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Problematic Social Media Use, Eating Attitudes and Body Shape Concerns Among Adults Aged 19–35 Years: A Cross-Sectional Study

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Abstract: Problematic social media use, eating-related attitudes, and concerns about body shape are distinct but potentially overlapping domains relevant to psychological wellbeing. Social media provides opportunities for communication and support, while some patterns of engagement and some appearance-focused experiences may coincide with distress. This study examined the relationships among these three domains in adults within the prespecified age range of 19-35 years. Method: A cross-sectional correlational analysis was conducted using the Bergen Social Media Addiction Scale (BSMAS), Eating Attitudes Test-26 (EAT-26), and Body Shape Questionnaire-16A (BSQ-16A). Of 88 submitted records, 80 met the age criterion and were retained. The analytic sample was aged 19 = 32 years (M = 22.05, SD = 2.68; 39 participants were recorded as female and 41 as male). Internal consistency was estimated using Cronbach's alpha. Pearson correlations with 95% confidence intervals were calculated, Spearman rank correlations were used as sensitivity analyses, and Welch independent-samples t tests compared the two recorded gender groups. Holm adjustment was applied within the prespecified families of three correlations and three group comparisons. Results: Internal consistency was .819 for BSMAS, .809 for EAT-26, and .949 for BSQ-16A. Pearson analyses showed positive associations between BSMAS and EAT-26 scores, r(78) = .271, p = .015; BSMAS and BSQ-16A scores, r(78) = .248, p = .026; and EAT-26 and BSQ-16A scores, r(78) = .455, p < .001. All three Pearson associations remained significant after Holm adjustment. In Spearman sensitivity analyses, the BSMAS - EAT-26 association did not reach significance, whereas the other two associations remained positive and statistically significant. Of the three gender-group comparisons, only the difference in BSQ-16A scores remained significant after Holm adjustment. Nineteen participants (23.8%) scored at or above the EAT-26 threshold of 20. Conclusion: In this sample, problematic social media use, eating attitudes, and body shape concerns were positively associated, with the strongest association observed between eating attitudes and body shape concerns. The EAT-26 result is a screening indicator, not a diagnosis or an estimate of disorder prevalence. Because the design is cross-sectional and the sample's representativeness is uncertain, the results do not establish causal direction and should not be generalised beyond the evidence available from this sample.

Keywords: *Problematic Social Media Use, Eating Attitudes, Body Shape Concerns, BSMAS, EAT-26, BSQ-16A, Cross-Sectional Study.*

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I. INTRODUCTION

Social media platforms have become environments for interpersonal communication, identity expression, entertainment, information seeking, and community participation. Their design can combine curated feeds, visual self-presentation, public or semi-public feedback, and repeated opportunities to observe how other people present their lives and bodies. These features may make appearance more salient for some users, particularly when images are selected, posed, filtered, edited, or presented alongside social approval metrics. At the same time, social media is not a single or uniform exposure: users encounter a wide range of content, and online communities can provide connection, information, validation, and support. A careful account therefore needs to distinguish the medium itself from particular patterns of use and particular experiences within it.

The present study focuses on three related but non-equivalent constructs. Body image is multidimensional and includes perceptions, thoughts, feelings, and behaviours concerning one's body. Body shape concerns are a more specific aspect of body image, involving worry, dissatisfaction, or preoccupation with body shape and appearance. Eating attitudes include beliefs and tendencies related to food, dieting, weight, and perceived control over eating. These constructs may overlap because body-related evaluations can be connected with food-related thoughts and behaviours, but they should not be treated as interchangeable. Body dissatisfaction alone does not establish an eating disorder, and a score above a screening threshold is not a clinical diagnosis. Keeping the constructs distinct is important both for measurement and for avoiding conclusions that exceed what questionnaire data can show.

Problematic social media use refers here to symptom-oriented engagement associated with experiences such as difficulty regulating use, preoccupation, or interference with other activities. It is conceptually different from the amount of time spent online or the frequency of platform visits. A person may use social media frequently for study, work, maintaining relationships, or accessing support without experiencing problematic engagement. Conversely, a person may report difficulty disengaging or negative consequences even when total time online is not especially high. Frequency-based exposure measures and symptom-based problematic-use measures therefore answer different research questions. The Bergen Social Media Addiction Scale (BSMAS) provides a brief self-report index of problematic-use symptoms; its total score is treated in this study as a continuous measure and not as a diagnosis of addiction or a clinical disorder.

One proposed process that may connect online experiences with body-image outcomes is appearance-based social comparison. People sometimes evaluate their own appearance in relation to peers, influencers, public figures, or other online accounts. Such comparisons may take place in environments where photographs are carefully selected or altered and where visible reactions can signal social approval. The comparison target may consequently be an incomplete representation of everyday appearance. Nevertheless, exposure does not produce the same response in every person. Content may be experienced as aspirational, neutral, humorous, educational, supportive, or distressing, depending on its nature and the viewer's circumstances. Prior body dissatisfaction, current mood, self-esteem, social context, and the personal meaning assigned to content are plausible factors, but they were not directly measured in the present dataset and cannot be tested as explanatory mechanisms here.

Research syntheses support the relevance of social comparison to body-related outcomes. Bonfanti et al. (2025), in a systematic review and meta-analysis comprising 83 studies and 55,440 participants, reported a pooled association of r = .454 between social-media-related social comparison and body-image concerns, and r = .36 between social comparison and eating-disorder symptoms. These estimates suggest that comparison processes merit attention in research on digital environments and body-related distress. They should not, however, be interpreted as estimates of the association between every form of social media use and every body-image or eating-related outcome. Social comparison is a specific psychological process, whereas a general problematic-use score captures a broader range of experiences. Differences in populations, measures, platforms, and study designs also limit direct equivalence between pooled literature estimates and findings from an individual sample.

A useful conceptual distinction is between online engagement, the psychological processes that may occur during or around that engagement, and body or eating-related experiences. Problematic-use symptoms describe difficulties or distress associated with regulating engagement; eating attitudes capture food, weight, and control-related thoughts and tendencies; and body-shape concerns reflect worry or preoccupation about appearance. These domains may covary without sharing a single cause or pathway. For example, problematic engagement could coincide with greater exposure to appearance-focused content, but people already experiencing body dissatisfaction may also seek particular online content or use platforms for reassurance. Other factors could influence both domains. The present study does not directly measure content exposure, social comparison, mood, or temporal sequence, so it examines whether the scale totals are associated rather than testing a mechanism or direction of effect.

Against this background, the present cross-sectional study examined the relationships among problematic social media use, eating attitudes, and body shape concerns in adults meeting the prespecified eligibility range of 19-35 years. The constructs were assessed using the BSMAS, EAT-26, and BSQ-16A, respectively. The analysis described participant characteristics and scale distributions, estimated internal consistency, calculated Pearson correlations with confidence intervals, and used Spearman correlations to assess whether the association pattern was similar under a rank-based approach. Exploratory comparisons were also made between the two gender categories recorded in the dataset using Welch independent-samples t-tests. The analysis was restricted to

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eligible records; the observed analytic sample ranged from 19 - 32 years of age.

The study's contribution is deliberately sample-specific. It reports effect estimates and confidence intervals rather than relying only on significance tests, considers multiplicity when interpreting the three correlations and three group comparisons, and treats sensitivity analyses as a check on robustness rather than as proof that one result is definitively correct. It also separates continuous scale scores from the EAT-26 screening indicator and from descriptive BSQ-16A score bands. These distinctions reduce the risk of presenting questionnaire scores as diagnoses or turning cross-sectional associations into causal claims. The findings can help identify questions for larger and more representative studies, but they cannot by themselves determine whether problematic social media use precedes body-related concerns, follows them, or shares antecedents with them.

II. LITERATURE REVIEW

- *Social Problematic Media Use as a Psychological Construct*

Social media use varies in purpose, intensity, emotional significance, and degree of control. Frequency and duration are simple exposure indicators, but they do not capture whether use interferes with daily responsibilities, displaces sleep, generates conflict, or feels difficult to regulate. Symptom-oriented measures therefore offer a different operationalisation: they assess experiences that may accompany problematic engagement rather than merely counting platform visits.

