2007 Quad Cities Eating Disorders Survey

800 Interviews with Residents of the Quad Cities Area
Conducted April 24 – 26, 2007

Sponsored by the
Amy Helpenstell Foundation

Survey Conducted & Designed by
McKeon & Associates, Chicago, Illinois

Survey Questions Developed by

Dr. Derek Ball, Marriage and Family Counseling Service
Dr. David Deopere, Robert Young Center
Mr. Dennis Duke, Robert Young Center
Mr. Michael Freda, Robert Young Center
Mr. Bud Helpenstell, Amy Helpenstell Foundation
Dr. William Hiebert, Marriage and Family Counseling Service
Mr. Jim Horstmann, Community Foundation of the Great River Bend
Mr. Randy Jacobs, Charleston / Orwig
Ms. Betsy Zmuda-Swanson, Private Therapist; Marriage and Family Counseling Service
Mr. Joe Vermiere, Rock Island County Regional Office of Education

Draft of Results Analyzed & Written by
David L. Deopere, Ph.D., Robert Young Center

The Amy Helpenstell Foundation is dedicated to improving the quality of life in the Quad-City area by funding educational programs, youth development activities, community development, and cultural activities.

In the Fall of 2006, The Amy Helpenstell Foundation became a stimulus to gather a variety of local professionals to study the issue of Eating Disorders in the greater Quad-Cities area.

A planning group was comprised and included the following members:

- Dr. Derek Ball, Marriage and Family Counseling Service
- Dr. David Deopere, Robert Young Center
- Mr. Dennis Duke, Robert Young Center
- Mr. Michael Freda, Robert Young Center
- Mr. Bud Helpenstell, Amy Helpenstell Foundation
- Dr. William Hiebert, Marriage and Family Counseling Service
- Mr. Jim Horstmann, Community Foundation of the Great River Bend
- Mr. Randy Jacobs, Charleston / Orwig
- Mr. Joe Vermiere, Rock Island County Regional Office of Education
- Ms. Betsy Zmuda-Swanson, Private Therapist; Marriage and Family Counseling Service

As a first step, it was decided to determine community need for a formal eating disorder program. An initial decision was to decide from whose perspective should research gauge community need – the community itself or potential program recipients and key referral agents. The methodology used to survey each of these groups is very different, and the information gained from interviewing each of these groups would be different.

It was determined to survey the general community about its understanding of eating disorders and the need for an eating disorder program. After submitting "Requests for Proposal" to several professional surveying prospects, McKeon & Associates from Chicago, Illinois was selected to engage in the following:

1. Design a questionnaire to determine: the area's understanding of eating disorders how widespread of a problem they believe it to be, availability of treatment and quality care for eating disorder problems in the area and other questions you or your staff would recommend. Determine demographics for study; age, income, education, etc. Final questionnaire for the survey will be subject to approval of you and your staff.

2. Design research model by breaking region into geographic areas to prioritize local needs. Example: Area 1 Quad-Cities, Area 2 Geneseo, Kewanee and Coal Valley in Henry County.

3. Conduct telephone survey with residents of region described in RFP using approved questionnaire and research model. An 800-subject interview sample is recommended for reliable accuracy in survey sub-groupings and regions. The calling will be done by a telephone research firm that conducts research for many of the largest marketing firms and major news organizations.

Various psychosocial categories typically correlated with Eating Disorders were identified by Ms. Betsy Zmuda-Swanson and Dr. David Deopere and edited by the full Committee and Mr. McKeon (Appendix A). The selected areas of study were then configured into final survey format by Mr. McKeon (Appendix B). The survey was conducted from April 24-26, 2007. Mr. McKeon presented a two page summary of the results along with 162 pages of cross-tabbed data and the draft results were analyzed, placed into tables and written by Dr. David Deopere.

Results

The sample for the Eating Disorders Survey included 800 persons who agreed to participate in a telephone interview about the topic. The subjects were surveyed during the last week of April 2007. The sample was stratified by population proportion in Scott, Rock Island and selected western portions of Henry County. The specific distribution of the sample by county of residence which can be seen in Table 1 was comprised of 51.5% female and 48.5% male. Approximately 44% of the sample was from Scott County, 41.3% from Rock Island County and 15% from Henry County. Data to compare the sample to the most recent Census Data has not been retrieved at this time.

The distribution of the sample by age, which can be seen in Table 1, was comprised of 11% from the age grouping of 18-30, 29% from the age grouping of 31-45, 33% from the age grouping of 46-60, 24% from the age grouping of 46-60 while 3% of the sample refused to disclose age. Table 2 shows that nearly half (47%) of those over 61 considered Eating Disorders to be more of a physical problem rather than a mental problem. In the other age groupings, nearly one-third of those in the 31-45 and 46-60 age groupings viewed the disorder as being about equally caused by physical and mental issues.

The distribution of the sample by race, which can be seen in Table 1, was skewed toward Caucasian with 88% of the sample followed by African American which totaled 5% and Hispanic which comprised 3% of the sample. Approximately 4% refused to disclose race.

The distribution of the sample by income, which can be seen in Table 1, included 1% reporting income below $10,000, 14% stated income between $10,000 and $25,000, 33% cited income from $25,000 to $50,000, nearly one quarter between $50,000 and $75,000 while 11% reported income above $75,000. Just under one-fifth (18%) refused to disclose income level.

Table 1. Selected demographic characteristics of the sample

Demographic Characteristic	Number	Percent
Sex (n = 800)		
Male	388	48.5%
Female	412	51.5%
County of Residence (n=800)		
Scott	350	43.8%
Rock Island	330	41.3%
Henry	120	15.0%
Age Groupings (n=800)		
18-30	86	11%
31-45	231	29%
46-60	263	33%
> 61	196	24%
Refused	24	3%
Race (n=800)		
Caucasian	706	88%
African American	42	5%
Hispanic	27	3%
Other	25	3%
Family Income (n=800)		
0 to $10,000	11	1%
$ 10,000 to $ 25,000	115	14%
$ 25,000 to $ 50,000	267	33%
$ 50,000 to $ 75,000	181	23%
> $ 75,000	88	11%
Refused	138	17%

The first three questions of the survey were open-ended with respondents being asked to name the most common forms, causes and symptoms of eating disorders,

Table 2. Subject perception of most common forms of eating disorder

Most Common Form of Eating Disorder *	Number	Percentage
Anorexia	500	62%
Bulimia	391	49%
Obesity	124	16%
Over-Eating	117	15%
Binge Eating	32	4%
Don't Know	28	4%

* Subjects were not limited to the number of disorders they could name which explains why percentages do not add up to 100%

Nearly two-thirds of the sample (62%) named Anorexia as the most prevalent form of an eating disorder while nearly half of the sample (49%) named Bulimia. Another 4% viewed binge eating as an eating disorder.

The data seems to suggest the general population has a basic awareness of the classic eating disorders vocabulary. Obesity was listed by 16% of the sample as an eating disorder. Other responses included over-eating (15%), compulsive eating disorder (1%), followed by a few responses that totaled less than 1%.

Table 3 shows significantly more women (69%) named Anorexia as an eating disorder than men (56%). The proportion of men and women naming Bulimia was more evenly split with 51% of the women citing Bulimia and 46% of the men. Slightly more men reported obesity as an eating disorder (18%) than women (13%).

Table 4 shows there is a significant difference (.05) between subjects under 61 and over 61 in naming anorexia and bulimia as eating disorders. This would suggest an inverse relationship between age and mentioning anorexia and bulimia as frequently named eating disorders. Table 4 shows that nearly three-fourths (72%) of the 18-30 year olds mentioned anorexia and 60% of them named bulimia as a common form of eating disorder. Just over two-thirds (67%) of those in the 30-60 age range cited anorexia and just over half (51%) stated bulimia as a disorder. Of the respondents over 61, only 47% named anorexia and 37% mentioned bulimia. In addition, just under a quarter (21%) of those over 61 stated a belief that over-eating was a disorder which is significantly different from the other age groups.

Table 3. Subject perception of most common forms of eating disorder by gender

Most Common Forms of Eating Disorder	Number	Percentage
Anorexia		
Women	283	69% *
Men	217	56%
Bulimia		
Women	211	51%
Men	180	46%
Obesity		
Women	54	13%
Men	70	18%
Over-Eating		
Women	61	15%
Men	56	14%

* Statistically significant at .05 Level

Table 4. Subject perception of most common forms of eating disorder by age group

Most Common Forms of Eating Disorder	Number	Percentage
Anorexia		
18-30 (n=86)	62	72%
31-45 (n=231)	154	67%
46-60 (n=263)	175	67%
> 61 (n=196)	92	47% *
Bulimia		
18-30 (n=86)	52	60%
31-45 (n=231)	119	52%
46-60 (n=263)	134	51%
> 61 (n=196)	72	37% *
Obesity		
18-30 (n=86)	14	16%
31-45 (n=231)	39	17%
46-60 (n=263)	40	15%
> 61 (n=196)	25	13%
Over-Eating		
18-30 (n=86)	5	6%
31-45 (n=231)	29	13%
46-60 (n=263)	38	14%
> 61 (n=196)	41	21% **

* Statistically significant at .05 Level from all other groups
** Statistically significant from 18-30 and 31-45 age groups

Table 5 shows there were no significant differences among race in naming anorexia as an eating disorder with 63% of Caucasians, 52% of Hispanics and 57% of African Americans naming the disorder. However, there was a significant difference (.05) between African Americans and Caucasians in their perceptions of bulimia and over-eating as an eating disorder. While 50% of Caucasians cited bulimia, only 31% of African Americans did so. By contrast, nearly a third (29%) of African Americans named over-eating as a disorder compared to only 15% of Caucasians (.05).

