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## Contextual and Mediating Factors in Body Image Dissatisfaction

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CONTEXTUAL AND MEDIATING FACTORS IN BODY IMAGE  
DISSATISFACTION

by

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Bachelor of Arts, University of North Dakota, 2000  
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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

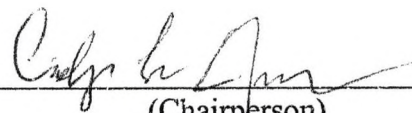
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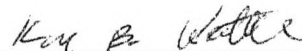
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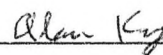
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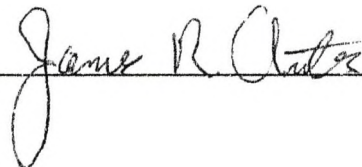


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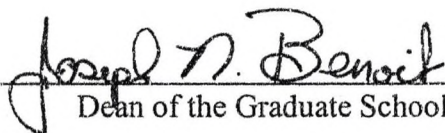


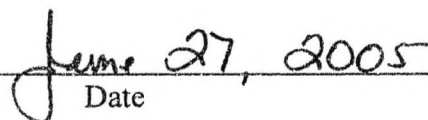






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God bless you all.

## ABSTRACT

The purpose of this study was to examine the specific nature of the interaction and contribution of variables related to body image in a nonclinical population using a path analysis. This paper discusses various theoretical models and variables in the development and maintenance of body image dissatisfaction and eating concerns. Several variables and personality traits have been suggested as etiological factors in the development of body image dissatisfaction. These variables stem from different theoretical models. The five theoretical models discussed are: (1) Developmental, (2) Social-comparison, (3), Self-discrepancy, (4) Self-objectification, and (5) Feminist theory. From these broad theoretical models, many variables are viewed as risk factors for developing and maintaining eating and body image concerns. Six of the more prominent variables are explored, including sociocultural influence, family environment, perfectionism, gender-role orientation, stress, and guilt/shame. My hypothesized path model consists of two contextual (exogenous) variables and five mediating (endogenous) variables. The two variables of family and media influences are hypothesized to be the strongest path variables to body image dissatisfaction. Therefore, the exogenous variables are hypothesized to have an effect on the mediating variables, but are not affected by the other variables.

To my mother for her kind heart and to my father for his great intelligence;  
both of which are necessary in this profession

## CHAPTER I

### INTRODUCTION

It is suggested that eating disorders are not simply disorders of eating, but are also disorders in body satisfaction and physical appearance (Rosen, Reiter, & Orosan, 1995). Not only is body image concern one of the essential features of eating disorders (Rosen, 1996), but it is also believed to be one of the leading causes of eating disorders (Rosen, 1997). For example, body image research has examined the subjective perceptions of, and attitudes towards, the size and shape of one's body and have found that body dissatisfaction (even after controlling for weight) is one of the strongest predictors of disordered eating in clinical and nonclinical populations (Davis, Claridge, & Fox, 2000).

Rosen (1997) points out that other variables, such as psychopathology, stress, and family dysfunction are associated with eating disorder symptoms concurrently, but add less to the prediction of eating disorders over time and after body image is controlled. Additionally, research suggests that body image concern may be one of the first symptoms in the development of an eating disorder, and may be one of the last symptoms to improve with treatment (Stewart & Williamson, 2003). Furthermore, Rosen et al. (1995) found that body image appears to be the most consistent predictor of recovery and relapse rates in eating disorders. For example, follow-up studies of eating disordered patients who restored their body weight and "recovered" from their eating disorder, showed that up to two thirds of those success cases were still dissatisfied and worried



excessively about their body shape (Rosen, 1996). Given this, it is no wonder why Bruch (1962) considered body image dissatisfaction the most important feature of an eating disorder, stating that successful treatment of the eating disorder without a corrective change in the body image would likely be short lived.

It is an overstatement to conclude that any person with a high level of body dissatisfaction will necessarily develop an eating disorder. However, the above information suggests that clinicians should be cognizant of the role of such body image problems as a possible precursor for eating disorders among women (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999).

This paper focuses exclusively on the female population in regards to body image dissatisfaction. Hilde Bruch (1962), as cited by Hsu and Sobkiewicz (1991), was the first to suggest that there is a disturbance of body image among women with eating disorders. It is now widely recognized that body image dissatisfaction is pervasive among all Euro-American women, not only women with eating disorders (Walszon, 1998). Rodin, Silberstein, and Striegel-Moore (1985) reported that merely being a woman in our society means feeling too fat. This trend is observed with great alarm by many social critics, who observe that women act as if they believe that the shape of their lives depends on the shape of their bodies (Seid, 1994). For example, Silberstein, Striegel-Moore, and Rodin (1987) state that women commonly report a fantasy that their lives would be totally transformed if only they were thin; having thinness and happiness becoming nearly synonymous.

It is well documented that being attractive matters far more in the life of a woman than of a man in our society (Silberstein et al., 1987). This was demonstrated in a report

by Rabak-Wagener, Eickhoff-Shemek, and Kelly-Vance (1998), who found that as many as two-thirds of young women experience significant dissatisfaction with their body size and shape, as compared to one-third of young men. Several reasons have been proposed for this apparent discrepancy.

One reason is due to the extreme gender discrepancies psychologists have recognized in appearance norms in our culture (Walszon, 1998). Whereas men are held to a standard of a moderate, muscular build that generally matches the actual size and shape of the average man, women are compared to a cultural ideal that has thinned beyond belief (Walszon, 1998). Additionally, women are rewarded in various ways for attractiveness, reaping the benefits of an attractive appearance in the interpersonal marketplace and in the occupational world (Rodin et al., 1985). It is not surprising then, that women strive zealously to achieve the slim appearance deemed attractive by today's standards (Silberstein et al., 1987).

Another possible reason for the gender discrepancy among body image dissatisfaction is that the different genders are reinforced for different attributes. For example, evidence indicates that in general, girls are praised more for physical appearance and boys for physical functioning such as athletic skills (Striegel-Moore & Kearney-Cooke, 1994). Therefore, if this is taken one step further and we assume that physically attractive girls are even more likely to be complimented on their appearance than less attractive girls, then the former may learn to overvalue their physical attributes, and consequently invest a greater degree of their overall self-worth in matters related to their appearance (Davis et al., 2000).



On the other hand, some studies have found no gender differences in body attitudes (Wilcox, 1997), which may relate to a recent increase in body image dissatisfaction in males (Cash, 1997). However, there are still differences in the nature of the body dissatisfaction. Men who are dissatisfied with body image, report wanting to be more muscular (Muth & Cash, 1997), whereas the majority of women desire to be more thin (Green & Pritchard, 2003). Given the above information and the preponderance of body image literature focusing on the female population, this paper will concentrate on adding unique and valuable insight to the existing literature on female body image dissatisfaction.

Preventing any disorder or symptom involves identifying the pathogenic factors that put individuals at risk for developing such a disorder. In the case of eating disorders, there are a variety of variables that have been identified as possible factors in the development of a negative body image, and thus, an eating disorder. These variables include, but are not limited to, prior or concurrent psychopathology, family dysfunction, developmental issues, difficulties meeting the responsibilities of the female role in society, the cultural emphasis upon thinness, and perfectionism (Heilbrun, Jr. & Putter, 1986; Heinberg, 1996). However, Thompson et al. (1999) suggest it is not enough to simply focus on these overt influences, but that clinicians must also acknowledge the more subtle forms of influence through a variety of behaviors. Examples given in this article include interpersonal influences, such as evaluating the attractiveness of others or gossiping about someone's weight as a subtle way of communicating the importance placed on looks and create or exacerbate body image concern. Despite the importance of

these factors, one study found that these variables add less to the prediction of eating disorders after controlling for body image (Rosen, 1996).

