line with Slater, different time lags might reveal different effect sizes and a predominance of effects in one direction or the other. Hence, we do not place a great premium on, for instance, the fact that we observed somewhat more *effects* of fat talk than *causes* of fat talk in our data. The opposite might be found with different time lags.

The mediating role of fat talk in Study 1 also bears on the issue of time lags and mutual causation. The fact that fat talk appears to mediate effects of body satisfaction on mental health, while not itself emerging as a significant effect of body satisfaction, suggests that the effects of body satisfaction on fat talk are more dynamic and short-term than the three week lag we investigated in Study 1 (and notably, effects of body satisfaction on fat talk did emerge in the slightly shorter second study). We understand this mediating role in the context of Beck's cognitive theory of depression. Fat talk manifests self-objectification and abjures personal control over weight issues (e.g., via a focus on "wishing" and "fearing," and a tendency towards expressions of regret and guilt). This kind of evaluation removes control from the self and emphasizes negative and distorted self-concepts, precisely the processes that lead to depressed affect in Beck's theoretical framework. In other words, we see fat talk as a concrete mechanism by which negative feelings in the specific domain of weight are amplified into broader negative feelings about the self.

We would also like to point out theoretical concerns and implications of the current research. Objectification theory posits that self-objectification is a result of society's objectification of women's (and, we would argue, men's) bodies. This has previously been examined in the area of mass media with less work exploring the interpersonal processes in reinforcing the ideal body image. Nonetheless, interpersonal messages reinforcing society's ideal body image are objectifying because they also suggest that people's bodies are objects that should be evaluated. Much of fat talk is explicitly evaluative and judgmental (e.g., "I'd really hate to get fat," "She looks terrible"). Hence, based on our communication perspective on self-objectification, we predicted and found support for the idea that fat talk both manifests and constructs the ideal body image. Our findings extend the objectification perspective into the area of interpersonal communication, suggesting that casual everyday conversation is an important part of the objectification process. Fat talk is one of the micro-level processes that sustain the broader societal discourse about weight.

Practical Application

Our contention is that fat talk has at least two substantially negative effects. First, it articulates an objectified and largely helpless vision of self as part of a stigmatized

group. Second, it escalates somewhat focused weight concerns into broader negative aspects of self-concept. Reducing the amount of fat talk will weaken those connections. Such reductions might be achieved via public health campaigns. For instance, Delta Delta Delta, an international collegiate women's fraternity, has launched an eating disorders prevention program (*Reflections: Body Image Program*). As part of this program, a weeklong event challenges women to be "fat talk free." Such programs reflect the intuition that fat talk has real and pernicious consequences over and above merely reflecting body dissatisfaction. Our study suggests that we should be encouraging such programs, and of course evaluating their effectiveness.

Other literatures discuss effectively and appropriately reducing problematic forms of talk (e.g., reducing patronizing talk in intergenerational settings: Hummert & Ryan, 2001). One useful direction for communication research on fat talk would be to consider *interpersonal* strategies for reducing its occurrence (e.g., changing the topic, directly confronting those engaging in it, humorous parody) and work in those other areas offers some clear paths for this work to follow.

Fat talk is diagnostic of both body image concerns and broader mental-health issues. While we would not suggest fat talk observation as a clinical tool, there are useful messages here for people in close relationships. Friends, family members, and romantic partners who engage in lots of this sort of talk may be struggling with more serious underlying issues, and our work does not suggest that fat talk is therapeutic or helpful in terms of those underlying issues. Therefore, those who interact with people who engage in such talk should seek out ways of confronting both the talk itself and possibly the deeper issues.

Finally, communication scholars are well positioned to consider whether positive forms of fat talk exist, and if so what they might look like. For instance, the theory of planned behavior (Ajzen, 1991) suggests that more empowered forms of fat talk might emphasize behavioral intentions ("I will . . .") and behavioral control ("I can . . ."). Our data demonstrate that *doing* fat talk (perhaps more so than hearing it) has consequences for self; hence we are encouraged to think that engaging in more empowered forms of fat talk might have positive consequences. Additional positive forms of fat talk deserving attention include the ways in which relational partners support each other to enact healthy behaviors, or provide positive feedback concerning weight-related achievements. Such health-related social support occurs in marriages (Homish & Leonard, 2008), and women report receiving encouragement to exercise, eat well, and watch their weight from friends (Gruber, 2008). Some of this encouragement might resemble more pernicious forms of fat talk, but support concerning attempts at healthy behavior clearly represents a counterpoint to the negatively-toned fat talk on which we have focused.

Limitations and Future Directions

Limitations to our study provide future directions. Longer-term longitudinal designs will assist efforts to capture the effects of engaging in fat talk over time (Slater, 2007).

Studies that examine *chronic* production of this talk over time (e.g., using diaries) will be able to uncover whether the short-term effects we documented here accumulate for some people and lead to very serious outcomes for a minority of habitual fat talkers. Additionally, other causes and consequences of fat talk should be explored in future studies (e.g., internalization of the thin ideal: Jacobi & Cash, 1994; weight discrepancy: Veale, Kinderman, Riley, & Lambrou, 2003).

As described above, we should explore and distinguish different types of fat talk, including more positive forms of this discourse (again, diary studies might be useful here). In particular, we emphasize uncovering more apparently positive forms of this talk and investigating their effects. Close application of uncertainty management perspectives might suggest that different types of fat talk serve different functions based upon the goals of interlocutors (Nichter, 2000). Expanding on the idea that there are moderators of fat talk effects, people who are committed to a healthy lifestyle and who have weight-related self-efficacy might be motivated by communication related to fat talk; those without such self-efficacy may be more likely to suffer the harmful consequences we have outlined in our data. These lead us to broader identity-related questions, and hence examinations of interconnections between individual cognitions about weight, and broader societal stereotypes and attitudes (Crandall et al., 2001; Harrison, 2000b).

Finally, we suggest that the study of fat talk offers a prime location in which to integrate studies of media processes (e.g., images of ideal bodies, weight-related advertising), and interpersonal processes (fat talk). Such work has potential for the entire field of communication in terms of integrating traditionally separate areas of interest. How does exposure to idealized media images and weight-themed television programming influence interpersonal conversation, and does such conversation mediate the effects of media on weight-related cognitions and attitudes?

Conclusion

Americans are inundated with media images of beautiful, successful, and thin women and men. Thinness is associated with attractiveness, creating a pressure to be thin and a desire to fit the ideal body image. Our results demonstrated that fat talk is a product of specific body-related dissatisfaction and more global mental health concerns, and is a mechanism whereby body dissatisfaction translates into broader mental health problems. At least in the short term, doing fat talk has consequences for critical mental health outcomes such as depression. By expressing dissatisfaction with one's own and criticizing others' weight, we are reinforcing the ideal body image. Further exploration of the causes and consequences of fat talk has the potential to lead to a healthier societal discourse about weight.

Note

- [1] Separate standard multiple regressions were run for each of the predictor variables. When all four of the variables were entered into one regression analysis, they were all nonsignificant

predictors. With such a small sample size, having seven predictor variables (the four independent variables, the variable controlling for the dependent variable at Time 1, sex, and BMI) both reduces our ability to detect effects and comes close to violating typical requirements for subjects–variables ratios in multiple regression (Cohen, 2008). Therefore, we run these as separate models.

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