The Bergen Social Media Addiction Scale was developed within a framework that adapts components commonly used to describe addictive behaviors to social media engagement (Andreassen et al., 2016). Its six-item format makes it practical for survey research, and a total score can be analyzed continuously. However, the word "addiction" in the measure's name should not be taken to mean that a respondent has a clinical disorder. A scale score is an indicator derived from self-report, and interpretation depends on the purpose of the study, the population, the measure's psychometric properties, and the availability of appropriate clinical validation.

The distinction between frequency and problematic engagement is important for interpretation. Time online can include academic communication, maintaining friendships, creative work, entertainment, or participation in supportive communities. A symptom-oriented measure instead asks whether engagement is accompanied by experiences such as preoccupation, difficulty controlling use, or conflict with other activities. Even then, a scale total is a summary of self-reported experiences rather than a direct observation of platform behavior. Researchers should avoid treating a higher score as proof that a person uses a particular platform for a particular purpose, or that all forms of use carry the same psychological meaning.

An additional conceptual issue is directionality. Problematic engagement might increase exposure to appearance-focused content, but pre-existing body dissatisfaction or eating-related distress could also influence online behavior. People may seek reassurance, appearance information, or communities related to weight and food; alternatively, they may use social media to distract themselves from distress. Cross-sectional associations cannot distinguish among these possibilities. The current study therefore treats problematic use as a correlate rather than as an established causal exposure.

- *Social Comparison, Idealized Images, and Body Image*

Social comparison theory proposes that people evaluate themselves in relation to others, particularly when objective standards are uncertain. Online visual environments may provide frequent comparison targets, including peers, influencers, public figures, and idealized representations. These targets are not necessarily representative of ordinary bodies or everyday experiences. When images are carefully selected or edited, comparisons can be based on information that is incomplete or misleading, even when viewers know in principle that online content is curated.

Visual platforms can make appearance salient through curated photographs, filters, editing tools, selective self-presentation, and visible feedback metrics. These features may shape the comparison environment, but their effects are not inevitable or identical for all users. The same image can be interpreted as inspiration, entertainment, a source of belonging, or a standard against which someone judges themselves. Individual differences in self-esteem, mood, critical media literacy, prior experiences, and the social context of viewing may help explain why similar exposure is associated with different outcomes. The current dataset does not include direct measures of these features or moderators, so they remain plausible explanatory concepts rather than tested mediators.

Appearance comparison is not identical to social media use. It describes a psychological process that may occur during exposure and can vary between individuals who encounter similar content. This distinction helps explain why a simple association between problematic use and body concerns may be modest even if specific comparison experiences are strongly associated with body image. A general problematic use score combines multiple motivations and experiences, whereas an appearance comparison measure targets a more specific mechanism.

Bonfanti et al. (2025) found positive associations between social media related social comparison, body image concerns, and eating-disorder symptoms across a broad body of research. The synthesis supports the relevance of comparison as a candidate process, but heterogeneity across studies means that effects should not be assumed to be identical across groups or platforms. It also does not establish that comparison is the only mechanism. Feedback, self-presentation, perceived norms, mood, social support, and the content of online communities may all contribute to how people interpret and respond to social media.

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➢ *Eating Attitudes and Screening*

Eating attitudes include beliefs and behaviours related to food, dieting, weight, and perceived control. Such attitudes exist on a continuum and may vary in clinical significance. The EAT-26 was developed as a measure of eating-related attitudes and symptoms, with its psychometric features and clinical correlates described by Garner et al. (1982). It is widely used as a screening instrument, but it is not a diagnostic interview. A high score may indicate that further evaluation is warranted, diagnosis requires broader clinical assessment and consideration of the individual's history, symptoms, impairment, and context.

Screening and diagnosis serve different purposes. A screening threshold is designed to identify individuals who may benefit from further assessment, often prioritising sensitivity over definitive classification. Therefore, the proportion of a sample exceeding a screening threshold should be described as a screening positive proportion or referral indicator, not as the prevalence of an eating disorder. This distinction is especially important in non-clinical convenience samples, where participants may differ from the populations in which a measure was originally validated.

Eating attitudes also need to be interpreted within a broader continuum of behaviour and wellbeing. A screening score may flag responses that warrant a closer conversation, but the meaning of the score depends on context, including the duration and severity of concerns, physical health, functional impairment, and the person's own account. The EAT-26 total cannot by itself, determine whether diagnostic criteria are met. In a non-clinical sample, a threshold count is best described as a screening indicator and should not be used to label participants or estimate disorder prevalence without appropriate diagnostic follow-up.

Self-report scores can also be influenced by interpretation of item wording, cultural expectations, willingness to disclose, and the fit between the instrument and the population. A total score is useful for consistent measurement, but it does not explain which experiences account for a participant's response. The current analysis therefore reports EAT-26 totals as a continuous variable and describes the threshold count cautiously.

➢ *Body Shape Concerns and Measurement*

The Body Shape Questionnaire was developed to assess concerns and preoccupation related to body shape. Evans and Dolan (1993) described shortened alternate forms, including the form relevant to the present study. A multi-item measure can capture a broader range of concerns than a single satisfaction question, but its score remains a self-report indicator. High internal consistency can show that items covary in a sample, it does not by itself demonstrate that the measure is one-dimensional, culturally equivalent, or diagnostically accurate.

Measurement also involves a balance between breadth and specificity. Multi-item questionnaires can capture patterns that a single question may miss, but a total score compresses potentially different experiences into one number. Two participants with the same total may endorse different items and therefore may not have identical needs. Item level profiles, qualitative follow-up, or validated subscale analyses can sometimes clarify these differences, provided that such analyses are justified in advance and supported by the instrument's scoring guidance. The present report uses total scores as specified and does not infer individual clinical profiles from them.

Body shape concerns may be related to eating attitudes because both can involve weight related worry, dissatisfaction, and attempts to change body shape. The constructs nevertheless remain distinct. Someone may experience body dissatisfaction without endorsing restrictive or compensatory eating behaviors, and eating-related difficulties may occur without a high score on everybody-image measure. Examining both scales allows their association to be estimated rather than assuming they measure the same phenomenon.

Score bands sometimes appear in descriptive reporting, but a threshold's meaning depends on its validation and intended use. If bands are used for descriptive purposes, they should be clearly identified as descriptive categories rather than diagnoses. In the present analysis, the BSQ-16A bands are used only to summarize the distribution and are not treated as clinical classifications.

➢ *Gender, Sampling, and Interpretation*

Group differences in body image and eating-related measures are often discussed in the literature, but mean differences should not be presumed in every sample. Social norms, cultural context, age, gender identity, measurement properties, and recruitment procedures can influence both scores and comparisons. A binary grouping in a dataset also does not capture the full diversity of gender identities. In this study, comparisons refer specifically to the two categories recorded in the data and should not be generalized to all men, women, or gender-diverse people.

Statistical significance is only one component of interpretation. A p-value does not quantify the probability that a hypothesis is true, and a non significant finding does not prove that groups are equivalent. Confidence intervals communicate uncertainty around estimates, while effect sizes help describe the magnitude of differences in standardized units. Adjustment for multiple testing is useful when several related comparisons are made because it reduces the chance of declaring a finding statistically significant simply due to the number of tests conducted.

A further consideration is cultural and social context. Appearance ideals, the social meaning of weight, and expectations about gender can differ across communities and can change over time. Measures developed or validated in one population may not function identically in another, even when translated accurately. Comparisons between recorded gender groups should therefore be read as sample specific score comparisons, not as evidence of fixed psychological differences between women and men. Future work should assess whether items are understood similarly across groups

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and should include participants whose identities are not represented by binary categories when recruitment and sample size permit meaningful, respectful analysis.

Overall, the literature supports investigating problematic social media use, eating attitudes, and body shape concerns together, while preserving the conceptual distinctions among them. It also supports caution about causal language, screening interpretation, and generalisability. The current study contributes a focused cross-sectional analysis, while leaving more specific mechanisms especially appearance-based comparison and content exposure for future research.