While studying body image in the disordered eating population, many authors have used nonclinical females as a control group (Damani, Button, & Reveley, 2001; Frank, 1991; Haworth-Hoepfner, 2000; Rosen et al., 1995; Sharpe, Ryst, Hinshaw, & Steiner, 1997; and Troop, Holbrey, & Treasure, 1998). While analyses did not find the same significance of body dissatisfaction between control groups and the eating disordered population, almost all analyses have found that nonclinical females do also demonstrate a negative body image (Damani et al., 2001; Rosen et al., 1995; & Troop et al., 1998). However, these results have never been expanded upon, with prior studies concentrating their focus on the pathological group. Given these findings, I posit that body image disturbances have been overlooked and insufficiently examined in the nonclinical population. The goal of this paper is to concentrate on this group, particularly a female nonclinical group, and to assess potential theories of the development of a negative body image within this population. I propose that the factors that contribute to body image dissatisfaction in a clinical population are the same as those in a nonclinical population. Subsequently, the following review of literature comes from research with a clinical population, setting up the justification for my hypothesized path variables to compare their degree of influence with a nonclinical population. If results prove to be consistent between the nonclinical population in this study and the clinical populations in prior studies, then this study would suggest that the nonclinical population should no longer be overlooked in body image research. This is important given the possible



implications that could result from body image concerns, such as the eventual development of an eating disorder or other pathology.

Even with all the attention that is placed on individual factors of body image concern, little is known about the widespread group of females who admit to dissatisfaction over their perceived body image. This should no longer be the case. Given that the literature suggests that body image concern is one of the greatest predictors in the development of eating disorders, those who report dissatisfaction over body image should be given attention to help prevent those who may go on to develop an eating disorder.

## CHAPTER II

### LITERATURE REVIEW

In relation to the purpose of this paper, the following review of literature will first introduce the construct of body image, followed by different theoretical models of body image dissatisfaction and eating disordered behavior. In addition, six variables that are reviewed within these various models as risk factors for the development of such concerns will be examined.

#### Body Image

Body image can be a source of pride or a source of great pain and dissatisfaction that is very vulnerable to outside feedback, such as a flirtatious whistle or a critical comment about our body size and shape (McFarland & Baker-Baumann, 1990). While body image concern has historically been ascribed to eating-disordered individuals, recent evidence indicates its association with eating disturbance and distress in non-eating disordered samples (Cash & Pruzinsky, 1990; Thompson, 1990). For example, the recent surge of interest in body image disturbance was fueled by findings in the mid-1980's of a high degree of subjective appearance dissatisfaction in non-eating-disordered individuals (Cash, Winstead, & Janda, 1986; Thompson & Thompson, 1986). To understand this disturbance, it is essential to look first at the different ways body image is defined.

### *Definitions and Conceptualization of Body Image*

Body image has been examined in the literature in different ways. Hsu and Sobkiewicz (1991) defined body image in two different ways. These definitions stem from a cognitive standpoint or a psychological standpoint. Cognitively speaking, body image is defined as a body schema. That is, a dramatic representation of the body in one's own consciousness. Psychologically speaking, body image is defined in terms of feelings and attitudes towards one's body (Hsu & Sobkiewicz, 1991). Raich, Soler, and Mora (1995) refer to body image as the way in which people view their physical self. Additionally, body image has been defined as a mental representation or internal picture people have of their physical body, which can be positive and accurate or can be negative, critical, and vague (McFarland & Baker-Baumann, 1990). In addition, there is some disagreement in the literature regarding whether body image is a static, unchangeable entity, or if it is malleable, subject to a variety of influences, with recent research suggesting it is just as much of a state dimension as it is trait (Altabe & Thompson, 1995).

Body image is believed by many theorists to be a multifaceted construct (Szymanski & Cash, 1995; Usmiani & Daniluk, 1997). For example, Raich et al. (1995) subdivided body image into three facets: 1) a perceptual component, which is one's estimation of his or her body size, 2) a subjective component resulting in body satisfaction or concern, and 3) a behavioral component, such as the avoidance of situations that cause the individual to experience physical appearance-related discomfort. Thompson et al. (1999) took this multifaceted construct a step further, suggesting four facets, including affective (i.e. being upset or distressed about one's appearance),



cognitive (i.e. unrealistic expectations for appearance), behavioral (i.e. avoidance of situations that elicit body image scrutiny), and perceptual features (i.e. estimation of one's body size). Finally, Gardner and Tockerman (1992) broke body image into two components, perceptual and attitudinal. The perceptual aspect describes the amount of distortion resulting from inaccurately estimating body size, whereas the attitudinal component reflects the level of satisfaction or dissatisfaction felt toward one's body or specific body parts (Gardner & Tockerman, 1992). As a result of body image being multifaceted, there are several types of disturbances that can be developed in regards to body image. The severity of these disturbances however, can vary greatly.

To understand an individual's level of body image disturbance, Thompson et al. (1999) proposed that body image be conceptualized as a continuum, with levels of disturbance ranging from none to extreme. At the highest end of the disturbance continuum, one is likely to find a body image disturbance so severe it will be associated with significant impairment in social and/or occupation functioning, which is indicative of an eating disorder. The low range of the continuum is proposed to conceivably be beneficial, leading to a healthy lifestyle of exercise and eating behaviors. However, Thompson et al. (1999) believe most people fall near the middle of the range, experiencing mild-moderate concern, distress, or dissatisfaction with their bodies. Cash (1996) also agrees with the continuum conceptualization, stating that body image can range from relatively benign discontent with some physical feature, to an obsessive, perhaps delusional, conviction that one's physical appearance is grotesque. Regardless of the level of body image disturbance, there are two main types of disturbance that can be formed: body image distortion and dissatisfaction.

### *Body Image Distortion*

Body image distortion is the overestimation of body width measurement, and is believed by some to be a unique characteristic for those individuals suffering from an eating disorder. However, over the past two to three decades, research has begun to show that body image distortion also occurs in non-eating disordered female controls (Crisp & Kalucy, 1974; Button, Fransella, & Slade, 1977; Strober, Goldenberg, Green, & Saxon, 1979). Birtchnell, Dolan, and Lacey (1987) further demonstrated that body image distortion is not limited to women suffering from eating disorders, but is also found in women with no current or previous history of an eating disorder who were at a normal body weight. Furthermore, many studies suggest that body size overestimation is a common phenomenon in the young female population and should not be considered unique to eating disorders (Button et al., 1977; Birtchnell et al., 1987).

### *Body Image Dissatisfaction*

Whereas body image distortion is a misrepresentation one sees while viewing his/her body shape, body image dissatisfaction can be defined as the feeling of being displeased or unsatisfied with the way one looks, regardless of actual shape or size. It is recognized that dissatisfaction with body shape and size is common among adolescent girls and women (Damani et al., 2001). In fact, this is believed to be such a common experience, that the dissatisfaction women feel with their appearance is referred to by some as a “normative discontent” (Rodin et al., 1985). This phrase has often been repeated to capture the essence of body image disturbance so prevalent among women that it should be considered a normal part of their life experience (Thompson et al.,



1999). However, Thompson et al. (1999) point out that normative should not be considered synonymous with benign.

Body image dissatisfaction is reported in a variety of forms. Some of the most common complaints being: feeling too fat in the stomach, thighs, buttocks, hips, or upper arms, concerns about a less proportioned or curvaceous physique, desire to have larger breasts, feeling too tall or short, and excessive worry over facial features, scars, and other skin blemishes (Garner & Garfinkel, 1997).

While there are conflicting results in the literature regarding the relationship between body image distortion and dissatisfaction, a majority of authors have argued that the correlation between the two constructs is negligible (Cash & Green, 1986; Keeton, Cash, & Brown, 1990; Mable, Balance, & Galgan, 1986), further suggesting that body image embodies different dimensions. For example, Mable et al. (1986) demonstrated that body image distortion was related primarily to gender and gender-role, whereas body image dissatisfaction was influenced by variables such as depression and self-esteem. Therefore, the authors concluded that because different sets of variables were associated with body image distortion and body image dissatisfaction, the two constructs are two different aspects of body image disturbance.

On the other hand, Gardner and Tockerman (1992) did demonstrate a relationship between body satisfaction and body size judgments; however, the correlations varied depending on the body regions and between men and women. Because these two constructs appear to be minimally related, some authors have suggested they play different roles. For example, body dissatisfaction is believed to be a predictor of eating disorder development, whereas body image distortion may be associated with

maintenance factors such as treatment response and relapse (Cash & Brown, 1987; Gardner & Tockerman, 1992). Given this statement and the fact that the preponderance of evidence suggests a minimal relationship between body image distortion and dissatisfaction, and the fact that this paper is taking a preventative stance on eating disorders, body image dissatisfaction will be the primary focus of this paper.