Table 5. Subject perception of most common forms of eating disorder by race

Most Common Forms of Eating Disorder	Number	Percentage
Anorexia		
Caucasian (n = 706)	444	63%
African American (n = 42)	24	57%
Hispanic (n = 27)	14	52%
Bulimia		
Caucasian (n = 706)	355	50% *
African American (n = 42)	13	31%
Hispanic (n = 27)	10	37%
Obesity		
Caucasian (n = 706)	104	15%
African American (n = 42)	12	29% **
Hispanic (n = 27)	2	7%
Over-Eating		
Caucasian (n = 706)	105	15%
African American (n = 42)	3	7%
Hispanic (n = 27)	6	22%

* Statistically significant at .05 Level from African American group
** Statistically significant at .05 Level from Hispanic group

Table 6 shows that anorexia was named by nearly two-thirds of the sample across all income levels; however, there some level of difference reported in perception of bulimia as a disorder. For example, while 62% of those making over $75,000 named bulimia, significantly fewer (36%) of those in the $10,000 - $25,000 range, 48% of those in the $25,000 to $ 50,000 range and 49% of those in the $50,000 to $75,000 range said bulimia was an eating disorder.

Table 6. Subject perception of most common forms of eating disorder by income level

Most Common Forms of Eating Disorder	Number	Percentage
Anorexia		
0 to $10,000 (n = 11)	5	45%
$ 10,000 to $ 25,000 (n = 115)	74	64%
$ 25,000 to $ 50,000 (n = 267)	163	61%
$ 50,000 to $ 75,000 (n = 181)	114	63%
> $ 75,000 (n = 88)	61	69%
Bulimia		
0 to $10,000 (n = 11)	6	55%
$ 10,000 to $ 25,000 (n = 115)	41	36%
$ 25,000 to $ 50,000 (n = 267)	129	48% *
$ 50,000 to $ 75,000 (n = 181)	89	49% *
> $ 75,000 (n = 88)	55	62% **
Obesity		
0 to $10,000	1	9%
$ 10,000 to $ 25,000	19	17%
$ 25,000 to $ 50,000	41	15%
$ 50,000 to $ 75,000	33	18%
> $ 75,000	13	15%
Over-Eating		
0 to $10,000	0	0%
$ 10,000 to $ 25,000	12	10%
$ 25,000 to $ 50,000	42	16%
$ 50,000 to $ 75,000	30	17%
> $ 75,000	10	11%

* Statistically significant at .05 Level from $10,000 - $25,000 group
** Statistically significant at .05 Level $10, 000 - $25,000, $25,000- $50,000 & $50,000 - $75,000 groups

Table 7 shows that significantly more Henry County residents (.05) named both anorexia and bulimia as common eating disorders than those residents in Rock Island or Scott County. Nearly three-quarters of Henry County residents named anorexia and 61% cited bulimia as an eating disorder. By comparison, approximately 60% of Scott County and Rock Island County residents named anorexia. Fewer than half of Scott County (47%) and Rock Island County (46 %) residents named bulimia as a disorder. It would be interesting, if possible, to further analyze the Henry County data by specific community. For example, it would fascinating to isolate the Geneseo data because that city is sometimes viewed as a more progressive community.

Table 7. Subject perception of most common forms of eating disorder by county of residence

Most Common Forms of Eating Disorder	Number	Percentage
Anorexia		
Scott (n = 350)	219	63 %
Rock Island (n = 330)	195	59 %
Henry (n = 120)	86	72 % *
Bulimia		
Scott	166	47 %
Rock Island	152	46 %
Henry	73	61 % **
Obesity		
Scott	55	16 %
Rock Island	51	15 %
Henry	18	15 %
Over-Eating		
Scott	58	17 %
Rock Island	47	14 %
Henry	12	10 %

* Statistically significant at .05 Level from Rock Island County
** Statistically significant at .05 Level from Rock Island and Scott County

Table 8 lists the rank order of what the subjects viewed as the causes of eating disorder. Nearly one of every five respondents (19%) view self-esteem as the leading cause followed by emotional or mental problems (14%) and the self-perception of being too fat (14%). Depression (11%), stress (10%) and peer pressure (10%) were frequently named as well. In terms of comparing the causative data by gender, Table 9 shows the only significant difference being that significantly more men (9%) than women (4%) viewed overeating as a cause of eating disorder (.05).

Table 8. Subject perception of most common causes of eating disorder

Causes of Eating Disorder	Number	Percentage
Self – Esteem Issues	150	19 %
Emotional / Mental Problems	116	14 %
Self-Perception of Being Too Fat	111	14 %
Depression	91	11 %
Stress	83	10 %
Peer Pressure	76	10 %
Over Eating	51	6 %
Society	23	3 %
Celebrity Comparison	22	3 %
Unbalanced Diet	19	2 %
Media	17	2 %
Health Problems	14	2 %
Lack of Exercise	14	2 %
Boredom	13	2 %
Lifestyle	12	2 %
Anxiety	11	1 %
Not Eating	10	1 %
Food Addiction	7	1 %
Family Issues	6	1 %
Lack of Self-Control	6	1 %
Abuse	5	1 %

Table 9. Subject perception of most common causes of eating disorder by gender

Perceived Cause of Eating Disorder.	Number	Percentage
Self - Esteem		
Women (n = 412)	87	21 %
Men (n = 388)	63	16 %
Emotional / Mental Problems		
Women (n = 412)	62	15 %
Men (n = 388)	54	14 %
Self-Perception of Being Too Fat		
Women (n = 412)	61	15 %
Men (n = 388)	50	13 %
Depression		
Women (n = 412)	51	12 %
Men (n = 388)	40	10 %
Stress		
Women (n = 412)	32	8 %
Men (n = 388)	51	13 %
Peer Pressure		
Women (n = 412)	43	10 %
Men (n = 388)	33	9 %
Over - Eating		
Women (n = 412)	18	4 %
Men (n = 388)	33	9 % *

* Statistically significant at .05 Level

Table 10 shows that the younger age groups reported self-esteem as a cause more often than those over 61 years old. For example, more than a quarter (27%) of those in the 18-30 age group stated self-esteem as a cause whereas only 12 % of those over 61 years of age listed self-esteem. The self-perception of being too fat was the most frequent cause stated by those over 61 (17%) and significantly different from the 31-45 age group. The 18-30 age group matched the over 61 age group that self perception of being too fat is a cause of eating disorder.

Table 10. Proportion of subject perception of most common causes of eating disorder by age group

Perceived Cause of Eating Disorder.	Number	Percentage
Self – Esteem		
18-30 (n=86)	23	27 %
31-45 (n=231)	48	21 %
46-60 (n=263)	49	19 %
> 61 (n=196)	24	12 % *
Emotional / Mental Problems		
18-30 (n=86)	8	9 %
31-45 (n=231)	35	15 %
46-60 (n=263)	42	16 %
> 61 (n=196)	27	14 %
Self-Perception of Being Too Fat		
18-30 (n=86)	15	17 %
31-45 (n=231)	24	10 %
46-60 (n=263)	33	13 %
> 61 (n=196)	34	17 % **
Depression		
18-30 (n=86)	9	10 %
31-45 (n=231)	32	14 %
46-60 (n=263)	31	12 %
> 61 (n=196)	17	9 %
Stress		
18-30 (n=86)	6	7 %
31-45 (n=231)	33	14 % ***
46-60 (n=263)	19	7 %
> 61 (n=196)	22	11 %
Peer Pressure		
18-30 (n=86)	11	13 %
31-45 (n=231)	26	11 %
46-60 (n=263)	24	9 %
> 61 (n=196)	13	7 %
Over - Eating		
18-30 (n=86)	4	5 %
31-45 (n=231)	14	6 %
46-60 (n=263)	16	6 %
> 61 (n=196)	14	7 %

* Statistically significant from 18-30 and 31-45 age groups
** Statistically significant from 31-45 age group
*** Statistically significant from 18 – 30 and 46 – 60 age groups

In terms of racial differences, Table 11 shows that more than twice the proportion (.05) of Caucasians (20%) than African Americans (10%) cited self-esteem as a cause. While only 11% of Hispanics listed self-esteem, it was not statistically significant from the Caucasian group. A significantly higher proportion of the Hispanic (30%) and Caucasian (15 %) groups listed emotional / mental problems as a cause compared to only 5% of the African Americans (.05). By far, the most frequent cause of eating disorders listed by the African American group was depression (24 %) which was significantly different from the Hispanic (4 %) response (.05).

