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Original Research

Body size ideals and dissatisfaction in Ghanaian adolescents: role of media, lifestyle and well-being



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ARTICLE INFO

Article history:

Received 18 August 2016

Received in revised form

2 January 2017

Accepted 4 January 2017

Available online 7 February 2017

Keywords:

Body image

Dieting

Physical activity

Psychosocial quality-of-life

Media pressure

ABSTRACT

Objectives: To inspire effective health promotion campaigns, we tested the relationship of ideal body size and body size dissatisfaction with (1) the potential resulting health-influencing factors diet, physical activity and well-being; and (2) with media as a potential influencer of body ideals.

Study design: This is a cross-sectional study in 370 Ghanaian adolescents (aged 11–18 years). **Methods:** Questionnaires included disordered eating (EAT26), diet quality (FFQ), physical activity (IPAQ), well-being (KINDL) and media influence on appearance (SATAQ: pressure, internalisation and information). Ideal body size and body size dissatisfaction were assessed using the Stunkard figure rating scale. Body mass index (BMI), skinfolds and waist were measured. Linear regressions were adjusted for gender, age and parental education. Also, mediation was tested: ‘can perceived media influence play a role in the effects of actual body size on body size dissatisfaction?’.

Results: Body size dissatisfaction was associated with lower well-being and more media influence (pressure and internalisation) but not with physical activity, diet quality or disordered eating. An underweight body size ideal might worsen disordered eating but was not significantly related to the other predictors of interest. Only a partial mediation effect by media pressure was found: especially overweight adolescents felt media pressure, and this media pressure was associated with more body size dissatisfaction.

Conclusions: To prevent disordered eating and low well-being, health messages should include strategies that reduce body size dissatisfaction and increase body esteem by not focussing on the thin body ideal. Changing body size ideals in the media might be an appropriate way since media pressure was a mediator in the BMI-dissatisfaction relation.

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Introduction

Theories exist that perceived ideal body size and consequently body size dissatisfaction might influence lifestyle and well-being.¹ Herein, the question is whether they predict health-promoting (e.g. healthier diet and more physical

activity) or health-compromising (e.g. extreme dieting and lower self-esteem) behaviours. Thus, ideal body size and body size dissatisfaction are important aspects to consider in health messages.

A first set of correlates of ideal body size and body size dissatisfaction are lifestyle (dietary intake, eating behaviour

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<http://dx.doi.org/10.1016/j.puhe.2017.01.006>

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and physical activity) and well-being. People might strive for their ideal body size by dieting and increasing physical activity, but unrealistic ideal body size might induce maladaptive patterns like eating disorders.^{2–4} Contrary, discrepancy between ideal body size and current body size might stimulate dissatisfaction, negative emotions and low self-esteem,⁵ as has been shown in Western adolescents.^{2,6–11} This negative emotional state might then lead to a drop in motivation and self-efficacy to adopt healthy behaviours. Indeed, studies mostly found lower activity levels with body size dissatisfaction.^{3,4,12} Interestingly, ‘feeling fat’ might be more relevant than ‘being fat’.¹³ After all, this ideal body size induced unhealthy lifestyle and low well-being might stimulate overweight and related comorbidities.

Media might be another important correlate of ideal body size and body size dissatisfaction. After all, the tripartite influence model proposes that three primary sources of influence contribute to body image development: parents, peers and also the media.¹⁴ Herein, the media is the component on which policy has most control. Internalisation of the media-delivered very thin ideal body size can occur and people with a different body size might feel pressured to adapt the media-endorsed ideal body size.¹⁵ Consequently, the media might act as a mediator since body mass index (BMI)-associated media pressure might enhance body size dissatisfaction.^{16–19} Nevertheless, peers might sometimes be more influential than the media.²⁰ Due to urbanisation and internet access, Western influences have now become ubiquitous. Yet, these media influential effects on body image might of course differ depending on ethnicity, e.g., no experimental media influence on body image was found among African-American women.²¹

In some of the African regions, the traditional preference for large bodies is still likely to be present, but it may be diminished in the face of continuing globalisation with the introduction of Western ideals.²² Nevertheless, almost no research in this population exists on the health-promoting or -compromising effects of ideal body size and body size dissatisfaction. Especially adolescents might be vulnerable to body size dissatisfaction and media messages.