In summary, there is no easy explanation of the phenomenon of body image concern, such as dissatisfaction and distortion. While difficult to define clearly, there is agreement in the literature that body image is multidimensional and complex, involving a variety of internal and external factors (Usmiani & Daniluk, 1997). Specifically, fear of fatness, weight phobia, or pursuit of thinness has been studied extensively in the realm of body image and eating disorders (Damani et al., 2001; Hsu & Sobkiewicz, 1991; Hawort-Hoepfner, 2000; Jarry, 1998; Rosen, 1996; Rosen et al., 1995; and Thompson & Heinberg, 1999). Many different theories regarding this phenomenon have been suggested and empirically tested with the aim of gaining a better understanding. Competing explanations of the different risk factors associated with the development and maintenance of body image concerns has emerged from this research. Risk factors here refer to personality, attitudinal, biological, family, culture, and other variables within or impinging on the individual. In cross-sectional studies, these variables have been evaluated as concurrent predictors of dissatisfaction and distortion in body image, while in prospective studies, identified as precursors or predictors of such future concerns (Leon, Keel, Klump, & Fulkerson, 1997).

Despite the research that has already been done, a comprehensive review of different variables, personality traits, and theoretical models regarding body image



dissatisfaction has not been conducted. Having this knowledge would be useful for practitioners to work from a preventative standpoint regarding body image concerns and the development of eating disorders. For example, dieting and body image concerns are high base rate behaviors that do not uniquely specify who among the 63 to 70 percent of girls reporting each behavior will develop eating disorders (Leon et al., 1997). Furthermore, Leon et al. (1997) state that understanding the underlying factors that contribute to body image concerns will better identify who is at risk for the later development of an eating disorder. This information would be valuable in understanding the etiology of eating disorders, developing primary prevention programs that focus on vulnerable groups, and improving treatment procedures and short and long term outcome.

Following are five theoretical models, and six variables and/or personality traits that stem from these models, that are viewed as being internal and external risk factors for an individual to develop body image dissatisfaction. The five theoretical models that will be explored are developmental, social-comparison, self-discrepancy, self-objectification, and feminist theories. The six factors discussed are sociocultural influences, family environment, perfectionism, gender-role identity, stress, and guilt/shame. It should be acknowledged that there is a good deal of overlap between many of these six factors; these are not independent variables. Therefore, when discussing each factor, other variables may be introduced as well to demonstrate various interactions.



## *Theoretical Models and Empirical Investigation of Body Image Dissatisfaction*

### *Developmental Theory*

Developmental theories focus on the important role of childhood and adolescent development in later body image disturbance, with factors including puberty and maturational timing, negative verbal commentary and teasing, and early sexual abuse or sexualization (Heinberg, 1996). Furthermore, developmental psychologists have discovered that body image takes shape as preschoolers internalize the messages and physical standards of society and then judge themselves against them (Lerner & Jovanovic, 1990). In this way, children develop conceptions of what is good (how one should look) and what is bad (how one should not look) with respect to height, weight, muscularity, hair color, and even brand name of clothing (Cash & Grant, 1996).

The work of Carol Gilligan and her colleagues (Gilligan, 1990; Brown & Gilligan, 1992) was influential in suggesting that early adolescence is a critical stage in the development of girls in our society. Given that pubertal changes are an important factor during this period, and that the preoccupation and obsession with appearance begins to bloom in girls during early adolescence, this period could be considered a critical phase for the development of body attitudes (Frank, 1999). For example, high levels of body dissatisfaction in the early pubertal periods are likely to predispose the female adolescent to develop eating problems during middle or later adolescence (Attie & Brooks-Gunn, 1989).

Puberty and the beginning of menses have been identified as a pivotal event around which the adolescent girl's body image and sexual identification also come to be recognized (Usmiani & Daniluk, 1997). During puberty the young girl's attention turns to

her developing body and the distinction between maleness and femaleness becomes more apparent (Rierdan & Koff, 1985). Some theorists suggest that this developmental transition in the female life cycle produces a sense of discontinuity in a girl's psychological self-structure, requiring reorganization and reintegration of these changes in terms of her gender role identity and body image (Attie & Brooks-Gunn, 1989). The reorganization of a girl's body image at this stage in development appears to be in the direction of greater feminine differentiation and sexual maturity (Golub, 1992).

The sexual maturity changes that often accompany puberty in adolescent girls can in some instances prove harmful and damaging in terms of how one feels about her body. For instance, girls whose breasts and hips develop earlier than those of their peers may receive unwanted attention and become self-conscious; rather than welcoming their new shape as a sign of emergent womanhood, many girls view it as unappealing fat (Cash & Grant, 1996). Additionally, research has confirmed that post-menarcheal girls in particular are extremely conscious of their changing bodies and roles, and frequently report dissatisfaction with their appearance (Usmiani & Daniluk, 1997).

In addition to sexual maturation and menses, gender roles are also intensified at puberty, as evidenced by increased attempts for pubertal girls to differentiate themselves from boys in appearance (Usmiani & Daniluk, 1997). Therefore, the development of gender role identity appears to include the crucial task of integrating physical changes with societal expectations of gender appropriate behavior and appearance (Bem, 1981), expectations that become more acute at this important juncture in a girl's development (Usmiani & Daniluk, 1997). As a result of these influences in puberty, adolescent females



are more likely to report less body satisfaction and place more importance on their bodies than adolescent males (McCabe & Ricciardelli, 2001).

### *Social-comparison Theory*

Social comparison theory (Festinger, 1954) suggests that information regarding oneself and the evaluation of one's own abilities and attitudes is based on comparison with perceptions of other people (Heinberg, 1996; Shaw & Waller, 1995). While the original formulation of this theory dealt with the effects of direct comparison, comparisons may also be made with individuals where there is only indirect contact (Richins, 1991), such as models used in the media (Shaw & Waller, 1995). Research maintains that a tendency to compare one's physical appearance to others (such as figures in the media), seems to be related strongly to body dissatisfaction (Striegel-Moore, McAvay, & Rodin, 1986). If it is the case that women are encouraged to use media images as a reference point when evaluating their own body, then the use of an ideal body shape (that is, one that is unattainable by the vast majority of the population) is likely to make women more dissatisfied with their own body image (Shaw & Waller, 1995).

Richins (1991) demonstrated evidence that this social comparison process is indeed a factor in the development of body image disturbance. For example, Richins (1991) found that young women reported comparing themselves with the images of women used in the media, and those comparisons led the women to be less satisfied with their own appearance. The frequency in which one compares herself is also a factor. If the frequency of comparing reaches high levels, to the point at which an individual is unable to look at other people without focusing on her own appearance, body image and

eating concerns are more likely to develop (Rosen, 1997). Unfortunately, the individual often selectively focuses on people who are more perfect looking than she is, rather than comparing herself to a normal range of people (Rosen, 1997).

An interesting aspect of the social comparison process was demonstrated by Waller, Shaw, Hamilton, Baldwin, Harding, and Sumner (1994). These authors found that women's body image was only affected when they saw whole-body pictures of models in the media (i.e. when they could compare bodily shape), and that no such effect was found in viewing head-only shots (Waller et al., 1994).

### *Self-discrepancy Theory*

Another theoretical perspective that appears useful in the study of body image is Higgins's self-discrepancy theory (Higgins, 1987). This theory distinguishes among three domains of the self (actual, ideal, and ought selves) and two standpoints on the self (own and significant other). According to the self-discrepancy theory, one's motivation is to attain congruity between one's actual self-concept and one's relevant self-guides (i.e. internalized ideal and ought selves) (Szymanski & Cash, 1995). Discrepancies between the actual self and these self-guides give rise to a range of negative psychological states, such as dejection, agitation, and dissatisfaction with one's body (Higgins, 1987).