➢ *Research Gap*

Although research has linked social media related comparison with body image concerns and eating disorder symptoms, a general measure of problematic social media use does not directly assess the content people encounter, the feedback they receive, or the comparisons they make. This creates an important conceptual distinction: a relationship between problematic use symptoms and body related scores would not, on its own, demonstrate that appearance-focused content or social comparison explains that relationship. The present study addresses a narrower empirical question by examining whether general problematic use scores covary with eating attitudes and body shape concerns in the available sample. It does not claim to measure or test the mechanisms that may account for any association.

A second gap concerns the transparent reporting of associations, uncertainty, and analytic robustness. Correlation estimates can be influenced by score distributions and individual observations, and a p-value alone does not communicate the magnitude or precision of a relationship. Reporting Pearson correlations with 95% confidence intervals alongside Spearman rank correlations provides a complementary view of the observed pattern. The rank based analyses are treated as sensitivity analyses, not as a substitute for the primary analysis or a guarantee that the data meet every assumption. Group comparisons also require attention to effect size, confidence intervals, and multiplicity, particularly when several outcomes are examined in the same sample.

A third gap concerns how screening tools and score bands are described in community or convenience samples. A threshold on a screening questionnaire is intended to flag respondents who may warrant further evaluation, it does not establish a diagnosis. Likewise, descriptive bands for body-shape questionnaire scores should not be treated as clinical categories unless their interpretation is validated for the population and purpose at hand. Clear reporting must therefore distinguish continuous symptom scores, screening indicators, and diagnostic outcomes. The present study reports the EAT-26 threshold count as a screening indicator and the BSQ-16A bands as descriptive summaries only. To address these questions, the study estimated internal consistency for the BSMAS, EAT-26, and BSQ-16A described the distribution of each scale total, estimated Pearson correlations with 95% confidence intervals, conducted Spearman sensitivity analyses, and compared the two gender groups recorded in the dataset using Welch tests. Holm adjustment was applied separately to the family of three correlations and the family of three group comparisons. Eligibility was restricted to adults aged 19-35 years, inclusive, and records outside this pre specified age range were excluded before the analytic sample was formed. These procedures support a transparent description of the available data while leaving causal and population-level claims outside the scope of the design.

➢ *Objectives*

- To estimate the internal consistency of the BSMAS, EAT-26, and BSQ-16A in the study sample.
- To describe participants' scores on problematic social media use, eating attitudes, and body shape concerns.
- To estimate the pair wise associations among the three scale totals using Pearson correlations and 95% confidence intervals.
- To assess the robustness of pair wise associations using Spearman rank correlations.
- To explore differences in scale totals between participants recorded as male and female using Welch independent-samples t-tests.
- To describe the proportion scoring at or above the EAT-26 screening threshold without interpreting it as diagnostic prevalence.

➢ *Hypothesis*

- H1: Higher BSMAS scores will be positively associated with EAT-26 scores.
- H2: Higher BSMAS scores will be positively associated with BSQ-16A scores.
- H3: Higher EAT-26 scores will be positively associated with BSQ-16A scores.
- H4: Mean BSMAS, EAT-26, and BSQ-16A scores may differ between participants recorded as male and female, these group comparisons are exploratory.

III. METHOD

➢ *Research Design*

The study used a cross-sectional correlation design. All variables were assessed at one measurement occasion, and no experimental manipulation was conducted. This design is appropriate for describing distributions and estimating contemporaneous associations, but it cannot establish temporal order or causality. The analytic sample was restricted to participants aged 19-35 years, inclusive.

➢ *Participants*

The analytic sample comprised 80 participants aged 19-32 years (M = 22.05, SD = 2.68). The recorded gender categories were female (n = 39) and male (n = 41). The observed maximum age was 32 years, therefore, no records were excluded for exceeding the upper eligibility limit. These characteristics describe the available sample and should not be interpreted as evidence of population representativeness.

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➢ *Measures*

- *Bergen Social Media Addiction Scale*

Problematic social media use was assessed with the six-item Bergen Social Media Addiction Scale (BSMAS; Andreassen et al., 2016). Items were rated on a five-point response scale and summed to produce a total from 6 to 30, with higher scores reflecting greater endorsement of problematic use symptoms. The score was treated continuously. No diagnostic or categorical interpretation was assigned because the analysis did not establish a validated cutoff appropriate to this sample.

- *Eating Attitudes Test-26*

Eating related attitudes were assessed with the 26-item Eating Attitudes Test (EAT-26; Garner et al., 1982). Items 1-25 were scored as Always = 3, Usually = 2, Often = 1, and Sometimes, Rarely, or Never = 0. Item 26 was reverse scored: Never = 3, Rarely = 2, Sometimes = 1, and Often, Usually, or Always = 0. Item scores were summed to produce a total ranging from 0 to 78. A total score of 20 or higher was treated as a screening/referral indicator, not a diagnosis. Five additional behavioral questions were not included in the total score and were not used to estimate diagnostic prevalence.

➢ *Body Shape Questionnaire-16A*

Body shape concerns were assessed using the 16-item Body Shape Questionnaire-16A (BSQ-16A; Evans & Dolan, 1993). Items were scored from 1 (Never) to 6 (Always), producing a possible total from 16 - 96. Higher scores indicate more frequent or intense body-shape concerns. For descriptive purposes, totals were grouped as below 38, 38-51, 52-66, and above 66. These bands were used to summarize score distribution only and were not treated as diagnoses or validated clinical thresholds for this sample.

➢ *Data Preparation and Scoring*

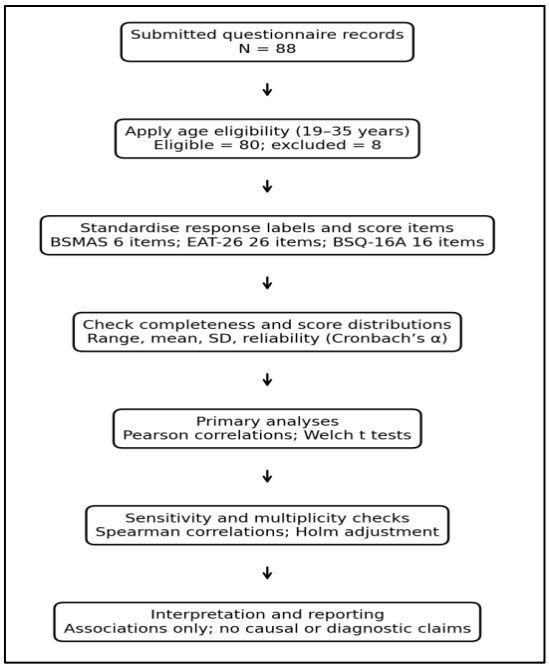


Fig 1 Data Processing and Statistical Analysis Workflow.

Workflow note: exclusions were based on the pre specified age criterion. All scale scoring and analyses should be interpreted in line with the stated item-level scoring rules and the results tables.

Item responses used to calculate the three scale totals were complete. Minor response label variants were standardized before scoring so that equivalent response categories were treated consistently. No item-level missing ness occurred on the 48 items used to calculate the scale totals. Height and weight were not included in the analysis because recorded values were not sufficiently consistent in format and units to support reliable conversion. The analysis therefore focuses on the three pre specified scale totals and recorded demographic variables.

➢ *Statistical Analysis*

The sample size was determined by the records available after applying the age criterion rather than by a prospective power calculation. Accordingly, non significant findings should not be interpreted as evidence that no association exists. Pearson correlation was used as the primary estimate of linear association, with Spearman correlation used to assess whether the direction and inferential pattern were similar under a rank based approach.

Analyses were conducted on the 80 records meeting the age criterion of 19-35 years, inclusive. Item responses were standardized for minor spelling/label variants before scoring. Descriptive statistics and Cronbach's alpha were calculated for each scale. Pearson correlations were estimated with Fisher-transformation 95% confidence intervals, and p-values for the three primary correlations were adjusted using the Holm procedure. Spearman correlations were computed as sensitivity analyses. Welch independent samples t-tests compared recorded female and male groups; female minus male mean differences, 95% confidence intervals, Cohen's d, and Holm-adjusted p-values are reported. All tests were two-sided. Calculations were performed in Python with pandas 2.2.3, SciPy 1.17.0, and statsmodels 0.14.6.