Table 11. Proportion of subject perception of most common causes of eating disorder by race

Perceived Cause of Eating Disorder.	Number	Percentage
Self - Esteem		
Caucasian (n = 706)	138	20 %
African American (n = 42)	4	10 %
Hispanic (n = 27)	3	11 %
Emotional / Mental Problems		
Caucasian	105	15 % *
African American	2	5 %
Hispanic	8	30 % *
Think They are Too Fat		
Caucasian	97	14 % *
African American	2	5 %
Hispanic	5	19 %
Depression		
Caucasian	78	11 %
African American	10	24 % **
Hispanic	1	4 %
Stress		
Caucasian	75	11 %
African American	6	14 %
Hispanic	0	0 %
Peer Pressure		
Caucasian	67	9 %
African American	4	10 %
Hispanic	2	7 %

* Statistically significant at .05 Level from African American group
** Statistically significant at .05 Level from Hispanic group

Table 12. Subject perception of most common causes of eating disorder by income level

Most Common Cause of Eating Disorder	Number	Percentage
Self - Esteem		
0 to $10,000 (n = 11)	2	18 %
$ 10,000 to $ 25,000 (n = 115)	17	15 %
$ 25,000 to $ 50,000 (n = 267)	59	22 %
$ 50,000 to $ 75,000 (n = 181)	27	15 %
> $ 75,000 (n = 88)	17	19 %
Emotional / Mental Problems		
0 to $10,000	3	27 %
$ 10,000 to $ 25,000	15	13 %
$ 25,000 to $ 50,000	32	12 %
$ 50,000 to $ 75,000	35	19 % *
> $ 75,000	16	18 %
Think They Are Too Fat		
0 to $10,000	0	0 %
$ 10,000 to $ 25,000	27	23 % **
$ 25,000 to $ 50,000	41	15 % ***
$ 50,000 to $ 75,000	19	10 %
> $ 75,000	5	6 %
Depression		
0 to $10,000	3	27 %
$ 10,000 to $ 25,000	16	14 %
$ 25,000 to $ 50,000	38	14 % ***
$ 50,000 to $ 75,000	20	11 %
> $ 75,000	6	7 %
Stress		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	7	6 %
$ 25,000 to $ 50,000	29	11 %
$ 50,000 to $ 75,000	20	11 %
> $ 75,000	6	7 %
Peer Pressure		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	11	10 %
$ 25,000 to $ 50,000	27	10 %
$ 50,000 to $ 75,000	21	12 %
> $ 75,000	5	6 %
Over Eating		
0 to $10,000	0	0 %
$ 10,000 to $ 25,000	11	10 %
$ 25,000 to $ 50,000	12	4 %
$ 50,000 to $ 75,000	14	8 %
> $ 75,000	8	9 %

* Statistically significant at .05 Level from $ 25,000 - $ 50,000 group
** Statistically significant at .05 Level from the $50,000 - $75,000 and > $ 75,000 groups
*** Statistically significant at .05 Level from the > $ 75,000 group

Table 12 shows how subjects from various income levels viewed causes of eating disorder. Although differences are revealed between a few of the groups, there are no apparent trends to be seen in the data. Table 13 shows that more of the Henry County (25%) and Scott County (21%) residents viewed self-esteem as a cause than those residing in Rock Island County (15%); and, more of the Scott County (18%) than Rock Island County residents (10%) viewed emotional / mental problems as a cause. Significantly more (.05) Rock Island County residents (14%) viewed stress as a cause than those residing in Henry (8%) or Scott Counties (8%).

Table 13. Subject perception of most common causes of eating disorder by county of residence

Most Common Causes of Eating Disorders	Number	Percentage
Self - Esteem		
Scott (n = 350)	72	21 % *
Rock Island (n = 330)	48	15 %
Henry (n = 120)	30	25 % *
Emotional / Mental Problems		
Scott	64	18 % *
Rock Island	34	10 %
Henry	18	15 %
Think They Are Too Fat		
Scott	51	15%
Rock Island	44	13 %
Henry	16	13 %
Depression		
Scott	42	12 %
Rock Island	37	11 %
Henry	12	10 %
Stress		
Scott	28	8 %
Rock Island	45	14 % **
Henry	10	8 %
Peer Pressure		
Scott	38	11 %
Rock Island	22	7 %
Henry	16	13 % *
Over-Eating		
Scott	16	5 %
Rock Island	31	9 % ***
Henry	4	3 %

* Statistically significant at .05 Level from Rock Island County
** Statistically significant at .05 Level from Scott County
*** Statistically significant at .05 Level from Scott & Henry Counties

Table 14 illustrates subject perception of the most common symptoms they associate with eating disorder. Loss of weight, skipping meals and vomiting / purging ranked as the top three symptoms listed. More women (25%) than men (18%) viewed loss of weight as the most common symptom they associate with eating disorder. No trends were noted when comparing eating disorder symptoms across various age ranges (Table 15) although there were slightly more in the 45-60 age range, when compared to all subjects under 45, who viewed loss of weight as the most prevalent symptom. More men (12%) than women (8%) viewed being overweight as a symptom (.05). Significantly more subjects over the age of 61 viewed being overweight as a symptom when compared to all subjects under the age of 45.

Table 14. Subject perception of most common symptoms of eating disorder by gender

Symptoms of Eating Disorder.	Number	Percentage
Loss of Weight / Very Thin		
Women (n = 412)	103	25 % *
Men (n = 388)	68	18 %
Skipping Meals / Not Eating		
Women (n = 412)	90	22 %
Men (n = 388)	68	18 %
Vomiting / Purging		
Women (n = 412)	73	18 %
Men (n = 388)	67	17 %
Overindulgence / Binging		
Women (n = 412)	52	13 %
Men (n = 388)	58	15 %
Overweight		
Women (n = 412)	31	8 %
Men (n = 388)	47	12 % *
Depression		
Women (n = 412)	32	8 %
Men (n = 388)	24	6 %

* Statistically significant at .05 Level

Table 15. Subject perception of most common symptoms of eating disorder by age group

Symptoms of Eating Disorder.	Number	Percentage
Loss of Weight / Very Thin		
18-30 (n=86)	16	19 %
31-45 (n=231)	38	16 %
46-60 (n=263)	65	25 % *
> 61 (n=196)	43	22 %
Skipping Meals / Not Eating		
18-30 (n=86)	18	21 %
31-45 (n=231)	42	18 %
46-60 (n=263)	54	21 %
> 61 (n=196)	39	20 %
Vomiting / Purging		
18-30 (n=86)	11	13 %
31-45 (n=231)	38	16 %
46-60 (n=263)	48	18 %
> 61 (n=196)	38	19 %
Overindulgence / Binge Eating		
18-30 (n=86)	8	9 %
31-45 (n=231)	36	16 %
46-60 (n=263)	34	13 %
> 61 (n=196)	26	13 %
Overweight		
18-30 (n=86)	5	6 %
31-45 (n=231)	16	7 %
46-60 (n=263)	25	10%
> 61 (n=196)	26	13 % *
Depression		
18-30 (n=86)	7	8 %
31-45 (n=231)	22	10 % **
46-60 (n=263)	19	7 %
> 61 (n=196)	8	4 %

* Statistically significant from 18-30 and 31-45 age groups
** Statistically significant from > 61 age group

Table 16 shows that African Americans viewed depression (21%) as the most prevalent symptom of eating disorder while only 6% of Caucasians agreed (.05). Hispanics viewed skipping of meals and not eating (26%) as most prevalent compared to only 7% of African Americans (.05). The responses of Caucasians were more evenly split among loss of weight (22%), skipping meals / being very thin (20%) and vomiting / purging (18%). Table 17 shows little relationship or significance comparing perceived symptoms of eating disorders to income levels. Table 18 shows that more residents from Henry County (.05) view skipping meals / being thin and overindulgence / binge eating as a symptom of eating disorders than residents from Scott and Rock Island Counties. Significantly fewer Rock

Island County residents (12%) view vomiting / purging as a symptom of eating disorder compared to Henry County (24%) and Scott County (20%).

Table 16. Subject perception of most common symptoms of eating disorder by race

Symptoms of Eating Disorder.	Number	Percentage
Loss of Weight / Very Thin		
Caucasian (n = 706)	152	22 %
African American (n = 42)	8	19 %
Hispanic (n = 27)	5	19 %
Skipping Meals / Not Eating		
Caucasian (n = 706)	143	20% *
African American (n = 42)	7	7 %
Hispanic (n = 27)	7	26 % *
Vomiting / Purging		
Caucasian (n = 706)	126	18 %
African American (n = 42)	5	12 %
Hispanic (n = 27)	3	11 %
Overindulgence / Binge Eating		
Caucasian (n = 706)	100	14 %
African American (n = 42)	4	10 %
Hispanic (n = 27)	0	0 %
Overweight		
Caucasian (n = 706)	67	9 % *
African American (n = 42)	1	2 %
Hispanic (n = 27)	3	11 %
Depression		
Caucasian (n = 706)	42	6 %
African American (n = 42)	9	21 % **
Hispanic (n = 27)	5	19 %

* Statistically significant at .05 Level from African American group
** Statistically significant at .05 Level from Caucasian group

Table 17. Subject perception of most common symptoms of eating disorder by income level