The difference between the social-comparison theory and the self-discrepancy theory is that in the social-comparison theory, one is comparing herself to an actual figure that is represented visually. On the other hand, the self-discrepancy theory focuses on an individual's tendency to compare her perceived appearance with her own imagined and internalized ideal (Thompson, 1992). The result of such a comparison is similar to the social comparison theory in that a discrepancy between the perceived self and the ideal



self may lead to dissatisfaction, assuming that the greater the discrepancy between one's perceived self and one's perceived ideal, the greater the dissatisfaction (Heinberg, 1996). Cash and Pruzinsky (1990) believe that these self-ideal discrepancies are a principal determinant of body image dissatisfaction.

Of particular interest is the finding that women report both ideal and ought discrepancies that are greater from their own point of view than from a significant other's perceived point of view (Szymanski & Cash, 1995). For instance, evidence attests to distorted beliefs about what a significant other truly finds most attractive, such that others' expectations and standards for attractiveness are seldom as extremely or stringently held when compared to one's own (Cash & Grant, 1996). For example, men are often more appreciative of a heavier female body type than women believe men are, nor do men idealize blonde beauty and large breasts to the degree women think (Cash & Grant, 1996). Furthermore, self-ideal discrepancies exceed self-ought discrepancies, but only from the individual's own standpoint (Szymanski & Cash, 1995).

Given this information, personal ideals appear to carry more weight in body image evaluations than do perceived others' ideals. In terms of body image dissatisfaction, assessing the significant other standpoint does not augment prediction beyond the consideration of one's own standpoint (Szymanski & Cash, 1995). Cash (1994) developed a perspective that suggests why this is. Cash (1994) states that specific contextual events serve to activate schema-driven processing of information about, and self-appraisals of one's body appearance. The activating events typically involve body exposure, social scrutiny, social comparisons, wearing certain clothing, looking in the mirror, eating, weighing, exercising, or some unwanted change in one's appearance

(Cash & Grant, 1996). These self-evaluations then draw on existing body image attitudes and discrepancies between self-perceived and self-idealized physical characteristics (Cash & Grant, 1996).

The social-comparison and self-discrepancy theories are the two theories that have the most treatment implications associated with them. Under these theories, schemas and cognitions are often discussed, which are two of the more popular treatment approaches when working with body image and eating disorders. As a result, schema therapy and cognitive-behavioral therapy will be discussed next before moving onto self-objectification theory.

*Schema therapy.* Kearney-Cooke and Striegel-Moore (1997) have found it useful to apply the construct of schemas to their work with women who experience body image disturbance, thus forming a negative body image schema. Once a negative body image schema is formed, it serves a powerful maintenance function for body image problems because the schema determines what is noticed, attended to, and remembered about experiences (Padesky, 1994). As a result, once formed, this schema is maintained in the face of contradictory evidence through processes of not noticing, distorting, and discounting contradictory information regarding one's body image (Beck, Freeman, Pretzer, Davis, Fleming, Ottavani, Beck, Simon, Padesky, Meyer, & Trexler, 1990). This makes changing one's body image extremely difficult.

One tool that is used to help clients develop alternative body schemas is guided imagery. This involves first having clients re-evaluate their body schemas in the developmental contexts in which they originated (i.e. imaging the scene that evoked the negative body image schema, the emotions experienced, beliefs activated, and behavior



elicited) (Kearney-Cooke & Striegel-Moore, 1997). This can help clients begin to rework and develop alternative schemas. Clients can then work on strengthening these alternative, more adaptive schemas of their bodies by creating a new script in which they are surrounded by more compassionate figures (rather than those who evoked the negative schema in childhood) and letting go of negative images (Kearney-Cooke & Striegel-Moore, 1997).

Kearney-Cooke and Striegel-Moore (1997) stress the importance of not only working through historical material related to body hatred, but also developing and strengthening alternative, more adaptive body schemas. These schemas must be developed in order for clients to be able to take in more positive feedback about their bodies (Kearney-Cooke & Striegel-Moore, 1997).

*Cognitive-behavioral therapy.* As mentioned prior, cognitive-behavioral interventions for treating body image issues are the most empirically documented approach (Cash, 1996) and dominates the scientific literature (Hutchinson, 1994). Cognitive-behavioral treatments are thought to be the treatment of choice by many leading researchers (Butters & Cash, 1987; Freedman, 1990). From the cognitive perspective, body image disturbance results from irrational thoughts and unrealistic or faulty expectations (Walszon, 1998). These cognitive errors then lead to emotional and behavioral responses (i.e. dieting), leading to the use of behavioral techniques to correct these faulty underlying belief structures (Hutchinson, 1994). Behavioral and cognitive strategies used in the cognitive-behavioral approach will be examined.

Therapy for eating disordered individuals requires a detailed behavioral assessment in order to pinpoint the dysfunctional attitudes and the situations in which

they occur (Rosen, 1997). One technique to aid in this is having clients use a self-monitoring diary to record situations that provoke self-consciousness about their appearance, positive or negative, body image thoughts or beliefs, and the effects of these on their mood and behavior (Rosen, 1997).

One behavioral consequence of suffering from a poor body image is continuous checking and grooming behavior. Therefore, behavioral techniques often focus on decreasing such actions, usually by means of self-management strategies (Rosen, 1997). Examples of such strategies include reducing the frequency of weighing, covering or taking away mirrors, setting a fixed time for dressing, and so forth, that are then recorded in a body image self-monitoring diary to help identify cues that trigger these checking behaviors and incorporate this into the behavior change plan (Rosen, 1997). Behavioral self-control strategies should be sure to suit the client's particular habit (e.g. not buy fashion magazines) (Rosen, 1997).

Cognitive factors are also presumed to be part of body image due to the definition that body image is a subjective view of one's body, which implies cognition (Altabe & Thompson, 1995). From a cognitive perspective, Altabe and Thompson (1995) believe it would be useful for therapists to investigate what cognitions occur when individuals encounter body image relevant information, stating this would provide insight into the nature of one's body image. Therefore, one could have a better understanding of how they respond to daily events, and clinically, it would likely lead to improvements in monitoring symptoms and pinpointing useful interventions (Altabe & Thompson, 1995).

Cognitive restructuring is one of the most common cognitive interventions used in treating this population. Cognitive restructuring encourages clients to evaluate the



evidence for and against the beliefs they hold regarding their bodies; the evidence rather than the belief itself is questioned, at least in the beginning (Rosen, 1997). This is a useful intervention due to the fact that these clients (due to distorted cognitive processes) typically overlook or refuse any feedback that is discrepant from their negative body image (Rosen, 1997). Because other people can be more objective, and usually more positive, about a client's appearance, it is desirable for the client to attend to such information and incorporate it into her self-image, thus beginning to restructure her thought processes (Rosen, 1997).

Rosen (1997) also states that intervening with negative body talk is useful in correcting negative body images. To achieve this, clients are asked to replace or distract herself from negative body talk and construe more objective and neutral self-descriptions that are free of emotionally loaded self-criticism (Rosen, 1997). Clients are asked to practice this neutral self-talk whenever she is reminded to do so by the sight of a particular body part or by intrusive negative body talk, the point being to distract herself from repeating self-criticism over and over or stop the thoughts all together (Rosen, 1997).

Cash and J.C. Rosen are believed to be the two leading figures in the development of cognitive-behavioral strategies (Thompson et al., 1999). Their respective programs have extensive empirical evaluation and support and should be considered as a treatment option for a wide variety of clinical populations for which body image problems are relevant (Thompson et al., 1999).

Cash's (1995) program consists of eight steps that include: (1) a comprehensive body image assessment, (2) body image education, (3) body image exposure and

desensitization, (4) identifying and questioning appearance assumptions, (5) discovering and correcting cognitive errors, (6) modifying self-defeating body image behaviors, (7) body image enhancement with pleasure activities, and (8) relapse prevention and maintenance of body image changes. These eight steps are offered in a cognitive-behavioral program when working with individuals who have eating and body image concerns.

Rosen (1996) stressed the importance of psychoeducation, cognitive restructuring, and self-monitoring (as discussed above). Rosen places greater emphasis on behavioral procedures to combat avoidance of situations that cue body image distress, as well as to reduce behaviors related to inspecting and checking one's appearance (Thompson et al., 1999).