➢ *Transparency and Reproducibility*

The Holm procedure was used to limit family wise error within the three planned pair wise correlations and, separately, within the three exploratory gender comparisons. Adjusted p-values were considered alongside unadjusted values, effect size estimates, and confidence intervals. Welch's t-test was selected because it does not require the two groups to have equal variances and accommodates unequal group sizes. These choices improve transparency but do not remove uncertainty due to sampling, measurement, confounding, or the limited size and composition of the sample.

The analysis used explicit scoring rules, standardized equivalent response label variants before scoring, and applied Holm adjustment separately to the three primary correlations and the three exploratory group comparisons. Data or code availability is not asserted because no public repository was specified for this manuscript.

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➢ *Ethics Approval and Informed Consent*

The study received approval from the Department of Psychology, United Psychological Foundation (UPF), under reference UPF/RESEARCH/DOP/2025/001, dated 19 December 2025. Dr. Devinder Dhalla is identified as the approving authority. Participants were provided with information about the research and the consent process before completing the questionnaire, referral outpatient department clients were informed about the study and consent was obtained before participation. Recruitment involved both online Google Forms respondents and referral OPD clients. Further recruitment details and a source specific breakdown were not available in the records reviewed and are not inferred here.

IV. RESULTS

➢ *Participant Characteristics and Scale Descriptives*

The eligible sample comprised 80 participants aged 19-32 years (M = 22.05, SD = 2.68). The recorded gender categories were female (n = 39) and male (n = 41). Mean BSMAS score was 17.73 (SD = 5.32; observed range = 6-29), mean EAT-26 score was 13.48 (SD = 9.50; observed range = 1-43), and mean BSQ-16A score was 46.76 (SD = 19.17; observed range = 16-89).

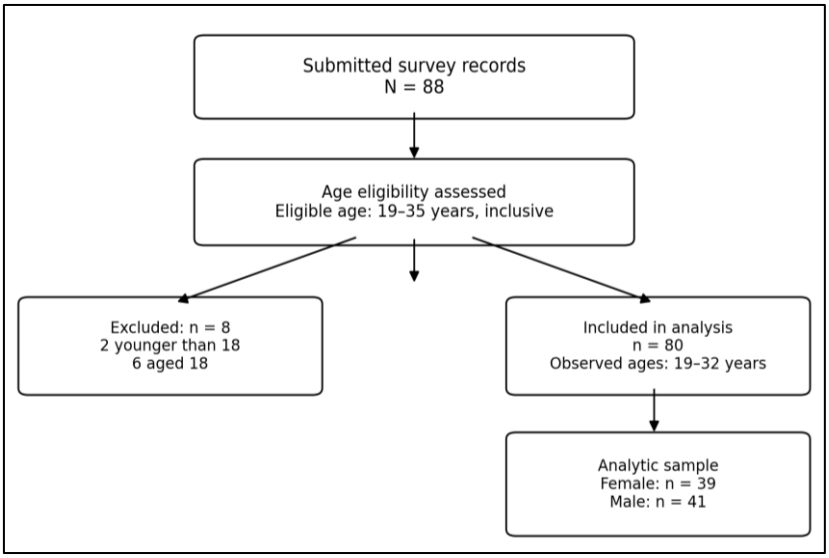


Fig 2 Participant Inclusion Flow Diagram.

Internal consistency was acceptable for the BSMAS (Cronbach's α = .819) and EAT-26 (α = .809), and excellent for the BSQ-16A (α = .949) in this sample. These coefficients describe internal consistency in the present eligible sample and do not, by themselves, establish validity or diagnostic utility.

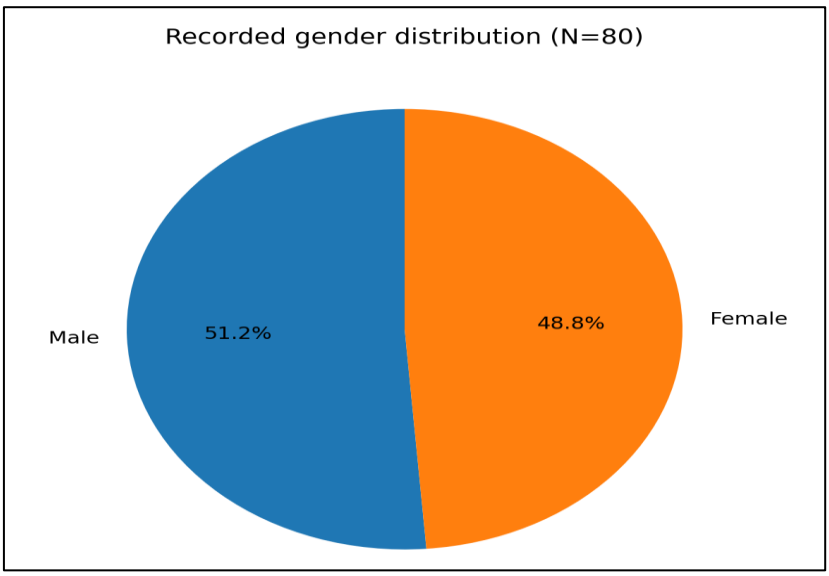


Fig 3 Recorded Gender Distribution in the Eligible Sample.

The pie chart describes the distribution of recorded gender categories in the analytic sample; it is not intended to imply representativeness beyond these respondents.

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Table 1 Descriptive Statistics and Internal Consistency of the Study Measures

Measure	Items	M	SD	Observed range	Cronbach's α
BSMAS	6	17.73	5.32	6-29	.819
EAT-26	26	13.48	9.50	1-43	.809
BSQ-16A	16	46.76	19.17	16-89	.949

Note. N = 80 eligible participants aged 19-35 years, inclusive. Possible total-score ranges are 6-30 for BSMAS, 0-78 for EAT-26, and 16-96 for BSQ-16A.

➢ *Associations Among the Three Measures*

All three Pearson correlations were positive. BSMAS scores were positively associated with EAT-26 scores, r(78) = .271, 95% CI [.054, .463], p = .015, Holm adjusted p = .030. BSMAS scores were also positively associated with BSQ-16A scores, r(78) = .248, 95% CI [.030, .444], p =.026, Holm-adjusted p = .030. The association between EAT-26 and BSQ-16A scores was larger, r(78) = .455, 95% CI [.262, .614], p < .001, Holm-adjusted p < .001.

Table 2 Pearson Correlations Among Scale Totals

Association	r	95% CI	p	Holm-adjusted p
BSMAS - EAT-26	.271	[.054, .463]	.015	.030
BSMAS - BSQ-16A	.248	[.030, .444]	.026	.030
EAT-26 - BSQ-16A	.455	[.262, .614]	< .001	< .001

Note. N = 80. Pearson correlations are two-sided; 95% confidence intervals use Fisher's z transformation. Holm adjustment was applied across the three primary correlations.

The magnitudes of the Pearson coefficients indicate positive associations that are modest for the two pairs involving BSMAS and larger for the association between EAT-26 and BSQ-16A. The confidence intervals are important: although the intervals for the three Pearson coefficients exclude zero, they also include a range of plausible association strengths. The coefficients should not be translated into individual level predictions, and shared variance should not be interpreted as proof that one construct causes another. The results describe the extent to which scores tended to vary together within this particular eligible sample.

Spearman sensitivity analyses produced positive coefficients for all three pairs. The BSMAS - EAT-26 association was not statistically significant, ρ = .212, p = .058; the BSMAS - BSQ-16A association was statistically significant, ρ = .223, p = .046; and the EAT-26 - BSQ-16A association was statistically significant, ρ = .523, p < .001. The Pearson and Spearman results therefore align in direction, but the BSMAS - EAT-26 finding is less robust to the choice of correlation method.