Symptoms of Eating Disorder	Number	Percentage
Loss of Weight / Very Thin		
0 to $10,000 (n = 11)	2	18 %
$ 10,000 to $ 25,000 (n = 115)	25	22 %
$ 25,000 to $ 50,000 (n = 267)	49	18 %
$ 50,000 to $ 75,000 (n = 181)	34	19 %
> $ 75,000 (n = 88)	21	24 %
Skipping Meals / Not Eating		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	25	22 %
$ 25,000 to $ 50,000	61	23 % *
$ 50,000 to $ 75,000	30	17 %
> $ 75,000 (n = 88)	12	14 %
Vomiting / Purging		
0 to $10,000	0	0 %
$ 10,000 to $ 25,000	26	23 %
$ 25,000 to $ 50,000	46	17 %
$ 50,000 to $ 75,000	25	14 %
> $ 75,000	15	17 %
Overindulgence / Binge Eating		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	14	12 %
$ 25,000 to $ 50,000	34	13 %
$ 50,000 to $ 75,000	28	15 %
> $ 75,000	8	9 %
Overweight		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	7	13 % **
$ 25,000 to $ 50,000	29	6 %
$ 50,000 to $ 75,000	20	13 % **
> $ 75,000	6	12 %
Depression		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	6	5 %
$ 25,000 to $ 50,000	25	9 %
$ 50,000 to $ 75,000	13	7 %
> $ 75,000	4	5 %

* Statistically significant at .05 Level from > $ 75,000 group

** Statistically significant at .05 Level from the $25,000 - $ 50,000 group

Table 18. Subject perception of most common symptoms of eating disorder by county of residence

Symptoms of Eating Disorders	Number	Percentage
Loss of Weight / Very Thin		
Scott (n = 350)	68	19 %
Rock Island (n = 330)	71	22 %
Henry (n = 120)	32	27 %
Skipping Meals / Not Eating		
Scott	65	19 %
Rock Island	59	18 %
Henry	34	28 % *
Vomiting / Purging		
Scott	70	20 % **
Rock Island	41	12 %
Henry	29	24 % **
Overindulgence / Binge Eating		
Scott	49	14 %
Rock Island	37	11 %
Henry	24	20 % **
Overweight		
Scott	38	11 %
Rock Island	24	7 %
Henry	16	13 %
Depression		
Scott	23	7 %
Rock Island	33	10 %
Henry	0	0 %

* Statistically significant at .05 Level from Rock Island & Scott Counties
** Statistically significant at .05 Level from Rock Island County
*** Statistically significant at .05 Level from Scott & Henry Counties

Table 19 shows that most subjects view eating disorders to be the result of mental problems (60%) rather than physical problems (4%). Just under a third of the respondents believe the causes of eating disorders are about equally split between physical and mental problems. When viewed from a county of residence perspective, nearly two thirds of the residents from Scott (64%) and Henry Counties (64%) viewed mental problems to be a causation of eating disorder compared to only 54% of the residents in Rock Island County. More Rock Island county residents viewed the cause of eating disorder to be equally split between mental and physical problems (38%).

Table 21 shows in general that more persons in the higher income ranges viewed eating disorder to be more of an equal split between mental and physical causes whereas the lower income groups viewed the disorder to be more directly related to mental problems.

Table 19. Comparison of subject beliefs that Eating Disorders are the result of physical or mental problems

General Cause of Eating Disorders (N = 800)	Number	Percentage
Physical	34	4 %
Mental	481	60 %
About Equal	258	32 %
Don't Know	27	3 %

Table 20. Comparison of subject beliefs that Eating Disorders are the result of physical or mental problems by county of residence

General Cause of Eating Disorders	Number	Percentage
Physical		
Rock Island (n = 330)	19	6 % *
Scott (n = 350)	14	4 % *
Henry (n = 120)	1	1 %
Mental		
Rock Island	179	54 %
Scott	225	64 % **
Henry	77	64 %
About Equal		
Rock Island	125	38 % ***
Scott	104	30 %
Henry	29	24 %
Don’t Know		
Rock Island	7	2 %
Scott	7	2 %
Henry	13	11 % ****

* Statistically significant difference at the .05 level from Henry County
** Statistically significant difference at the .05 level from Rock Island County
*** Statistically significant difference at the .05 level from Scott & Henry Counties
**** Statistically significant difference at the .05 level from Scott & Rock Island Counties

Table 21. Comparison of subject beliefs that Eating Disorders are the result of physical or mental problems by income level

General Cause of Eating Disorders	Number	Percentage
Physical		
0 to $10,000 (n = 11)	1	9 %
$ 10,000 to $ 25,000 (n = 115)	5	4 %
$ 25,000 to $ 50,000 (n = 267)	10	4 %
$ 50,000 to $ 75,000 (n = 181)	5	3 %
> $ 75,000 (n = 88)	3	3 %
Mental		
0 to $10,000	8	73 %
$ 10,000 to $ 25,000	80	70 % *
$ 25,000 to $ 50,000	176	66 % *
$ 50,000 to $ 75,000	96	53 %
> $ 75,000)	53	60 %
About Equal		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	27	23 %
$ 25,000 to $ 50,000	74	28 % **
$ 50,000 to $ 75,000	73	40 % ***
> $ 75,000	31	35 % **
Don’t Know		
0 to $10,000	1	9 %
$ 10,000 to $ 25,000	3	3 %
$ 25,000 to $ 50,000	7	3 %
$ 50,000 to $ 75,000	7	4 %
> $ 75,000	1	1 %

* Statistically significant difference at the .05 level from the $50,000 - $75,000 income group
** Statistically significant difference at the .05 level from the < $10,000 income group
*** Statistically significant difference at the .05 level from the < $10,000, $25,000 - $50,000 and > $75,000 income groups

Table 22 shows that women (27%) and men (21%) are about evenly split in terms of having had an eating disorder or knowing someone with an eating disorder. However, more of the men (77%) than women (71%) indicated that had not experienced the disorder nor did they know anyone who had (.05). Table 23 shows a significant difference between the proportion of Caucasians (25%) and African Americans (10%) who knew someone with an eating disorder (.05). No significant differences were found when comparing across age, county of residence or income level.

Table 22. Proportion of subjects who have personally experienced eating disorders or known someone with an Eating Disorder in the past five years by gender

Known Someone with Eating Disorder	Number	Percentage
Yes		
Women (n = 412)	112	27 %
Men (n = 388)	83	21 %
No		
Women (n = 412)	289	70 %
Men (n = 388)	297	77 % *
Don't Know		
Women (n = 412)	11	3 %
Men (n = 388)	8	2 %

* Statistically significant at .05 Level

Table 23. Proportion of subjects who have personally experienced eating disorder or have known someone with an Eating Disorder in the past five years by race

Known Someone with Eating Disorder	Number	Percentage
Yes		
Caucasian (n = 706)	176	25 % *
Hispanic (n = 27)	7	26 %
African American (n = 42)	4	10 %
No		
Caucasian (n = 706)	512	73 %
Hispanic (n = 27)	20	74 %
African American (n = 42)	37	88 % **
Don't Know		
Caucasian (n = 706)	18	3 %
Hispanic (n = 27)	0	0 %
African American (n = 42)	1	2 %

* Statistically significant at .05 Level from African American

** Statistically significant at .05 Level from Caucasian

When asked where persons with eating disorders turn for help, nearly a quarter of the respondents (24%) indicated they would seek out their family doctor and about one in five persons (21%) indicated they would go to a hospital or clinic. Psychologists ranked next in order as a resource for help with eating disorders (16%). Table 25 shows that significantly more persons in the > $75,000 income range would seek out a psychologist when compared to the lower income groups (.05). There are no differences when analyzing this data and comparing county of residence, gender or race.

Table 24. Subject perception of where persons with eating disorders have gone for help

Where Persons Go For Help (n = 160)	Number	Percentage
Family Doctor	39	24 %
Hospital / Clinic	33	21 %
Psychologist	25	16 %
Mental Health Clinic	11	7 %
Dietician / Nutritionist	7	4 %
Trinity Medical Center	6	4 %

Table 25. Subject perception of persons with eating disorders who have gone to psychologist compared by age group

Persons Who Go to Psychologist	Number	Percentage
Psychologist (n = 25)		
< $10,000	1	20 %
$10,000 - $25,000	2	8 %
$25,000 - $50,000	8	19 %
$50,000 - $75,000	5	15 %
> $75,000	7	37 % *

* Statistically significant difference at the .05 level from $10,000- $25,000 income group

It seems that most persons (65%) believe that persons they have known to have received treatment for eating disorders were satisfied with the treatment they received (Table 26). No significant difference in satisfaction levels were found when comparing to age, county of residence, gender, race or income levels. When subjects were asked if they thought persons being treated for eating disorders were being treated inside or outside of the Quad-Cities, most seemed to think (45%) that persons were going outside of the area (Table 27). Table 28 shows that nearly two – thirds of the total sample (64%) believe eating disorders requires treatment while another quarter believes it depends on the severity. Very few (6%) believe eating disorders can be solved on their own.