Butters and Cash (1987) also developed a cognitive-behavioral body image treatment program that is multimodal in nature. This program consists of such components as relaxation training, imaginal desensitization, in vivo desensitization, cognitive restructuring, stress inoculation, and relapse prevention strategies.

Over time, researchers have demonstrated the efficacy of cognitive-behavioral therapy approaches for aiding in the improvement of body image concern (Butters & Cash, 1987; Fisher & Thompson, 1994). However, the clinical significance of the observed body image improvements is seldom examined (Cash & Grant, 1996). A statistically significant improvement by no means yields a functionally normal or adaptive body image (Grant & Cash, 1995). For example, Rosen (1990) argues that treatment studies often focus too much on eating behavioral changes as the defining

criteria for improvement; however, such behavioral changes are not necessarily indicative of body image change (Cash & Grant, 1996).

Furthermore, Hutchinson (1994) found cognitive-behavioral techniques to be useful only in an adjunctive capacity with clients who have mild body image issues. With few exceptions (Freedman, 1990), these techniques are believed to fail in addressing cases where body image dissatisfaction is entrenched in the identity of an individual and continually reinforced by social values (Hutchinson, 1994).

Due to some of these conclusions, Freedman (1990) strongly recommended that cognitive-behavioral treatment for body image issues include feminist insights. For example, Freedman (1990) states that cognitive-behavioral therapy should include undoing the irrational nature of society's expectations and teaching clients to develop behavior that is competent, autonomous, and directed towards self-development (Walszon, 1998). Feminist therapy will be discussed in detail later in this paper under the feminist theory section, but first, our attention is turned to the self-objectification theory.

### *Self-objectification Theory*

The self-objectification theory is an attempt to provide a sociocultural analysis of the origins of body dissatisfaction, recasting the focus toward cultural practices of sexually objectifying the female body (Noll & Fredrickson, 1998). According to objectification theory, the first psychological consequence is that women are socialized to view and treat themselves as objects, becoming preoccupied with their own physical appearance, an effect Fredrickson and Roberts (1997) termed self-objectification (Noll & Fredrickson, 1998). According to Noll and Fredrickson (1998), self-objectification is defined as valuing one's own body more from a third-person perspective, focusing on



observable body attributes (e.g. How do I look?), rather than from a first-person perspective that focuses on nonobservable body attributes (e.g. What am I capable of?), and that incorporating this third-person perspective can be a costly view of oneself.

Objectification theory asserts that it is our culture that socializes girls and women to adopt this third-person perspective on their own bodies, and that this self-objectification has important consequences for women's emotional experiences, which over time, may contribute to women's disproportionate risks for a broad range of psychological disorders, including eating disorders (Fredrickson & Roberts, 1997).

Objectification theory also proposes that self-objectification creates increased opportunities to experience shame, especially shame about one's body, due to the increased likelihood for women to evaluate themselves relative to internalized or cultural ideals, and often failing to meet these ideals (Noll & Fredrickson, 1998). Based on this reasoning, objectification theory posits that body shame can motivate dieting and binge-purge cycles that may be linked to women's increased risk for anorexia nervosa and bulimia nervosa (Fredrickson & Roberts, 1997).

### *Feminist Theory*

Our primary culture today is patriarchal in focus, which has led to the elevation of the stereotypical masculine traits to a superior position and downgrading feminine traits as inferior and subordinate (McFarland & Baker-Baumann, 1990). The result of this socialization of females in a patriarchal culture leads women to value themselves in terms of their bodies, as objects of love, as child bearers, as nurturers, and as ornaments for men (Hutchinson, 1994). These powerful messages that are repeated throughout one's development, teaches women that a successful life means to please, to be in a

relationship, to be chosen, and to belong, and that the success and failure in accomplishing these goals is determined by the appearance of one's body (Hutchinson, 1994). The feminist theory argues that this socialization process for women emphasizes ignoring personal needs, serving others, and the notion that women have to sacrifice relationships in order to pursue their own development, must be modified (Shisslak & Crago, 1994).

As our culture has become more civilized, the devaluing of the feminine has become more sophisticated in that it is hidden in our standards for beauty and appearance, the female body and role expectations, as well as in our economic, legal, and educational institutions (McFarland & Baker-Baumann, 1990). Therefore, according to the feminist theory, society continues to exert control over the female body in order to keep women in a "one down" position (McFarland & Baker-Baumann, 1990). McFarland and Baker-Baumann (1990) posit that consumerism is the main way of controlling the female body by constantly telling women that they need to look a certain way in order to be acceptable; therefore, as long as women are focused on the beautification of their bodies, they continue to accept the culture's denigration of the natural female body.

Part of the experience of being a woman involves being treated as a sexual object; a body to be looked at and evaluated (Noll & Fredrickson, 1998). Increasingly, feminist theorists have been exploring the profound negative consequences of our culture's pervasive practice of sexually objectifying women's bodies (e.g. Fredrickson & Roberts, 1997; Kashak, 1992). For example, feminists assert that an important aspect of a woman's social learning is the equating of physical attractiveness with self-esteem, and that in general, women have over-identified with their bodies and that a woman's sense



of self-worth often is contingent on conforming to the prevailing norms for thinness and attractiveness (Striegel-Moore & Marcus, 1995). As a result, low self-esteem and self-worth are likely to develop, despite personal accomplishments that are achieved beyond one's physical appearance.

The conflict between traditional and nontraditional female roles is another factor that has been blamed by feminine theorists for the recent increase in body image and eating disorder concerns. For instance, women may become fearful and anxious in pursuing nontraditional feminine roles, due to the inadequate support for these women (Shisslak & Crago, 1994). The feminist theory argues that this thinking can be restructured by helping women to acknowledge, accept, and feel comfortable with their power, despite the negative reaction they may get from men and other females who believe that women who act for themselves deprive and hurt others (Shisslak & Crago, 1994). This empowerment is one step towards women accepting themselves despite what role they choose and what their physical bodies look like. Working toward increasing a women's empowerment is also a key role in the treatment of body image concern and eating disorder symptomology; therefore, we now turn our attention to treatment issues under the feminist approach.

*Feminist therapy.* Feminist treatment can be differentiated from cognitive-behavioral techniques in three primary ways. First, the feminist literature criticizes approaches that focus on treating body image problems by changing a woman's appearance (e.g. diet and exercise) (Thompson et al., 1999). Hutchinson (1994) points out there is a shortage of approaches to help women accept their bodies as they are, and a plethora of programs directed at changing the body. Much of the treatment literature



states, “change your body and it will change your life;” however, feminists argue that it is not necessarily the body that needs to change, but the body image (Hutchinson, 1994).

Second, feminist authors have different assumptions regarding psychotherapy, typically shunning the traditional hierarchical doctor-patient relationship because of the belief that it only reinforces women’s sense of dependency and helplessness (Thompson et al., 1999). Instead, feminist therapy relies on an egalitarian relationship characterized by therapist self-disclosure, greater informality and nurturance, and patient advocacy (Wooley, 1995). Finally, feminist interventions focus on different etiological factors that play a role in the development of body image disturbance, namely the role of sexual abuse in the later development of body image dissatisfaction and shame (Thompson et al., 1999).

In developing prevention programs for eating disorders and body image issues, therapists need to recognize that our current society may have a vested interest in promoting rather than preventing these disorders and concerns (Shisslak & Crago, 1994). For instance, Wolf (1991) maintains that the current emphasis on thinness is a direct solution to the dangers posed by the women’s movement. Chronic dieting leads to passivity, anxiety, emotionality, and low self-esteem; these Wolf (1991) contends are traits that the dominant culture wants to create in women in order to cancel out opposite traits that the women’s movement has begun to instill, such as courage, self-esteem, and a sense of effectiveness (Shisslak & Crago, 1994).

Shisslak and Crago (1994) state that the feminist approach typically entails challenging the current beauty myth, looking at sex role conflicts, and empowering women. Feminist programs should explore ways in which current society and the power

of the mass media promote the beauty myth, which is psychologically restrictive and/or physically unhealthy (Shisslak & Crago, 1994). Therefore, one intervention in this approach would be to include a segment on the images of women presented by the media and the effect of these images on women's physical and mental health (Shisslak & Crago, 1994). This is important because one goal of a feminist treatment approach is to allow women to make peace with their bodies, which first requires positive physical and mental health.