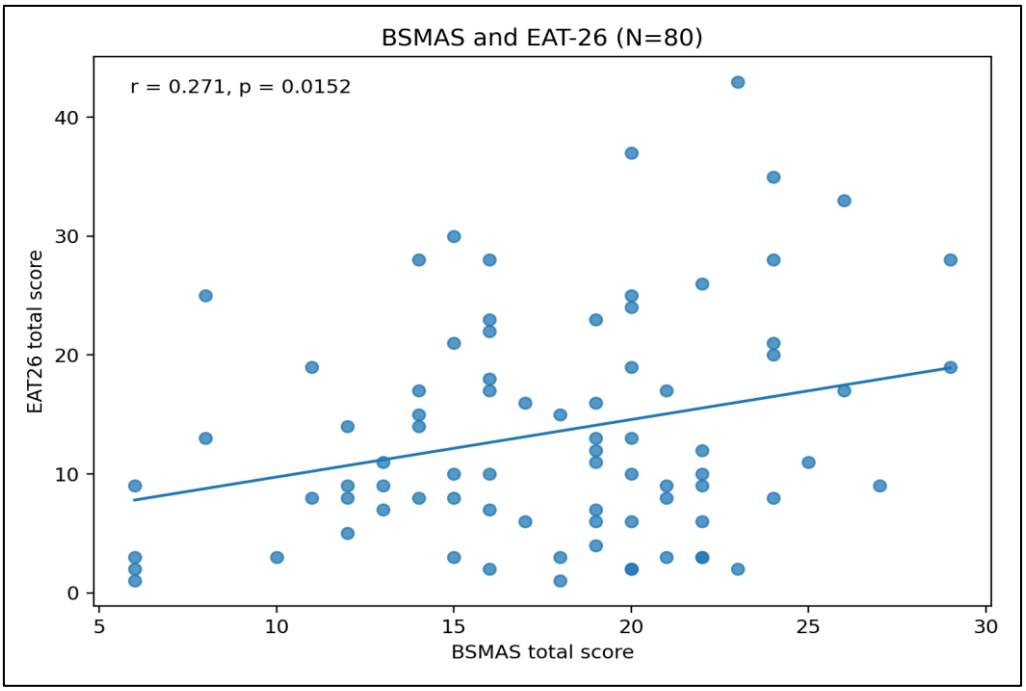


Fig 7 Scatterplot of BSMAS and EAT-26 Total Scores.

Each point represents one eligible participant. The fitted line summarises the linear trend; the cross-sectional design does not establish temporal order or causation.

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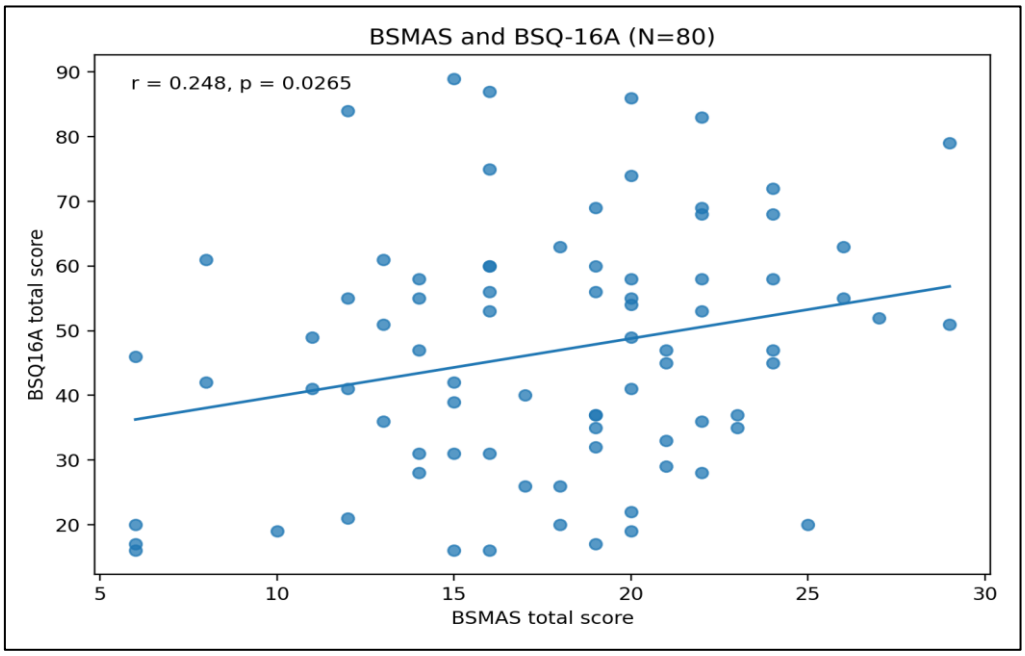


Fig 8 Scatterplot of BSMAS and BSQ-16A Total Scores.

Each point represents one eligible participant. The fitted line summarises the linear trend; the cross-sectional design does not establish temporal order or causation.

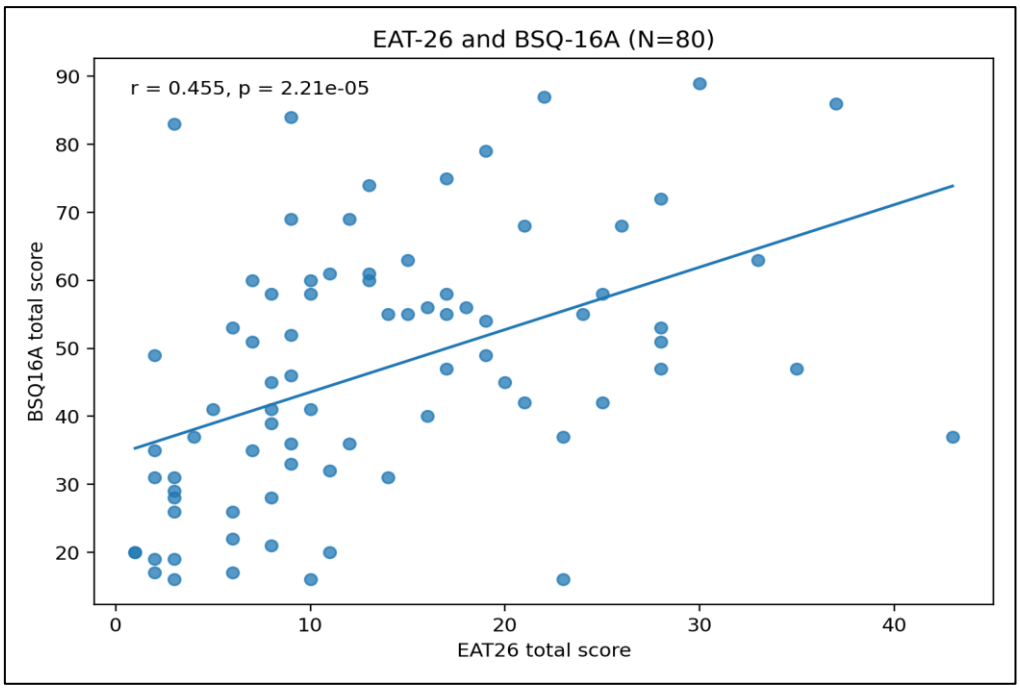


Fig 9 Scatterplot of EAT-26 and BSQ-16A Total Scores.

Each point represents one eligible participant. The fitted line summarises the linear trend; the cross-sectional design does not establish temporal order or causation.

➢ *Group Comparisons by Recorded Gender*

Welch tests compared scores between participants recorded as female (n = 39) and male (n = 41). For BSMAS, the female group scored higher on average (M = 19.03, SD = 4.33) than the male group (M = 16.49, SD = 5.90), mean difference = 2.54, 95% CI [0.24, 4.83], t(73.33) = 2.20, p = .031, Holm-adjusted p = .062, d = 0.49. For EAT-26, female scores (M = 15.33, SD = 9.96) exceeded male scores (M = 11.71, SD = 8.80), but the difference was not statistically significant, mean difference = 3.63, 95% CI [-0.57, 7.82], t(75.73) = 1.72, p = .089, Holm adjusted p = .089, d = 0.39. For BSQ-16A, female scores (M = 52.41, SD = 18.53) were higher than male scores (M = 41.39, SD = 18.41), mean difference = 11.02, 95% CI [2.80, 19.24], t(77.75) = 2.67, p = .009, Holm adjusted p = .028, d = 0.60.