Table 26. Subject perception of the satisfaction of those persons who have been treated for eating disorders

Satisfaction with ED Treatment	Number	Percentage
Satisfied	104	65 %
Not Satisfied	13	8 %
Don’t Know / Not Sure	43	27 %

Table 27. Subject perception of whether those persons who have been treated for eating disorders were treated in the Quad Cities area

Satisfaction with ED Treatment (n = 160)	Number	Percentage
Treated in the Quad-Cities	29	18 %
Treated Outside of the Quad-Cities	72	45 %
Both	20	12 %
Don't Know / Not Sure	39	24 %

Table 28. Subject perception whether persons with eating disorders can solve problem on their own

Need for Treatment of ED (n = 160)	Number	Percentage
Can Solve on Their Own	47	6 %
Requires Treatment	516	64 %
Depends on Severity of Problem	197	25 %
Don't Know / Not Sure	40	5 %

Most subjects (60%) would recommend a friend or family member seek help at the first sign of an eating disorder and this was especially true of Henry County residents (Table 30). Nearly three – quarters of Henry County residents (72%) compared to 56% of Rock Island and 59 % of Scott County residents would make an immediate suggestion of treatment whereas more Rock Island County (18%) and Scott County residents (19%) would wait a few weeks (.05). In any event, few (8%) would wait even a few months or say nothing at all (6%). Table 31 shows than significantly more women (63%) than men (56%) would say something immediately whereas significantly more men (8%) than women (5%) wouldn't say anything at all.

Table 29. When subject would recommend that a friend or family member seek help for an eating disorder.

When Treatment Would be Recommended (N = 800)	Number	Percentage
At First Signs of Problem	479	60 %
After a Few Weeks	139	17 %
After a Few Months	64	8 %
Wouldn't Say Anything	51	6 %
Don't Know / Not Sure	67	8 %

Table 30. When subject would recommend that a friend or family member seek help for an eating disorder by county of residence

When Treatment Would be Recommended	Number	Percentage
At First Signs of Problem		
Rock Island (n = 330)	185	56 %
Scott (n = 350)	208	59%
Henry (n = 120)	86	72% *
After a Few Weeks		
Rock Island	60	18 % **
Scott	66	19 % **
Henry	13	13 %
After a Few Months		
Rock Island	34	10 % **
Scott	24	7 %
Henry	6	5 %
Wouldn't Say Anything		
Rock Island	30	9 % **
Scott	20	6 % **
Henry	1	1 %
Don't Know / Not Sure		
Rock Island	21	6 %
Scott	32	9 %
Henry	14	12 %

* Statistically significant at the .05 level compared to Rock Island and Scott Counties
** Statistically significant at the .05 level compared to Henry County
***

Table 31. When subject would recommend that a friend or family member seek help for an eating disorder by gender

When Treatment Would be Recommended	Number	Percentage
At First Signs of Problem		
Women (n = 412)	261	63 % *
Men (n = 388)	218	56%
After a Few Weeks		
Women	69	17 %
Men	70	18 %
After a Few Months		
Women	31	8 %
Men	33	9 %
Wouldn't Say Anything		
Women	19	5 %
Men	32	8 % **
Don't Know / Not Sure		
Women	32	8 %
Men	35	9 %

* Statistically significant at the .05 level compared to men
** Statistically significant at the .05 level compared to women

Table 32 shows that more persons in the youngest 18-30 age group (70%) than the > 61 age group (53%) would recommend treatment at the first sign of a problem (.05). By contrast, more persons in the > 61 group wouldn't say anything at all when compared to those from 31 – 60 years old (.05). Table 33 shows a significant difference in race comparisons. More Caucasians (62%) and Hispanics (59%) than African Americans (36%) would make a recommendation for treatment at the first sign of a problem (.05) while the African Americans (33%) than Caucasians (16%) would wait a few more weeks (.05).
When looking at this issue by income level, it was interesting that none of the persons reporting income below $10,000 were uncertain as to what they would do. All of them indicated they would say something sooner or later but none indicated they would say nothing or didn't know what they would do (Table 34).

Table 32. When subject would recommend that a friend or family member seek help for an eating disorder by age group

When Treatment Would be Recommended	Number	Percentage
At First Signs of Problem		
18-30 (n = 86)	60	70 % *
31-45 (n = 231)	142	61 %
45-60 (n = 263)	163	62 %
> 61 (n = 196)	104	53 %
After a Few Weeks		
18-30	9	10 %
31-45	50	22 % **
45-60	41	16 %
> 61	31	16 %
After a Few Months		
18-30	6	7 %
31-45	12	5 % **
45-60	28	11 % ***
> 61	17	9%
Wouldn't Say Anything		
18-30	7	8 %
31-45	7	3 %
45-60	13	5 %
> 61	22	11 % ****
Don't Know / Not Sure		
18-30	4	5 %
31-45	20	9 %
45-60	18	7 %
> 61	22	11 % **

* Statistically significant at the .05 level compared to > 61 age group
** Statistically significant at the .05 level compared to 18 – 30 age group
*** Statistically significant at the .05 level compared to 31 - 45 age group
**** Statistically significant at the .05 level compared to 31 – 45 & 45-60 age groups

Table 33. When subject would recommend that a friend or family member seek help for an eating disorder by race

When Treatment Would be Recommended	Number	Percentage
At First Signs of Problem		
Caucasian (n = 706)	435	62 % *
Hispanic (n = 27)	16	59 % *
African American (n = 42)	15	36 %
After a Few Weeks		
Caucasian	114	16 %
Hispanic	7	26 %
African American	14	33 % **
After a Few Months		
Caucasian	59	8 %
Hispanic	0	0 %
African American	5	12 %
Wouldn't Say Anything		
Caucasian	40	6 %
Hispanic	3	11 %
African American	4	10 %
Don't Know / Not Sure		
Caucasian	58	8 %
Hispanic	1	4 %
African American	4	10 %

* Statistically significant at the .05 level compared to African American group
** Statistically significant at the .05 level compared to Caucasian group

Table 34. When subject would recommend that a friend or family member seek help for an eating disorder by income level

When Treatment Would be Recommended	Number	Percentage
At First Signs of Problem		
0 to $10,000 (n = 11)	3	27 %
$ 10,000 to $ 25,000 (n = 115)	76	66 % *
$ 25,000 to $ 50,000 (n = 267)	179	67 %
$ 50,000 to $ 75,000 (n = 181)	99	55 %
> $ 75,000 (n = 88)	43	49 %
After a Few Weeks (n = 139)		
0 to $10,000	4	36 %
$ 10,000 to $ 25,000	15	13 %
$ 25,000 to $ 50,000	41	15 %
$ 50,000 to $ 75,000	35	19 %
> $ 75,000	16	18 %
After a Few Months (n = 64)		
0 to $10,000	4	36 % **
$ 10,000 to $ 25,000	7	6 %
$ 25,000 to $ 50,000	18	7 %
$ 50,000 to $ 75,000	15	8 %
> $ 75,000	10	11 %
Wouldn't Say Anything (n = 51)		
0 to $10,000	0	0 %
$ 10,000 to $ 25,000	14	12 % ***
$ 25,000 to $ 50,000	9	3 %
$ 50,000 to $ 75,000	12	7 %
> $ 75,000	8	9 %
Don't Know / Not Sure (n = 67)		
0 to $10,000	0	0 %
$ 10,000 to $ 25,000	3	3 %
$ 25,000 to $ 50,000	20	7 % ****
$ 50,000 to $ 75,000	20	11 % ****
> $ 75,000	11	12 % ****

* Statistically significant at the .05 level compared to < $10,000, $50,000-$75,000 and >$75,000 groups
** Statistically significant at the .05 level compared to $10,000 - $25,000 & $25,000 - $50,000 groups
*** Statistically significant at the .05 level compared to $25,000 - $50,000 group
**** Statistically significant at the .05 level compared to the $10,000-$25,000 group

Table 35. Where subject would recommend a friend or family member to seek help for an eating disorder

Recommended Treatment Site (n = 749)	Number	Percentage
Family Doctor	375	50 %
Hospital / Clinic	86	11 %
Psychologist	53	7 %
Eating Disorder Professional	42	6 %
Mental Health Clinic	23	3 %
Eating Disorder Clinic	19	3 %

Table 35 shows that half (50 %) of the total respondents would recommend their family doctor as the place to seek assistances for an eating disorder. This result is interesting because Table 19 shows that most persons think that eating disorders are the result of mental rather than physical problems. Just over 10 % would recommend a hospital or clinic for treatment. Table 36 shows that more folks in the 46-60 and > 61 age group (.05) would seek out their family physician for help while more subjects from the younger group, 18 – 30 and 31-45, would go to a hospital or clinic (.05).

There seems to be a stigmatization associated with eating disorders as most subjects (75%) believe there is shame associated with seeking treatment associated with eating disorders (Table 37). Interestingly, Table 38 shows that it is the younger groups who believe there is shame associated with seeking treatment (.05) while there are significantly fewer persons in the > 61 group (63%) who believe this to be true (.05).