The above information demonstrates why Hutchinson (1994) points out that making peace with their bodies involves women identifying the obstacles to positive feelings towards their bodies, such as the way they have internalized the treatment and judgments of significant others, the body shame that they have taken on from family role models, and the tyranny of the internalized, ideal bodies. To accomplish this treatment goal, interventions from a feminist perspective include relieving isolation, heightening awareness of and exploring the roots of body issues, exploring blockages and resistance to change, and re-embodiment (Hutchinson, 1994).

Empowerment is also a key variable in improving and treating eating and body image issues. Bruch (1977) was the first to advocate increasing an individual's sense of self-direction and self-worth as an integral part of the treatment process in eating disorders and body image disturbance. Kearney-Cooke and Striegel-Moore (1997) agree with this notion, stating that helping women to focus on themselves and to define their own visions can strengthen intrinsic power, which includes developing a new relationship with their bodies.



Interventions that assist in achieving this goal involve developing a lifestyle that makes a shift from a reactive stance of trying to sculpt their bodies into the current ideal to a more proactive, life-affirming focus on acceptance of their bodies and a commitment to take care of them (Kearney-Cooke & Striegel-Moore, 1997). This process could potentially lead to a sense of fear that learning to accept oneself will cause a woman to abandon her self-control and develop more unhealthy attitudes (Rosen, 1997). However, if this intervention proves successful, it will likely help empower the individual who is suffering from eating disorders and body image disturbance, thus lowering such concerns (Kearney-Cooke & Striegel-Moore, 1997).

Another way to help empower women is to help them see other women as their allies rather than as their competitors (Shisslak & Crago, 1994). As Wolf (1991) points out, since women are not a minority group but comprise more than half of the human population, they could not have been dominated for so long without colluding in their own oppression. Therefore, by working together, women not only empower themselves but also have a better chance of affecting social change, which in itself is empowering (Shisslak & Crago, 1994). According to Wolf (1991), only solidarity among women will give them what beauty promises, a sense of power, significance, and self-worth. Gilligan (1982) adds that women need to develop the courage to speak in their own voice, a voice that is different from the male-dominated one of our culture.

A feminist approach to the treatment of disordered eating and body image disturbance must work at helping women become whole, seeing the toxicity of the patriarchal culture, and encouraging them to take political action against it (Hutchinson, 1994). Hutchinson (1994) adds that while women wait for the culture to change, they



must also heal their minds, releasing the many effects of mixed messages regarding their bodies; these women must take back their bodies as homes, not as enemies or commodities, even if those bodies fail to conform to external or internalized standards of appearance.

### *Summary of Theoretical Models*

After reviewing these five theoretical models on body image dissatisfaction, it is apparent there are a number of areas where they converge and diverge from one another. First, the developmental theory converges with social-comparison theory in the premise that body image takes shape as one internalizes messages of physical beauty and standards of society and then judges themselves against these standards. Developmental theorists believe that one internalizes these messages as early as preschool, leading one to go through developmental stages of his or her life in the context of social-comparison tendencies.

Second, social-comparison and self-discrepancy theories also are interrelated. Where these theories converge is in the aspect that there is some form of comparison being made regarding the way one looks. However, these theories diverge in respect to the standard to which one is comparing him or herself. In social-comparison theory, one is compared to an actual figure other than him or herself. On the other hand, self-discrepancy theory consists of comparisons that are internalized; where one compares his or her perceived appearance with their own imagined and internalized ideal.

A third area of interrelatedness is a result of one giving into social-comparison or self-discrepancy tendencies. If one begins to repeatedly compare him or herself to another figure or an internalized figure, this will likely result in the increased likelihood

of self-objectification. This self-objectification leads one to give into cultural pressures to view and treat themselves as objects of beauty, placing self-worth and importance strictly on physical standards rather than internal standards such as intelligence or relationship skills.

Lastly, self-objectification and feminist theories also interact with one another. For example, these theories converge with respect to an underlying cultural emphasis. Both theories cite cultural issues (sexual objectification and patriarchal in nature) as forces that lead to an increased likelihood of body image dissatisfaction. Where the theories begin to diverge is in the personalization of these cultural issues. In feminist theory, one has personalized the cultural messages of self-objectification, sexualization, and patriarchal power, resulting in the females fight for empowerment and to find her gender-role identity.

By discussing these prior theoretical models, I have laid the ground work for why I have chosen the six risk factors that are explored in this paper. As a result of discussing theory, along with the resulting predictor variables for body image dissatisfaction and eating concern, I am adding new and valuable insight into the vast arena of body image literature. In addition, this paper offers new insight given that my list of six variables is quite comprehensive when compared to other literature reviews, which has looked at only one, two or three variables, often times keeping these variables separate, ignoring how they interact with one another. As a result, it is important to stress that these variables are not independent, and that there is a good deal of overlap between the six different variables I will discuss. Therefore, when discussing each variable, other variables may be



introduced as well to demonstrate various interactions that justify the hypotheses and posited path analysis.

The risk factors that I have chosen to focus on in this paper can be external, outside of the individual (e.g. sociocultural influence, family environment), or they can be internal personality characteristics one carries (e.g. gender-role orientation or susceptibility to feelings of guilt and shame). Six of the more frequently cited factors within the above theoretical models for developing eating and body image concerns were chosen for further investigation. The six variables explored are: sociocultural influence, family environment, perfectionism, gender-role orientation, guilt/shame, and stress. The variables of sociocultural and parental influence come from many of the theories, namely developmental, social-comparison, self-objectification, and feminist. Gender-role orientation also stems from more than one of the theories, such as developmental and feminist. Issues of perfectionism are taken from the self-discrepancy theory in that individuals place high standards on themselves for how they ought to look in comparison to how they do look. Lastly, the emotional components of guilt/shame and stress are discussed as resulting from issues within the self-discrepancy and self-objectification theories. The following is an in-depth examination of each of these six factors.

### *Internal and External Risk Factors of Body Image Dissatisfaction*

#### *Sociocultural Factors*

The sociocultural perspective of body image disturbance, particularly body image dissatisfaction, is one of the most discussed and perhaps the most empirically validated of body image factors (Heinberg, 1996; Thompson et al., 1999). The sociocultural theory of body image disturbance examines the influences of common or



culture-wise social ideals, expectations, and experiences on the etiology and maintenance of body image dissatisfaction (Heinberg, 1996). For example, Usmiani and Daniluk (1997) argue that body image is formed to a degree as a function of the culturally defined images of a desirable bodily appearance, and that therefore, one's body satisfaction may be influenced by the degree to which he or she believes they meet those cultural standards.

The forefront of sociocultural pressure has been identified as the media (i.e. fashion magazines, movies, television, and advertising) and the role it plays in the contribution to body image disturbances and eating dysfunctions (Thompson & Heinberg, 1999). For instance, the mass marketing of body image through print media and television advertising has been well documented as a powerful force in creating the 1990's perception of the tall, thin, and toned ideal for women (Rabak-Wagener et al., 1998), resulting in a non-ideal comparison for a majority of women. Strice, Schupak-Neuberg, Shaw, and Stein (1994), as cited by Haworth-Hoeppner (2000), illustrated this in the eating disorder literature. They sampled undergraduate females and found that exposure to the media-portrayed thin ideal was related to eating pathology, suggesting that women may directly model after disordered ideals. This social comparison process is seen as a possible mechanism that connects media exposure or pressures to the development of heightened internalization of media values, leading in turn to body dissatisfaction and/or distortion and eating disturbances (Thompson & Heinberg, 1999).

The sociocultural model also emphasizes that the current standard for thinness is omnipresent and without resorting to extreme and maladaptive behaviors, all but impossible to achieve for the average women (Thompson & Heinberg, 1999). For

example, the ideal for the female body, represented by actresses, models, and Miss America contestants, represents the thinnest 5% of women today (Walszon, 1998). Therefore, a “statistical deviation has been normalized” so that 95% of women today feel they do not measure up to the ideal (Seid, 1994). The fact that 95% of women cannot measure up to this ideal, without extreme efforts at dieting and exercise, is thought to be a central reason why a majority of women report significant dissatisfaction with their current body size and shape, a dissatisfaction that has been empirically linked to an increased risk of developing an eating disorder (Walszon, 1998).