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The group comparison estimates also show why adjusted inference matters. The female minus male BSMAS difference was positive in the unadjusted test, but it did not remain below the conventional .05 threshold after the Holm correction. The EAT-26 difference was uncertain because its confidence interval included both a small negative difference and a potentially meaningful positive difference. The BSQ-16A difference remained statistically significant after adjustment, but the distributions within each group were broad and overlapped. Group averages should therefore not be used to infer any individual participant's concerns or experiences.

After Holm adjustment across the three exploratory group comparisons, the difference in BSQ-16A scores remained statistically significant (adjusted p = .028). The BSMAS group difference did not meet the adjusted threshold (adjusted p = .062), and the EAT-26 group difference was not statistically significant (adjusted p = .089). These findings apply to the recorded categories in this sample and should not be generalised to all genders or all adults.

Table 3 Welch Independent Samples t-Tests by Recorded Gender

Measure	Male M (SD)	Female M (SD)	Female − male [95% CI]	t(df)	p	Holm p	d
BSMAS	16.49 (5.90)	19.03 (4.33)	2.54 [0.24, 4.83]	2.20 (73.33)	.031	.062	0.49
EAT-26	11.71 (8.80)	15.33 (9.96)	3.63 [-0.57, 7.82]	1.72 (75.73)	.089	.089	0.39
BSQ-16A	41.39 (18.41)	52.41 (18.53)	11.02 [2.80, 19.24]	2.67 (77.75)	.009	.028	0.60

Note. Male n = 41; female n = 39. Welch tests are two-sided; Holm adjustment was applied across the three exploratory group comparisons.

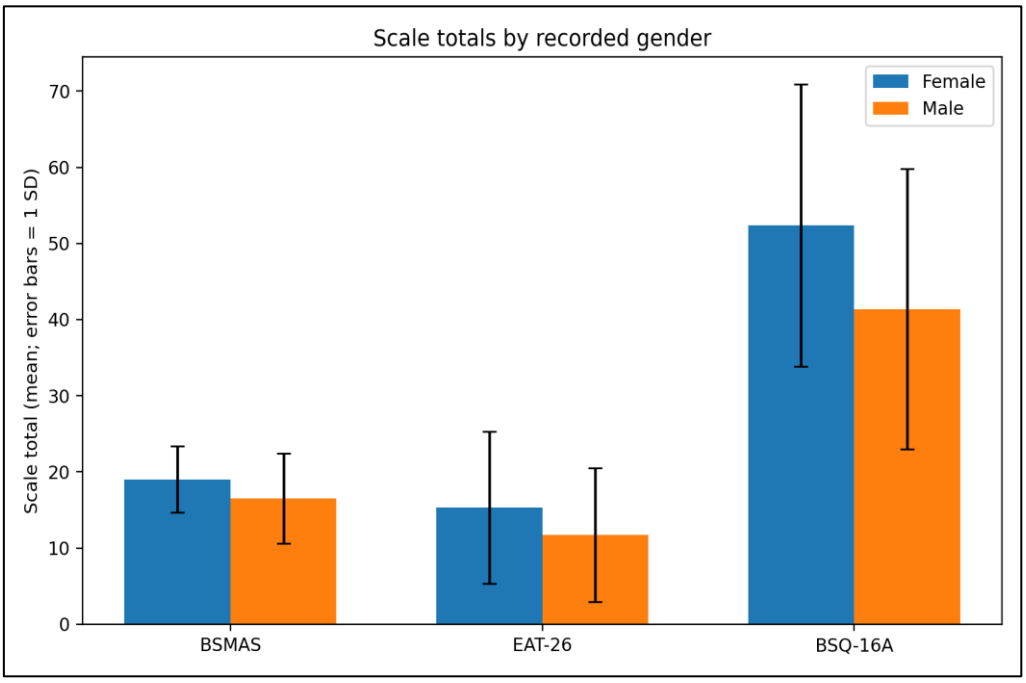


Fig 4 Scale Totals by Recorded Gender.

Error bars represent one standard deviation and are descriptive, not confidence intervals. Welch tests and Holm adjusted results are reported in the statistical tables.

➢ *Screening Indicator and Descriptive Body-Shape Bands*

Nineteen of the 80 eligible participants (23.8%) scored at or above the EAT-26 screening threshold of 20. This proportion should be interpreted as the share meeting a screening/referral indicator, not as the prevalence of an eating disorder. BSQ-16A scores were distributed as follows: below 38, n = 29 (36.3%); 38-51, n = 17 (21.3%); 52-66, n = 21 (26.3%); and above 66, n = 13 (16.3%). These bands are descriptive only.

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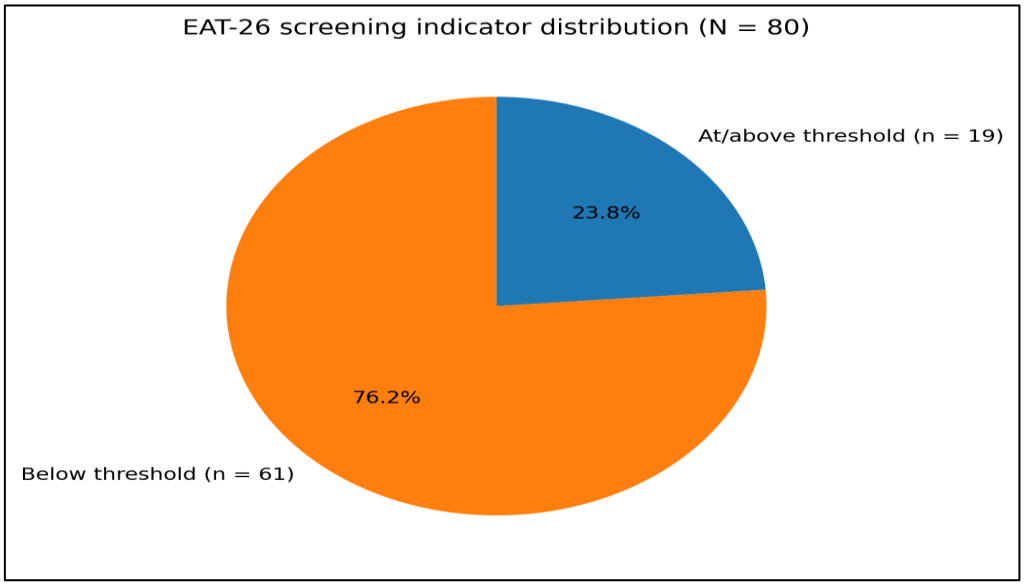


Fig 5 EAT-26 Screening-Threshold Distribution. The Threshold is a Screening Indicator, Not a Diagnosis.

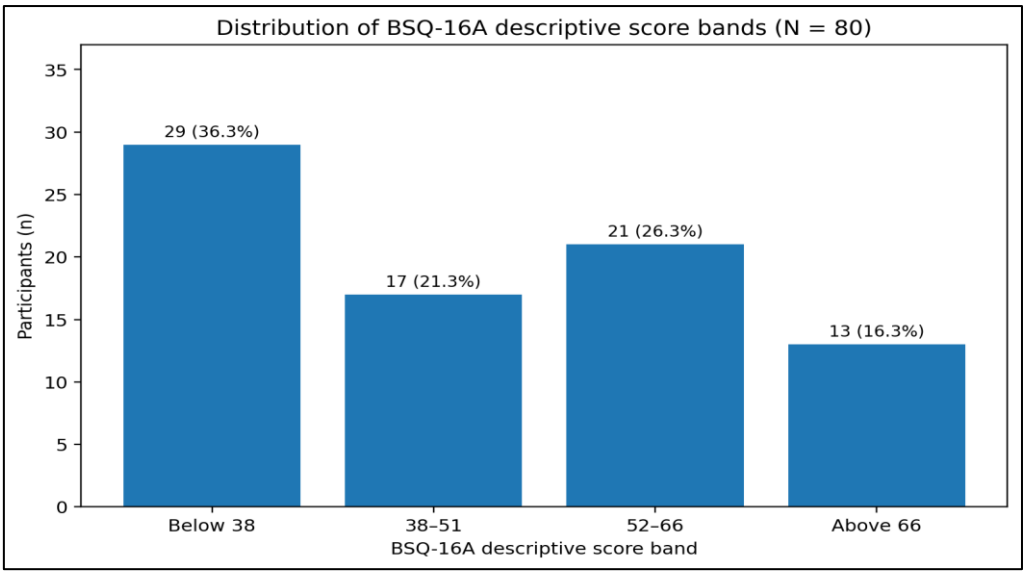


Fig 6 Distribution Across Descriptive BSQ-16A Score Bands.