Table 36. Where subject would recommend a friend or family member to seek help for an eating disorder by age

Recommended Treatment Site	Number	Percentage
Family Doctor		
18 – 30 (n = 79)	27	34 %
31 – 45 (n = 224)	101	45%
46 – 60 (n = 250)	138	55 % *
> 61 (n = 174)	95	55 % **
Hospital / Clinic		
18 – 30	15	19 % ***
31 – 45	34	15 % ***
46 – 60	23	9 %
> 61	11	6 %
Psychologist		
18 – 30	6	8 %
31 – 45	16	7 %
46 – 60	14	6 %
> 61	17	10 %
Eating Disorder Professional		
18 – 30	6	8 %
31 – 45	19	8 % ****
46 – 60	13	5 %
> 61	4	2 %
Mental Health Clinic		
18 – 30	3	4 %
31 – 45	7	3 %
46 – 60	5	2 %
> 61	8	5 %
Eating Disorder Clinic		
18 – 30	1	1 %
31 – 45	6	3 %
46 – 60	8	3 %
> 61	4	2 %

* Statistically significant at the .05 level compared to 18-30 & and 31-45 age groups
** Statistically significant at the .05 level compared to 18-30 age group
*** Statistically significant at the .05 level compared to 46 – 60 & > 61 groups
**** Statistically significant at the .05 level compared to 46 – 60 & > 61 groups

Table 37. Subject perception of shame associated with seeking treatment for Eating Disorders

Perception of Shame Associated with Treatment	Number	Percentage
Yes	602	75 %
No	94	12 %
Don't Know	104	13 %

Table 38. Subject perception of shame associated with seeking treatment for Eating Disorders by age

Perception of Shame Associated with Treatment	Number	Percentage
Yes		
18-30 (n = 86)	71	83 % *
31-45 (n = 231)	195	84 % **
46-60 (n = 195)	195	74% *
> 61 (n = 196)	124	63%
No (n = 94)		
18-30	8	9 %
31-45	10	4 %
46-60	37	14% ***
> 61	37	19% ****
Don't Know (104)		
18-30	7	9 %
31-45	26	4 %
46-60	31	14%
> 61	35	19% *****

* Statistically significant difference at the .05 level from > 61 age group
** Statistically significant difference at the .05 level from 46 – 60 & > 61 age groups
*** Statistically significant difference at the .05 level from 31-45 age group
**** Statistically significant difference at the .05 level from 18-30 & 31-45 age groups
***** Statistically significant difference at the .05 level from 18-30 age group

An overwhelming number of the participants in the survey (85%) know that eating disorders could be fatal while a mere 2% of the total sample believe eating disorders to not be fatal (Table 39). Another 13% did not know. When asked how eating disorders could be fatal Table 40 shows there were three primary responses: (1) death / starvation / other forms of suicide (27%); (2) heart strain / failure (24 %); and, (3) organ failure / body shuts down (21%).

Table 39. Subject perception as to whether Eating Disorders can be fatal

Can Eating Disorders Be Fatal (n = 800)	Number	Percentage
Yes	678	85 %
No	18	2 %
Don't Know	104	13 %

Table 40. Subject perception of how eating disorders can be fatal

How Eating Disorder Can Be Fatal (n = 678)	Number	Percentage
Death / Starvation/ Other Forms of Suicide	180	27 %
Heart Strain / Failure	161	24 %
Organ Failure / Body Shuts Down	139	21 %
Lose All Nutrition from Body	64	9 %
Health Problems in General	39	6 %
Affects Physical Condition	34	5 %
Stroke	22	3 %
Immune System Shuts Down	20	3 %
Diabetes	11	2 %
High Blood Pressure	10	1 %
Chemical Imbalance	6	1 %
Mental Problems / Brain Damage	5	1 %
Sleep Apnea	4	1 %

Table 41 shows that most all subjects (99%) believe women to be the most likely to experience an eating disorder closely followed by persons with depression (95%). The respondents ranked teens third (92%), followed by persons who worry about their weight (88%), overweight people (87%) and people who always try to look good (83%). Table 42 shows that significantly more men (51%) believe they are more likely to have an eating disorder while only 41% of the women believed men could have the disorder (.05).

Table 41. Rank order (%) of groups subjects believe to be more or somewhat likely to have an eating disorder

Group (n = 800)	More Likely	Somewhat Likely	Total
Women	72 %	27 %	99 %
People with Depression	66 %	29 %	95 %
Teens	73 %	19 %	92 %
People Who Worry About Their Weight	62 %	26 %	88 %
Overweight People	57 %	30 %	87 %
People Who Always Try to Look Good	51 %	32 %	83 %
Thin People	24 %	44 %	68%
People with At Least Some College Education	12 %	52 %	64 %
People Who Exercise	16 %	32 %	48 %
Men	6 %	40 %	46 %
Children	12 %	28 %	40 %
People Usually in a Good Mood	7 %	28 %	35 %
People who are Okay with Themselves	8 %	15 %	23 %

Table 42. Comparison by gender of men being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
Likelihood of Men having an Eating Disorder		
Men (n = 388)	197	51 % *
Women (n = 412)	169	41 %

* Statistically significant at the .05 level

When looking at the perception as to whether teens are more likely to experience an eating disorder (Table 43) there is more disparity based on gender, county of residence, race and income level. Nearly all of the women in the sample (95%) compared to 89% of the men believed teens to be somewhat or more likely to have an eating disorder (.05). A higher proportion of Henry County residents (95%) than Rock Island (93%) or Scott (89%) County residents believe teens to be somewhat or more likely to have an eating disorder. Just over three quarters of the African American respondents (79%) compared to 93% of Caucasians believe teens are somewhat or more likely to have an eating disorder which was a significant difference (.05). Finally, there also seemed to be differences across income groups with more subjects at the lower income levels believing teens to be somewhat or more likely to have an eating disorder (.05).

Table 43. Comparison by gender, county of residence, race and income level of teens being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
Gender		
Men (n = 388)	346	89 %
Women (n = 412)	390	95 % *
County of Residence		
Rock Island (n = 330)	306	93 %
Scott (n = 350)	312	89 %
Henry (n = 120)	118	95 % **
Race		
Caucasian (n = 706)	658	93 % ***
Hispanic (n = 27)	25	93 %
African American (n = 42)	33	79 %
Income Level		
< $10,000 (n = 11)	11	100 % ****
$10,000 - $25,000 (n = 115)	112	97 % *****
$25,000 - $50,000 (n =267)	252	94 % ******
$50,000 - $75,000 (n = 181)	153	85 %
> $75,000 (n = 88)	79	90 %

* Statistically significant at the .05 level
** Statistically significant at the .05 level from Rock Island & Scott Counties
*** Statistically significant at the .05 level from the African American group
**** Statistically significant at the .05 level from the $25,000 - $50,000, 50,000 - $75,000 & > $75,000 groups
***** Statistically significant at the .05 level from the 50,000 - $75,000 & > $75,000 groups
****** Statistically significant at the .05 level from the 50,000 - $75,000 group

Table 44 reveals that persons making less than $10,000 income level (55%) seem less likely to view overweight persons as somewhat or more likely to have an eating disorder (.05). At least 85% of the other higher income levels figured overweight persons as being likely to have an eating disorder.

Table 44. Comparison by income level of overweight persons being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
Income Level		
< $10,000 (n = 11)	6	55 %
$10,000 - $25,000 (n = 115)	99	86 % *
$25,000 - $50,000 (n = 267)	237	89 % *
$50,000 - $75,000 (n = 181)	163	90 % *
> $75,000 (n = 88)	75	85 % *

* Statistically significant at the .05 level from the < $10,000 group

Table 45. Comparison by county of residence and income level of children being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
County of Residence		
Rock Island (n = 330)	110	33 %
Scott (n = 350)	146	42 % *
Henry (n = 120)	62	52 % *
Income Level		
< $10,000 (n = 11)	6	55 % **
$10,000 - $25,000 (n = 115)	53	46 % **
$25,000 - $50,000 (n = 267)	128	48 % ***
$50,000 - $75,000 (n = 181)	64	35 %
> $75,000 (n = 88)	20	23 %

* Statistically significant at .05 level from Rock Island County
** Statistically significant at .05 level from > $75,000 group
*** Statistically significant at .05 level from the $50,000 - $75,000 & > $75,000 groups

Table 45 shows that more than half of the Henry County residents believe that children were somewhat or more likely to have an eating disorder when compared to only a third (33%) of Rock Island County residents (.05). Forty – two percent (42%) of Scott County

residents believe children were somewhat or more likely to have an eating disorder and that was also significant at the .05 level when compared to Rock Island County. It also appears that fewer of those subjects in the higher income ranges were less certain that children were likely to have an eating disorder (.05).

Table 46 shows that more men (40%) than women (32%) believe persons usually in a good mood are more likely or somewhat likely to have an eating disorder (.05). Again, age differences show up with the younger persons believing that persons usually in a good mood being more likely or somewhat likely to have an eating disorder (.05).

Table 47 shows the demographic breakdown of persons who usually try to look good being more likely or somewhat likely to have an eating disorder. More than 90% of Henry County residents believe persons who usually try to look good are more likely or somewhat likely to have an eating disorder and this compares to 83% from Rock Island County and 81% from Scott County (.05). More women (87%) than men (79%) believe persons who usually try to look good are more likely or somewhat likely to have an eating disorder (.05). There were significant differences between the two youngest groups and the two older groups with the younger portion of the sample believing that persons who usually try to look good are more likely or somewhat likely to have an eating disorder (.05).