Kearney-Cooke and Striegel-Moore (1997) emphasized this point further stating that women are encouraged to look outside themselves to adopt a lifestyle that enables them to reach this beauty ideal at any cost, if only they try hard enough. However, as these women look outside themselves at the current ideals for their age, it is like looking into a funhouse mirror; the images that come back via magazines or television are not realistic (Kearney-Cooke & Striegel-Moore, 1997).

Ironically, this current ideal and standard of thinness portrayed by the media is for the most part fictionalized itself. Photographic techniques, such as airbrushing, soft-focus cameras, composite figures, editing, and filters blur the realistic nature of media images, leading women to believe that the models are realistic representations of actual people rather than carefully manipulated and artificially developed images (Thompson & Heinberg, 1999). Despite this fact, many women internalize these standards, become profoundly dissatisfied with themselves (Davis, 1985), and spend countless hours and dollars attempting to achieve an impossible look (Freedman, 1986).



Proponents of cultural impact on body image and eating behaviors cite the higher prevalence rate of eating disorders in western culture, among whites, and particularly among women (Haworth-Hoepfner, 2000). In fact, the diagnosis of anorexia nervosa was classified as a cultural-bound syndrome in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1987). These proponents also emphasize the power of cultural standards of beauty that emphasize slenderness as a key feature of feminine identity, so that even women without eating disorders experience body image concerns, particularly dissatisfaction (Haworth-Hoepfner, 2000).

There are many reasons why the sociocultural influence is greater on the female population. McCabe and Ricciardelli (2001) believe it is an influence that impacts females more than males as early as adolescence. These authors noted that during adolescence, peers were perceived to pressure girls to move closer to the societal ideal of extreme thinness, but the same pressure was not seen to be operating on boys to encourage them to increase muscle size or shape.

Another factor in female vulnerability to sociocultural pressures is what is now viewed as being sexually attractive or beautiful. For the past 30 years or so, ultra slenderness has epitomized the ideal body shape, in startling contrast to the voluptuousness that was admired during the post-war decade (Silverstein, Perdue, Peterson, Vogel, & Fantini, 1986). Furthermore, Garner and his colleagues documented that over the past few decades, thinness has become a central feature in the definition of feminine beauty, citing the significant decrease in body weight and measurement in Miss American Pageant contestants and Playboy Magazine centerfold models from 1959-1979 (Garner, Garfinkel, Schwartz, & Thompson, 1980). However, during this same time



period, the average weight of women has increased, resulting in a paradoxical shift of young women becoming heavier, while the beauty ideal for this same age group has become lighter (Silberstein et al., 1987).

Lastly, in the past decade or so, society has added another mixed message for females resulting in a cultural pressure to be thin: exercise. Kilbourne (1994) pointed out that the ultimate paradox is the use of females for selling exercise machines “to build him up and to slim her down.” While men are encouraged to develop muscles and strength, the women are expected to stay slim, lean, and hard (Frank, 1999). Therefore, the fitness movement has contributed to a redefinition of the ideal female body, which is now not only characterized merely by thinness, but also now by firm, shapely muscles (Silberstein et al., 1987).

In addition to there being a discrepancy between females and males in terms of their vulnerability to this sociocultural influence, ethnicity is also believed to be a factor. Researchers have suggested that African American women do not experience body dissatisfaction to the extent of their Euro-American counterparts (Harris, 1995; Thomas & James, 1998). Even with higher weight levels (Gray, Ford, & Kelly, 1987) and body mass indices (Akan & Grilo, 1995), African American women report more satisfaction with their bodies, while Caucasian women report greater body dissatisfaction and eating concerns.

However, the low prevalence of body image dissatisfaction and eating-related problems among African American women could be viewed as inaccuracies that stem from the overgeneralization and over-publication of Euro-American norms (Bond & Cash, 1992; Thomas & James, 1998). For example, Ogden and Elder (1998) found that

Caucasian daughters were the most dissatisfied with their bodies, while the most satisfied were the Caucasian mothers and Asian daughters, with results remaining after controlling for BMI. Ogden and Elder (1998) concluded that the results may reflect the Caucasian daughters' exposure to media images of very thin women as their role model, while Asian daughters' greater body satisfaction is a result of the lack of identification with the media role models who are predominately white. In addition, these authors argue that the Caucasian mothers also reported a great deal of body satisfaction due to an absence of identification with the media models, which are not only white, but also quite young.

Despite these results, Harris (1995) argues that whereas some evidence does exist to support the relation between subcultural factors and body attitudes, other possible explanations have not been explored. In particular, Harris points to the assessment process traditionally used to examine ethnic minority body attitudes. For example, inconsistencies in the conceptualization (i.e. as a one-dimensional construct rather than multidimensional) and measurement of body image attitudes may account for misinterpretations and/or the low incidence of body dissatisfaction found among ethnic minorities (Harris, 1995).

Two studies were cited by Thompson and Heinberg (1999) on cultural influence. These studies suggest culture does in fact play a crucial role in the development and/or maintenance of eating and body image concerns. The first study was by Levine, Smolak, and Hayden (1994) and found that 70% of girls who read magazines on a regular basis endorse them as an important source of beauty and fitness. Another study by Nichter and Nichter (1991) found that adolescent girls endorsed their ideal body image as the models found in fashion magazines aimed at teenage girls. These subjects on average reported



their ideal teenage girl to be 5'7", 100 pounds, and a size 5 with long blonde hair and blue eyes. Both of these studies suggest that the mass media in today's culture is rather influential over young women and their ideas regarding healthy body image.

In addition, Hamilton and Waller (1993) demonstrated that anorectic and bulimic women's body size estimation increased following 6-7 minutes of looking at media images, and that non-eating disordered women showed less healthy scores on the scales of the Eating Attitudes Test that reflect restrictive eating behavior (Waller, Hamilton, & Shaw, 1992).

Given all these media pressures to be thin, some literature has emerged addressing treatment considerations that specifically target media messages when working with body image dissatisfaction. In terms of treatment issues, the media could be encouraged to move away from the use of a narrow range of "ideal" female forms, and to begin presenting a wide range of female body shapes as acceptable (Shaw & Waller, 1995). However, while this approach would likely have a broad impact, the media has a very different agenda (sale, advertising), which would make them reluctant to change (Shaw & Waller, 1995). A related treatment approach could be to reduce an individual's exposure to such images by encouraging more selective viewing of the media; however, the pervasive nature of the media makes it difficult to enforce and achieve a substantial reduction in such exposure (Shaw & Waller, 1995). Given this, Shaw and Waller (1995) believe the most feasible treatment measure that could be taken to reduce body image dissatisfaction and eating-disordered behavior is psycho-educational. An educational approach might encourage individuals to be less willing to assume that the media



presentation of the “ideal” as accurate, encouraging them to question their own acceptance of such images (Shaw & Waller, 1995).

Training in media analysis that could be applied to a critique of advertisements in magazines is believed to be a useful psycho-educational approach (Frank, 1999). Rabak-Wagener et al. (1998) conducted a study that investigated such educational interventions in relation to the mass media. These authors focused on having individuals critique popular fashion advertisements and creating more inclusive fashion advertisements. The intervention was designed to challenge fashion advertising credibility among college students. The results of this study suggested that this particular intervention was more effective with women than with men, and that beliefs regarding body image ideals were changed more readily than behaviors. Rabak-Wagener et al. (1998) concluded from their findings that the link between using media advocacy techniques, specifically those that reframe the issues to create new norms and change attitudes and behaviors, is particularly important.

Frank (1999) also explored the use of psycho-educational techniques for prevention of body image and eating concerns. This program uses Barbie dolls as a cultural artifact to illustrate the dramatically distorted ideal that girls are encouraged to identify with. A large poster demonstration reveals the distorted body that Barbie would have were she to grow to human-sized proportions. This program has succeeded in eliciting a positive response among girls in middle and high schools (Frank, 1999).

Due to the ever expanding role of sociocultural pressure on our society to be thin and achieve a certain ideal, one is bound to develop unhealthy attitudes and/or a stereotype concerning what happens if he or she does not achieve this thin ideal.