Table 4 Distribution Across Descriptive BSQ-16A Score Bands

BSQ-16A score band	n	%
Below 38	29	36.3
38-51	17	21.3
52-66	21	26.3
Above 66	13	16.3
Total	80	100.0

Note. BSQ-16A bands are descriptive and should not be interpreted as diagnoses or as validated local clinical thresholds. Percentages may not sum to exactly 100 because of rounding.

➢ *Summary of Findings*

Across the eligible sample, all three Pearson correlations were positive, with the strongest association between eating attitudes and body shape concerns. The two associations involving problematic social media use were smaller. Spearman analyses were consistent in direction, although the BSMAS - EAT-26 association did not reach conventional statistical significance in the rank based analysis. Of the three exploratory gender group comparisons, only the BSQ-16A difference remained statistically significant after Holm adjustment.

V. DISCUSSIONS

One interpretation is that problematic use symptoms may index a broader pattern of emotionally salient engagement that co-occurs with eating related concerns and

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body shape worry. However, the study cannot identify the process connecting these experiences. For example, a person who already feels dissatisfied with their body may seek appearance related content, monitor feedback more closely, or use social platforms during periods of distress. Conversely, repeated comparison experiences may coincide with increased dissatisfaction. A third possibility is that other variables such as mood, stress, peer context, or general psychological distress are related to both online engagement and body image outcomes. The observed correlations are compatible with several explanations and cannot discriminate among them.

The findings provide evidence of positive cross-sectional associations among problematic social media use, eating attitudes, and body shape concerns in this sample of adults aged 19-32. The strongest association was between EAT-26 and BSQ-16A scores, while correlations involving

BSMAS were smaller. These effect sizes indicate related but non-identical constructs. Because the study is cross-sectional, the results cannot determine whether problematic use contributes to body-related concerns, whether such concerns shape online behaviour, or whether other factors influence both.

H1 received qualified support. Pearson correlation indicated a positive association between BSMAS and EAT-26 scores, but the corresponding Spearman analysis did not reach conventional statistical significance. The result should therefore be interpreted cautiously rather than as a robust association across analytic methods.

H2 received support in both Pearson and Spearman analyses: BSMAS scores were positively associated with BSQ-16A scores, although the associations were modest. The BSMAS measures general problematic use symptoms and does not identify whether respondents viewed appearance focused content or engaged in appearance comparison, so the observed association does not establish a specific mechanism.

The relatively larger EAT-26 - BSQ-16A correlation is conceptually plausible because eating attitudes and body shape concerns include related content about weight, appearance, and efforts to manage body shape. At the same time, the constructs are not interchangeable: the EAT-26 includes eating-related attitudes and behaviours beyond body dissatisfaction, while the BSQ-16A focuses on concerns about shape. Their association supports studying both domains, but it does not justify collapsing them into one composite score. Separate reporting helps preserve the distinction between eating related risk indicators and appearance related distress.

H3 was supported by both Pearson and Spearman analyses. EAT-26 and BSQ-16A scores showed a moderate positive association, consistent with conceptual overlap between eating-related attitudes and concerns about body shape while remaining distinct measures.

Internal consistency estimates were .819 for BSMAS, .809 for EAT-26, and .949 for BSQ-16A. These values indicate that the items showed reasonable to high internal consistency in this sample. Cronbach's alpha is not proof of validity, unidimensionality, measurement invariance, test-retest reliability, or clinical utility.

The EAT-26 threshold analysis identified 19 participants (23.8%) scoring 20 or above. This is a screening indicator only and must not be presented as the prevalence of eating disorders. BSQ-16A bands are also descriptive categories rather than diagnoses.

The gender comparison pattern should also be understood descriptively rather than as a statement about inherent differences. The sample contained only two recorded categories, and the data do not establish how participants' gender identities, social experiences, or exposure to appearance norms were assessed. Differences could reflect recruitment, sampling variability, contextual pressures, measurement properties, or other unmeasured factors. A more informative future design would recruit a larger and more diverse sample, measure relevant social and contextual experiences directly, and assess measurement comparability before interpreting group differences substantively.

In group comparisons, the female minus male difference was statistically significant after Holm adjustment for BSQ-16A only. The BSMAS difference was significant before but not after adjustment, and the EAT-26 difference was not statistically significant. Group means should not be interpreted as inherent or universal differences, and the dataset's two recorded gender categories do not capture the full diversity of gender identities.

The broader literature provides a rationale for examining these constructs together, but it does not establish that the same mechanisms operate in this sample. Bonfanti et al. (2025) reported positive pooled associations between social media related social comparison and body image concerns, as well as eating disorder symptoms. The present study measures general problematic social media use rather than appearance-based social comparison, so its findings are related to but not a direct replication of that literature.

If age-restricted associations are observed, several explanations may be relevant. General problematic-use symptoms can reflect social, emotional, and behavioral experiences that are not appearance related. Participants may use platforms for different reasons, and exposure to visual content may vary. Individual factors such as mood, self-esteem, peer context, cultural expectations, and prior body dissatisfaction could influence both social media use and body related outcomes. Unless these variables are measured, they remain possible explanations rather than demonstrated mediators or confounders.

Finally, the cross-sectional design limits interpretation of directionality. It is possible that problematic engagement precedes body image concerns, that body image concerns shape online engagement, or that both are associated with

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other factors. Longitudinal measurements would help clarify temporal ordering, while experimental or quasi-experimental approaches could test more specific causal hypotheses. The present results are best treated as an initial description of associations that can inform, but not replace, more rigorous follow-up research.

➢ *Practical Implications*

The findings suggest that problematic social media use, eating attitudes, and body shape concerns may be useful to assess as related but distinct domains. In research or practice settings, a single score should not be used as a substitute for a broader assessment of the person's experiences, functioning, and context. The modest correlations observed here indicate that problematic social media use alone would be an inadequate proxy for eating related attitudes or body shape concerns.

Digital wellbeing education may be most useful when it goes beyond screen time totals. People can be encouraged to reflect on how different types of content affect mood, self-evaluation, and daily functioning, and to recognise that highly curated online images are not neutral samples of everyday appearance. Such education should avoid blaming individuals for using social media and should recognise that online communities can also provide belonging, information, and support.

Where body image or eating related concerns are identified, screening results should be communicated carefully and non-stigmatisingly. An EAT-26 score at or above the threshold used in this study should prompt consideration of further assessment according to appropriate clinical procedures, not a diagnosis based on the questionnaire alone. A person's needs should be evaluated in context, and any referral decisions should be made by appropriately qualified professionals.

Researchers and service providers should avoid presenting group averages as standards against which individuals should judge themselves. The observed group difference in body shape concerns does not establish that all members of one group experience greater concern than all members of another group. Individual variation is substantial, and inclusive practice should consider gender diversity, cultural context, disability, age, and other relevant factors. At an institutional level, educators, clinicians, and platform designers may consider how appearance focused content, recommendation systems, public feedback, and social comparison cues shape user experience. The current study did not test interventions or platform features, so no specific intervention can be claimed to be effective on the basis of these results. The practical implication is to treat content and user experience as important questions for future evaluation rather than assuming that reducing time online alone will resolve body image concerns.