Table 46. Comparison by gender and age of persons usually in a good mood being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
Gender		
Men (n = 388)	154	40 % *
Women (412)	132	32 %
Age		
18-30 (n = 86)	36	42 % **
31-45 (n = 231)	99	43 % ***
46-60 (n = 263)	87	33 %
> 61 (n = 196)	54	28 %

* Statistically significant at .05 level from women
** Statistically significant at .05 level from > 61 group
*** Statistically significant at .05 level from the 46-60 and > 61 age group

Table 47. Comparison by county of residence, gender and age of persons who usually try to look good being more likely or somewhat likely to have an eating disorder

Group	Number	Percent
County of Residence		
Rock Island (n = 330)	275	83 %
Scott (n = 350)	282	81 %
Henry (n = 120)	109	91 % *
Gender		
Men (n = 388)	308	79 %
Women (n = 412)	358	87 % **
Age		
18-30 (n = 86)	77	90 % ***
31-45 (n = 231)	189	82 %
46-60 (n = 263)	227	86 %
> 61 (n = 196)	157	80 %

* Statistically significant at .05 level from Rock Island & Scott Counties
** Statistically significant at .05 level from Men
*** Statistically significant at .05 level from the > 61 age group

The question of which age group is more likely to have an eating disorder was asked of the subjects and Table 48 shows the results. Consistent with other questions in the survey, nearly half (47%) of the respondents believe teenagers as most likely to have an eating disorder. This was followed by younger adults (23%).

Table 48. Subject perception of which age group is most likely to have an eating disorder

Group (n = 800)	Number	Percent
Teenagers	373	47 %
Younger Adults	184	23 %
All About the Same	100	12 %
Middle Age Adults	56	7 %
Older Adults	36	4 %
Don’t Know	30	4 %
Pre-teens	21	3 %

Table 49 shows that most of the subjects did not believe income level had much to do with eating disorders as nearly half thought all the income levels were all about the same. Just over a quarter named middle income persons and very few (6%) thought the wealthier people were particularly prone to eating disorders. Table 50 shows that the vast majority of the subjects (79%) believe health insurance should pay for eating disorders at the same level as any other health problem with few in disagreement (7%). Table 51 reveals further analysis of the parity issue and shows some differences in gender, race and income level. More women (82%) than men (76%) believe in benefits parity for eating disorders (.05). More African Americans in the sample (90%) than Caucasians (78%) believed benefits should be the same (.05). Looking at the belief in benefits parity by income level the highest (89%) and lowest (91%) levels of income agreed that benefits for eating disorders should be the same as insurance for other physical care. Only 63% of those in the $10,000-$25,000 income range believe benefits should be the same.

Table 49. Subject perception of which income group is most likely to have an eating disorder

Group (n = 800)	Number	Percent
All About the Same	344	43 %
Middle Income People	209	26 %
Don't Know	117	15 %
Poor People	79	10 %
Wealthy People	51	6 %

Table 50. Subject perception of whether health insurance should pay for eating disorders at the same level as any other health problem

Group (n = 800)	Number	Percent
Yes, Should Pay the Same	629	79 %
No, Should Not Pay the Same	55	7 %
Don't Know	116	14 %

Table 51. Comparison by gender, race and income level as to whether health insurance should pay for eating disorders at the same level as any other health problem

Group	Number	Percent
Yes, Should Pay at the Same Level		
Gender		
Men (n = 388)	293	76 %
Women (n = 412)	336	82 % *
Race		
Caucasian (n = 706)	551	78 %
Hispanic (n = 27)	20	74 %
African American (n = 42)	38	90 % **
Income Level		
< $10,000 (n = 11)	10	91 % ***
$10,000 - $25,000 (n = 115)	73	63 %
$25,000 - $50,000 (n = 267)	219	82 % ***
$50,000- $75,000 (n = 181)	143	79 % ***
> $75,000 (n = 88)	78	89 % ****

* Statistically significant at .05 level from Men
** Statistically significant at .05 level from the Caucasian group
*** Statistically significant at .05 level from the $10,000 - $25,000 income group
**** Statistically significant at .05 level from the $10,000 - $25,000 & $50,000 - $75,000 income groups

Subjects were next asked if they thought eating disorders were a widespread problem in society. They were offered a choice from a belief the disorder was widespread, common, somewhat rare or very rare (Table 52). Nearly half of the pool (47%) considered eating disorders as a common problem with just under a quarter (23%) believing it to be widespread. Only 2% of the sample believed eating disorders to be rare in society. Further analysis of this question (Table 53) reveals that 28% of the women respondents believe eating disorders to be widespread compared to only 18% of the men (.05). By contrast, about one of every five men (19%) deems eating disorders to be somewhat rare compared to only12% of the women (.05). Race differences were also found in those subjects who believe eating disorders to be very widespread. For example, nearly a third of the Hispanics (30%) and about a quarter of the Caucasians (24%) view the problem as very widespread compared to only 10% of the African Americans (.05).

Table 52. Subject perception of eating disorder prevalence

Group (n = 800)	Number	Percent
Very Widespread	186	23 %
Common	377	47 %
Somewhat Rare	126	16 %
Very Rare	17	2 %
Don't Know	94	12 %

Table 53. Comparison by gender and race of subject perception of the prevalence of eating disorders

Group	Number	Percent
Very Widespread		
Gender		
Men (n = 388)	70	18 %
Women (n = 412)	116	28 % *
Race		
Caucasian (n = 706)	170	24 % **
Hispanic (n = 27)	8	30 % **
African American (n = 42)	4	10 %
Somewhat Rare		
Gender		
Men (n = 388)	75	19 % ***
Women (n = 412)	51	12 %

* Statistically significant at .05 level from Men
** Statistically significant at .05 level from the African American group
*** Statistically significant at .05 level from Women

Subjects were asked if they thought prevention and education programs about eating disorders should be offered in local schools. Table 54 shows that an overwhelming proportion (89%) of the sample agreed prevention and education should be offered in schools. This is not surprising given the fact that nearly half of the respondents stated previously that teenagers were the most likely age group to have an eating disorder (Table 48). Only 5% of the sample did not believe prevention and education should be offered in the schools about eating disorders. Looking at a county breakdown of the interest in education and prevention issue in schools (Table 55), most of the Rock Island County

residents (91%) believe programs should be offered in the schools compared to 82% of Henry County residents who share the same desire for educational programming. Eighty-nine percent (89%) of Scott County residents believed prevention and education about eating disorders should be offered in their local schools. Nearly all of the respondents in the younger age groups (92% and 93%) desire prevention programming in the schools compared to 86% of the 46-60 age groups (.05).

Table 54. Subject perception to provide school prevention and education programs for eating disorders

Group (n = 800)	Number	Percent
Should Provide Prevention and Education	709	89 %
Should Not Provide Prevention and Education	40	5 %
Don't Know	51	6 %

Table 55 Comparison by county of residence and age of persons who believe prevention and education programs should be provided in schools

Group	Number	Percent
County of Residence		
Rock Island (n = 330)	299	91 % *
Scott (n = 350)	312	89 %
Henry (n = 120)	98	82 %
Age		
18-30 (n = 86)	80	93 % **
31-45 (n = 231)	212	92 % **
46-60 (n = 263)	225	86 %
> 61 (n = 196)	171	87 %

* Statistically significant at .05 level from Henry County
** Statistically significant at .05 level from the 46 – 60 age group

Subjects were then asked if they thought the general community would benefit by having a greater awareness of the symptoms and warning signs that are typically associated with eating disorders (Table 56). Eighty-four percent (84%) agreed the community would benefit and only 3% disagreed. The remaining 13% didn't know whether the community would benefit.

Table 56. Subject perception whether community would benefit by having a greater awareness of symptoms / warning signs of eating disorders

Group (n = 800)	Number	Percent
Yes, Community would benefit	669	84 %
No, Community would not benefit	25	3 %
Don't Know	106	13 %

Subjects were asked where they get personal information about healthcare. Table 57 shows that over half (52%) said they get healthcare information from their physician followed by friends and neighbors (20%) and the internet (20%). About one in ten respondents report getting information from magazines (10%), newspapers (9%) and television (9%). When asked what specific newspapers they find healthcare information, Table 58 reveals that nearly half (49%) state the Quad City Times, just over a quarter (26%) said a "local" paper and 16% said the Dispatch / Argus. It is unfortunate that it is unknown what proportion of the 26% who stated "local" perhaps meant Quad City Times, Dispatch / Argus or a rural paper.

Table 57. Subject's stated source of acquiring information on healthcare

Group (n = 800)	Number	Percent
My Doctor	418	52 %
Friends / Neighbors	160	20 %
Internet / Websites	158	20 %
Magazines	77	10 %
Newspapers	74	9 %
Television	71	9 %
Clinics	32	4 %
None, Refused, Don't Know	84	10 %

* Respondents typically named more than one source so numbers total more than 800 but percentages utilize 800 denominators.

Table 58. Newspapers identified by subjects for getting information about healthcare

Group (n = 74)	Number	Percent
Quad City Times	36	49 %
Local paper	19	26 %
Dispatch	12	16 %
USA Today	5	7 %
Chicago Tribune	2	3 %

Subjects were also asked what web sites, magazines, television stations and clinics they frequent to seek healthcare information. Table 59 shows that nearly 45% of the internet users said they use Web MD followed by Google (26%) and Yahoo (9%). Table 60 shows that the most popular magazines for seeking healthcare information is Health magazine (17%), Prevention (17%), Good Housekeeping (9%) and Redbook (6%). Ten other magazines comprised the remaining responses. Table 61 shows that nearly a quarter of those using television as a healthcare source stated Discover Health (21%) followed by NBC (17%), all stations (13%), CNN (11%) and CBS (10%). None report ABC although 7% state WQAD. Table 62 shows the rank order of what clinics were named as sources for healthcare information with 25% naming Community Healthcare followed by Trinity Regional Health System (16%), Family Health (16%), Davenport Medical Center (12%), Genesis (12%) and University of Iowa Hospitals (6%). It is unclear what respondents meant when citing Davenport Medical Center as it could be Trinity Terrace Park or Genesis.