Therefore, our first study aim was to test whether ideal body size and body size dissatisfaction were associated with health-influencing (compromising or promoting) lifestyle factors (physical activity, dietary pattern, eating behaviour) and low well-being in Ghanaian urban adolescents and whether this was independent from actual BMI. The second study aim was to test the association of ideal body size and body size dissatisfaction with perceived media influence (internalisation, pressure and as information source) and specifically whether media plays a role in the effects of actual body size on body size dissatisfaction. Since the ideal body size might be shifted recently in this population, the two directions of dissatisfaction were tested separately i.e., ‘body too thin’ or ‘body too heavy’.

Methods

Study design

The study was conducted in the Greater Accra Metropolitan Area. Accra, the capital city of Ghana, is one of the most

populated African cities. Cross-sectionally data from adolescents (aged 11–18 years) without any diagnosed self-reported illness were sampled. Five secondary schools ($N \pm 500$ students) were selected randomly from a publically available list of all schools in the Accra Metropolitan area. In each school, half of the classes (spread over all years) were invited, of which a total of 370 adolescents accepted to participate, resulting in a participation ratio of 32.2%. Gender and age groups were equally represented. Data collection took place from July to August 2014 at the student's school. Anthropometric measurements were executed immediately after completing the questionnaire, not fixed to a certain time of the day. Questionnaires were self-administered, but the researcher was present for assistance. The questionnaires were pretested to ensure clarity ($N = 10$; no adjustments necessary). Based on the ‘2010 Population and Housing Census’,²³ the three most prevalent ethnicities in the Accra Metropolitan area are 39.7% Akan, 27.4% Ga-Dangme, 20.1% Ewe, which is a very similar distribution to our sample. Nevertheless, our sample has a higher parental educational level.

All procedures were in accordance with the 1964 Helsinki declaration and its later amendments. A written informed consent was obtained from the parents and a verbal assent was received from the students and schools. Approval was obtained from the Ethical clearance committee of the Ghent University Hospital and the Noguchi Memorial Institute of Medical Research.

Ideal body size and body size dissatisfaction

The person's own ideal body size and his/her current body size were requested via the Stunkard figure rating scale.²⁴ This is a rating scale made up of nine silhouettes for both males and females. These were classified as underweight (figures 1–2), normal weight (figures 3–4) and overweight/obese (figures 5–9). The scale has been shown to achieve comparable results as culturally adapted scales,²⁵ and 85.7% of women with obesity (from the same city as the present study) can be correctly identified as obese by using their responses to this scale.²⁶

Following the self-discrepancy theory, body image focuses on the discrepancy between how one sees one's self (current/own) and how one would ideally like to be (ideal/own).¹ Body size dissatisfaction was therefore calculated as the difference or discrepancy between the chosen silhouette for current body size and ideal body size. Apart from using the absolute continuous score, this dissatisfaction was also categorised as follows: (a) ‘body size self-reported as too thin’ when ideal body size was bigger than the self-reported size; (b) ‘body size self-reported as satisfactory’ when self-reported size and ideal body size were the same; and (c) ‘body size self-reported as too heavy’ when the ideal body size was smaller than the self-reported size. Body size dissatisfaction was also directly inquired by the question ‘I am satisfied with my body size’ with a 3-level scale (agree-neutral-disagree).

Health-compromising or health-promoting behaviours

Physical activity

Physical activity was assessed using the International Physical Activity Questionnaire (IPAQ).²⁷ The responses from the IPAQ

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