VI. LIMITATIONS

Several limitations should guide interpretation. First, the recruitment method and sampling frame are not represented in the analytic dataset, consequently, selection bias cannot be evaluated fully and the findings should be treated as sample specific rather than generalised to all adults aged 19-35 years.

Second, the cross-sectional design does not establish temporal precedence or causality. The direction of association could be reciprocal, and unmeasured variables may contribute to the observed relationships. The findings therefore describe concurrent associations rather than effects or causal pathways.

Third, all three primary constructs were assessed using self-report scales. Responses may be influenced by recall, social desirability, interpretation of item wording, and willingness to disclose. Common method variance may also contribute to associations when several constructs are measured using similar response formats at one occasion.

Fourth, the study measured general problematic social media use but did not directly assess time spent on platforms, the types of content encountered, appearance based comparison, feedback experiences, or platform specific behaviour. The analysis therefore cannot identify which online activities, if any, are most closely related to body shape concerns or eating attitudes.

Fifth, the BSMAS - EAT-26 association was statistically significant in the Pearson analysis but not in the Spearman sensitivity analysis. This discrepancy indicates that the strength of evidence depends partly on the analytic method and warrants cautious interpretation.

Sixth, Cronbach's alpha provides information about internal consistency but does not establish validity, unidimensionality, measurement invariance, test-retest reliability, or clinical utility. The BSQ-16A score bands were used descriptively and should not be interpreted as diagnostic categories.

Finally, height and weight data were not analysed because recorded formats and units were inconsistent. No conclusions about body mass index or its relationship with the study variables can be drawn from these data.

➢ *Future Directions*

Future research should use larger samples with transparent recruitment procedures and clearly stated eligibility criteria. Sampling plans should aim to represent the intended population and should report how participants were approached, how many responded, and whether nonresponse may have introduced bias. A priori sample size planning should be tied to the smallest association or group difference considered substantively meaningful.

Longitudinal studies could assess whether problematic social media use predicts later changes in eating attitudes or body shape concerns after accounting for baseline scores. Repeated measures would also allow researchers to examine reciprocal relationships, such as whether body image concerns predict subsequent patterns of online engagement.

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Temporal evidence would strengthen inference, although longitudinal associations alone would not eliminate confounding.

Future studies should distinguish general problematic use from specific online experiences. Useful variables may include exposure to appearance focused content, frequency of appearance comparisons, engagement with diet or fitness content, perceived social support, feedback on posted images, platform specific use, and the emotional response to content. These measures would make it possible to test more precise hypotheses than a general symptom score can support.

Measurement quality should be examined in the population and language in which the study is conducted. Researchers should report the exact versions of the measures, translation and adaptation procedures, scoring rules, and evidence for validity. Measurement invariance should be considered before interpreting group differences as differences in the underlying construct. If the goal is clinical screening, threshold performance should be evaluated against an appropriate clinical assessment rather than inferred from internal consistency alone.

Analytic plans should specify primary outcomes, hypotheses, exclusion rules, and approaches to multiple testing before analysis where feasible. Results should include effect sizes and confidence intervals, and sensitivity analyses should be reported even when they do not match the primary result. Reproducible code and a clear record of software versions can improve transparency, subject to participant privacy and ethics requirements.

Future studies should define and apply age eligibility consistently. If a study is restricted to adults aged 19-35 years, inclusive, screening procedures should exclude records outside that range before analysis. Studies involving minors require separate age appropriate study materials, formal ethics oversight, and clearly documented consent, assent, and any required parental or guardian permission. Screening measures should not be described as diagnostic tools, and studies should have a plan for responding if questionnaires identify possible distress or need for support.

Finally, intervention studies could evaluate whether media literacy programmes, content curation strategies, peer-support approaches, or other interventions improve wellbeing or reduce harmful comparison. Such interventions should be assessed directly rather than assumed to work from correlational evidence. Research should also examine potential benefits of social media, including social connection and access to supportive communities, so that recommendations do not reduce a complex environment to a simple harm narrative.

VII. CONCLUSION

In this sample of 80 adults aged 19-32, problematic social media use was positively associated with eating attitudes and body shape concerns, while eating attitudes were more strongly associated with body shape concerns. The BSMAS - EAT-26 association was less robust in sensitivity analysis, and only the gender group difference in BSQ-16A remained statistically significant after correction for multiple comparisons. Nineteen participants scored at or above the EAT-26 screening threshold, this is not a diagnosis or prevalence estimate. Because the design was cross-sectional and the sample may not be representative, the findings should be interpreted as associations within this sample rather than evidence of causal effects.

The study supports examining problematic social media use, eating attitudes, and body shape concerns as related but distinct domains. Future research with broader recruitment, longitudinal measurement, and more direct assessment of appearance focused content and social comparison is needed to clarify mechanisms and improve generalisability.

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APPENDICES

APPENDIX A. SCALE SCORING SUMMARY

- Bergen Social Media Addiction Scale (BSMAS): Six items rated on a 1–5 scale; items are summed for a total score of 6–30. Higher scores indicate greater endorsement of problematic-use symptoms. No diagnostic cutoff is applied in this study.
- Eating Attitudes Test–26 (EAT-26): Items 1–25 are scored Always = 3, Usually = 2, Often = 1, and Sometimes/Rarely/Never = 0. Item 26 is reverse-scored as Never = 3, Rarely = 2, Sometimes = 1, and Often/Usually/Always = 0. The 26 item scores are summed for a total score of 0–78. A score of 20 or higher is a screening/referral indicator and is not a diagnosis.
- Body Shape Questionnaire–16A (BSQ-16A): Sixteen items are scored from 1 (Never) to 6 (Always), producing a total score of 16–96. The descriptive bands used here are below 38, 38–51, 52–66, and above 66. They are not treated as diagnostic categories.

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APPENDIX B. STATISTICAL REPORTING NOTES

- Pearson correlations are reported with 95% confidence intervals and two-sided p values.
- Spearman rank correlations are sensitivity analyses for the associations among the scale totals.
- Welch independent-samples t tests are used for the two recorded gender groups.
- Holm adjustment is applied separately to the family of three correlations and the family of three group comparisons.
- Cohen's d is reported as a standardised effect-size estimate for group comparisons.
- Screening-threshold counts and descriptive score bands are not interpreted as diagnostic prevalence.

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APPENDIX C. STATISTICAL OUTPUT EXHIBITS AND REPRODUCIBILITY

The following exhibits present the study analyses in a conventional statistical-software output layout. Values were calculated from the participant-level dataset using the scoring rules and analysis procedures described in this manuscript. The exhibits are provided to support transparent review. Researchers can reproduce the analyses in IBM SPSS Statistics by implementing the stated scoring rules and checking the resulting output against the reported values.

- *C1. Descriptive Statistics*

Descriptive Statistics

Scale	N	Mean	SD	Minimum	Maximum
BSMAS total	80	17.73	5.32	6	29
EAT-26 total	80	13.48	9.50	1	43
BSQ-16A total	80	46.76	19.17	16	89

- *C2. Internal Consistency*

Reliability Statistics

Scale	Items	Cronbach alpha	N
BSMAS	6	.819	80
EAT-26	26	.809	80
BSQ-16A	16	.949	80

- *C3. Pearson Correlations and Multiplicity Adjustment*

Correlations (Pearson)

Variable pair	r	95% CI	p	Holm p
BSMAS – EAT-26	.271	[.054, .463]	.015	.030
BSMAS – BSQ-16A	.248	[.030, .444]	.026	.030
EAT-26 – BSQ-16A	.455	[.262, .614]	< .001	< .001

- *C4. Welch Group Comparisons*

Independent-Samples Comparisons (Welch)

Outcome	Female M (SD)	Male M (SD)	t (df)	p	Holm p
BSMAS	19.03 (4.33)	16.49 (5.90)	2.20 (73.33)	.031	.062
EAT-26	15.33 (9.96)	11.71 (8.80)	1.72 (75.73)	.089	.089
BSQ-16A	52.41 (18.53)	41.39 (18.41)	2.67 (77.75)	.009	.028