Table 59. Internet / Websites identified by subjects for getting information about healthcare

Group (n = 158)	Number	Percent
Web MD	71	45 %
Google.com	41	26 %
Yahoo.com	15	9 %
MSN.com	7	4 %
Other Medical Websites	7	4 %
Search Engines	7	4 %
Healthcare.com	2	1 %
AOL.com	2	1 %

Table 60. Magazines identified by subjects for getting information about healthcare

Group (n = 77)	Number	Percent
Health Magazine	13	17 %
Prevention	13	17 %
Good Housekeeping	7	9 %
Redbook	5	6 %
Modern Maturity	4	5 %
AARP	4	5 %
Reader's Digest	4	5 %
Ladies Home Journal	4	5 %
American Medical Journal	4	5 %
Health & Fitness	3	4 %
Doctor's Journal	3	4 %
U.S. News & World Report	3	4 %
Newsweek	3	4 %
Scientific Journal	2	3 %

Table 53. Television stations identified by subjects for getting information about healthcare

Group (n = 71)	Number	Percent
Discover Health	15	21 %
NBC	12	17 %
All Stations	9	13 %
CNN	8	11 %
CBS	7	10 %
CNBC	4	6 %
WQAD	5	7 %
PBS	4	5 %

Table 53. Clinics identified by subjects for getting information about healthcare

Group (n = 32)	Number	Percent
Community Health Care	8	25 %
Trinity Regional Health System	5	16 %
Family Health	5	16 %
Davenport Medical Center	4	12 %
Genesis	4	12 %
University of Iowa Hospitals	2	6 %

APPENDIX A

Potential Areas of Study in Eating Disorders Survey

In general, we're attempting to determine the public's perception of eating disorders.

Some potential questions; or, area of questioning might be:

- What is an Eating Disorder?
- Do you know any other common names for Eating Disorders?
- Do you think childhood obesity is an Eating Disorder?
- Do you think compulsive eating is an Eating Disorder?
- Can Eating Disorders be fatal?
- If you knew someone with an Eating Disorder, where would you suggest he / she go for help?
- How far would you be willing to travel to get help for an Eating Disorder?
- Do you think an Eating Disorder is a physical or mental problem?
    - How could we get a response for "both" without leading them? For example, if we just ask them if it is "both," I would guess many would simply agree, not knowing how to decide.
- Should health insurance pay for Eating Disorders at the same level as any other health problem?
- How widespread are Eating Disorders?
- Do you think there is a relationship between gender and people with Eating Disorders?
- Do you think there is a relationship between age and people with Eating Disorders?
- Do you think there is a relationship between educational level and people with Eating Disorders?
- Do you think there is a relationship between intelligence and people with Eating Disorders?
- Do you think there is a relationship between income levels and people with Eating Disorders?
- Do you think exercise is related to Eating Disorders? Too much? Too little?
- This isn't a question, but do we explore the public's views about (a) dieting; and, (b) taking diet drugs.
- Eating disorders and obese kids are related to bullying. In other words, do you think overweight kids get bullied more than size proportionate kids?
- Are Eating Disorders treatable?
- To what degree do you think public perception shapes what you view as a beautiful body?
- Do you think that people who are comfortable with their bodies, regardless of size, are happier than those people who are not comfortable with their bodies?
- Do you think people who are happy with their bodies are more or less likely to have an Eating Disorder?
- Do you think that people with an Eating Disorder can simply choose to do something about it, or does it require treatment?
    - Another way to say this: Are Eating Disorders treatable or are they simply a dietary choice that someone with more willpower could fix?
- Would you feel ashamed to seek treatment for an Eating Disorder?
- How important is it to like your body in order to be healthy?
- Would you be ashamed to admit you like (or dislike) your body size?
- Do you think anyone likes their body size? Are your views shaped by culture?
- Do you know anyone personally that has been diagnosed with an Eating Disorder?
- Are they being treated in the Quad Cities area or outside-the-area?
- Are you able to describe any symptoms related to Eating Disorders?
- Do Eating Disorders only affect women?
- Do you think that Eating Disorders are a medical problem that requires treatment? Or, something a person can fix on their own?
- If you had a loved one who you suspected of having an eating disorder, who/where would you call for help?
- Do you think that medical insurance should pay for treating an eating disorder?
- Do you think there would be value in school prevention education programs related to Eating Disorders? How about community-wide education programs?
- Do you think the Quad Cities needs a specialized treatment center for Eating Disorders?
- Do you think the community would benefit by having a greater awareness about symptoms/warning signs of Eating Disorders (much like heart disease/cancer)?

APPENDIX B

Final Eating Disorders Survey

___ Female ___ Male

DRAFT QUESTIONAIRRE

1. What are the most common forms of Eating Disorders?

_____

2. What are the most common causes of Eating Disorders?

_____

3. What are the most common symptoms related to Eating Disorders?

_____

4. Do you believe most Eating Disorder problems are a result of physical problems or psychological (mental) problems?

___ Physical
___ Psychological (mental)
(Don't Read) ___ About equal
(Don't Read) ___ Don't Know

5. Have you or anyone you know had an Eating Disorder problem in the past three year?

___ Yes – (Go to 5a, b, c)
___ No _ (Go to Q 6)
(Don't Read) ___ Don't Know - (Go to Q 6)

5a. How many sought medical assistance for their Eating Disorder problems?

___ Everyone
___ About 75%
___ About half
___ About 25%
___ Almost no one
(Don't Read) ___ Don't Know

5b. Of those who received medical treatment were they satisfied with the treatment they received?

___ Yes
___ No
(Don't Read) ___ Don't Know

5c. Of those who received medical treatment were they treated in the Quad Cities area or outside-the-area?

___ Quad Cities area
___ Outside-the-area
___ Both
(Don't Read) ___ Don't Know

6. Are Eating Disorders a medical problem that requires treatment or something a person

can remedy on their own?

___ **A medical problem**
___ **Something a person can remedy on their own**
(Don't Read) ___ **Depends on the severity of the problem**
(Don't Read) ___ **Don't Know**

7. When would you recommend to a friend or family member to seek medical help for an Eating Disorder problem?

___ **At the fist signs of a problem**
___ **After a few weeks**
___ **After a few months**
(Don't Read) ___ **Wouldn't say anything, it is a personal problem**
(Don't Read) ___ **Don't Know**

8. Generally speaking, do you feel people are ashamed to seek treatment for an Eating Disorder?

___ **Yes**
___ **No**
(Don't Read) ___ **Don't Know**

9. Can Eating Disorders be fatal?

___ **Yes**
___ **No**
(Don't Read) ___ **Don't Know**

10. Please tell me whether each of the following groups would be More Likely, Some What Likely, Less Likely, or Not Likely at All to have an Eating Disorder problem …

	M.L.	S.W.L.	L.L.	N.L.A.
a. Women	_____	_____	_____	_____
b. Men	_____	_____	_____	_____
c. People with at least some college education	_____	_____	_____	_____
d. People with a high school degree or less	_____	_____	_____	_____
e. People who exercise	_____	_____	_____	_____
f. People who don't exercise	_____	_____	_____	_____
g. Over weight people	_____	_____	_____	_____
h. People who worry about their weight	_____	_____	_____	_____
i. People who don't worry about their weight	_____	_____	_____	_____
j. People who are usually in a good mood	_____	_____	_____	_____
k. Thin people	_____	_____	_____	_____

l. People who suffer from depression _____ _____ _____ _____

m. People who always try to look good _____ _____ _____ _____

n. People who are OK with themselves _____ _____ _____ _____

11. Which age group is most likely to have an Eating Disorder problem?

___ Older people
___ Middle age people
___ Younger people
___ Teenagers - ___ Girls Or ___ Boys (Don't Read)
___ Both
___ Preteens
(Don't Read) ___ All about the same
(Don't Read) _____ Don't Know

12. Which income group is most likely to have an Eating Disorder problem?

___ Wealthy people
___ Middle income people
___ Poor people
(Don't Read) ___ All about the same
(Don't Read) _____ Don't Know

13. Should health insurance pay for Eating Disorders at the same level as any other health problem?

___ Yes
___ No
(Don't Read) ___ Don't Know

14. How widespread are Eating Disorders problems?

___ Very widespread
___ Common
___ Somewhat rare
___ Very rare
(Don't Read) ___ Don't Know

15. Do you think there would be value in school prevention education programs related to Eating Disorders?

___ Yes
___ No
(Don't Read) ___ Don't Know

16. Would your community benefit by having a greater awareness about symptoms/warning signs of Eating Disorders (much like heart disease/cancer)?

___ Yes
___ No
(Don't Read) ___ Don't Know

17. Does the Quad Cities need a specialized treatment center for Eating Disorders?

___ Yes
___ No

(Don’t Read) ___ Don’t Know

18. In which age category are you?___ 18-30 ___ 31-45 ___ 46-60 ___ 61> ___ Refused

19. Are you: ___ Caucasian ___ Hispanic ___ African American ___ Other

20. What is your family income:
___ 0 to $10,000 ___ >$10,000 to $25,000 ___ >$25,000 to $50,000
___ >$50,000 to$75,000 ___ >$75,000 ___ Refused