Therefore, within this cultural explanation, the implied bias towards being thin rather than fat deserves special attention and will be discussed in some detail here.

The effects of the media pressures were documented in a national survey of body image. This survey concluded that Americans were considerably more dissatisfied with their bodies (Cash et al., 1986) than they had been at the time of a survey done 13 years earlier (Berscheid, Walster, & Bohrnstedt, 1973). Both surveys revealed that dissatisfaction with weight and body shape were the most salient sources of body image dysphoria. Such dissatisfaction is likely due in part to the continual cultural emphasis of thinness and attractiveness portrayed in advertisements, movies, and television, encouraging people, particularly women, to slim down for beauty reasons (Cash, Counts, & Huffine, 1990). On the other side of this coin, being overweight is a highly stigmatized condition that engenders considerable social prejudice and discrimination (Cash, 1990). Therefore, implied in all of these sociocultural messages is our society's counterpoint to "what is beautiful is good" is clearly "what is fat is bad" (Silberstein et al., 1987). However, what is wrong with Silberstein's statement is that it implies that beautiful only means being thin and that fat people cannot also be beautiful, but rather they are bad people, whereas thin people evidently are both beautiful and good. In addition, a large amount of research suggests that just as thinness is valued and rewarded by current society, its opposite, obesity, is abhorred and punished (Thompson et al., 1999).

For instance, Walszon (1998) discovered that thin and attractive males and females are consistently viewed as being happier, smarter, and more socially confident than their overweight and less attractive counterparts. This leads to differential treatment in important settings. For example, teachers are known to give more encouragement and



positive attention to more thin and attractive students, and less attractive and overweight children are at a higher risk of neglect or maltreatment (Walszon, 1998). In addition, thin and attractive adults are more likely to be hired, promoted, and receive higher starting salaries than less attractive and overweight persons (Hatfield & Sprecher, 1986).

This appearance-based treatment and prejudice against fat people may be a function of how we are socialized in our culture at such a young age, as well as how parents teach anti-fat attitudes to their children (Robinson, Bacon, & O'Reilly, 1993). For instance, Dion (1976) found that children by the age of six are already biased against chubby or obese people and would rather play with physically handicapped or facially disfigured children than with an obese child.

These anti-fat attitudes that begin at such a young age may affect not only overweight children, but normal weight children as well. The overweight child experiences the harsh stigmatization associated with obesity and learns the societal view that if one is obese, there is something wrong with them; while on the other hand, normal weight children may learn a deep-seated fear of becoming overweight (Silberstein et al., 1987).

These societal dynamics have likely fueled the pursuit of thinness and avoidance of weight gain to both the clinical extremes, as well as the more mild, albeit dysfunctional, dissatisfaction with one's body (Cash et al., 1990). This is also accompanied by a "fear of fat" and by a strong desire and repeated attempts to lose weight (Bailey & Goldberg, 1989; Cash & Hicks, 1990). Research supports this notion, indicating that this fear of fat is a chief complaint among many non-clinical and clinical



individuals, and can be used as an assessment tool in determining the severity of body dissatisfaction and/or drive to be thin (Goldfarb, Dykens, & Gerrard, 1985).

The term fear of fat is also referred to as “fat phobia,” which can be defined as a pathological fear of fatness often manifested as negative attitudes and stereotypes about fat people (Robinson et al., 1993). One such common attitude is that fatness is self-inflicted or under one’s control, resulting in a tendency to blame those who are overweight. Because most overweight individuals buy into this obesity stereotype and blame themselves excessively for their weight, it is important to bolster their resistance and remove this blame by educating them on the non-behavioral, genetic, and physiological causes of obesity that results in the complex etiology of obesity and the difficulties of treatment (Robinson et al., 1993; Rosen, 1997).

In addition to negative attitudes, stereotypes are also very present due to this fat phobia. Robinson et al. (1993) found evidence of both positive and negative stereotypes about fat people. The most common negative stereotypes included viewing fat people as undisciplined, inactive, and unappealing, having poor self-control, and having more emotional and psychological problems. The most common positive stereotypes were that fat people are friendly, warm, humorous, and easy to talk to. When dealing with stereotypes however, the issue of what is a positive, as opposed to a negative, stereotype is unclear, as these stereotypes have not been welcomed by many fat people (Robinson et al., 1993).

In conclusion, the cultural pressures toward thinness are obvious in our society. It is argued that body image is formed to a degree as a function of the culturally defined images of a desirable bodily appearance, with the media being credited as the greatest

influence in the contribution to body image dissatisfaction. This sociocultural variable is a dangerous risk factor given the evidence that the current cultural standard of thinness is an illusion, and without resorting to extreme and maladaptive behaviors, nearly impossible to achieve for the average woman. Despite this, many women still internalize and idealize this false standard, resulting in profound dissatisfaction with their bodies. In fact, sociocultural influence is so powerful on women's body images that even women without eating disorders experience a great deal of body image concern and dissatisfaction. Given this information, in my study I chose to focus exclusively on the role the media plays in women developing body image dissatisfaction. I used a measure that assess the importance individuals place on these media messages and how much they incorporate these messages into their lives and self-schemas.

While no woman in our society can truly avoid being influenced in some way by the cultural environment, there are differences in the susceptibility (Frank, 1999). Therefore, related research in the sociocultural vein looks for factors both outside and inside the individual that may unduly amplify the individual's susceptibility to sociocultural norms; for example, family environment, perfectionism, or irrational beliefs regarding weight and appearance (Walszon, 1998).

#### *Family Influence*

Despite the cultural pressures towards thinness discussed above, cultural influences do not fully explain why certain women develop problems with body image or eating, whereas other women do not (Martz, Handley, & Eisler, 1995). Pike and Rodin (1991), as cited by Leon et al. (1997), posited that families, specifically mothers, might either reinforce or counteract the influence of cultural factors on their daughters. For



example, there is a general view that “good enough” parenting (Winnicott, 1965) is important in protecting our children against eating pathology. Good-enough parenting is a notion derived from the Winnicotian concept of the good-enough mother and refers here to both mothers and fathers whose parenting behaviors and attitudes are both viewed as influential factors in the development of girl’s body attitudes (Frank, 1999).

However, Frank (1999) asserts that it is not enough to be good enough when it comes to protecting girls against concerns and/or pathology for which the etiology is thought to be partly interlinked with the sociocultural environment. Not only should parents be “good enough,” they also need to be culture-wise in order to help their daughters develop healthier attitudes and become resistant to disturbances related to weight and physical appearance (Frank, 1999). If we consider that the intellectual phase of development of the early adolescent is characterized by thinking that is not yet abstract, one cannot expect a child to have the ability to look from above and take a stand apart from the sociocultural environment and view it in a critical way (Frank, 1999). Therefore, Frank (1999) states it is at this juncture that the adult environment is significant in its potential to intervene in offering an alternative perspective on the dominant view.

Frank (1999) developed the term culture-wise to describe parents who are able to view the sociocultural environment with a critical perspective. As a mediator to culture, the family can operate as a formidable influence, transmitting and conveying cultural messages about thinness and body shape that are healthier and crucial to the processes associated with the production of body image concerns (Haworth-Hoeppner, 2000). More specifically, Frank (1996) found that it was more important that mothers manifest



behaviors that are culture-wise (e.g. does not complain about weight and body) and that fathers showed culture-wise attitudes (e.g. disagrees with the statement that a woman who wears sexy dresses should expect men to demand sexual favors from her).

Therefore, parents who are able to mediate and offer an alternative perspective on the dominant view may be able to serve as a buffer for their daughters against cultural messages, thereby helping them resist and deal more effectively with this outside pressure (Frank, 1999). In addition, Frank (1999) asserts that parents should also work at developing a culture-wise capability in our sons due to the fact that their participation and perpetuation of society's norms and values also have a serious impact on girls and women.

Therefore, it is when there is little or no mediation on the part of parents that media messages are able to step in and act as a surrogate parent in teaching what is important and not important, valuable and not valuable, thus forming the point where parenting and culture variables converge (Frank, 1999).

A cautionary note is that parents often misinterpret culture-wise parenting to mean the withdrawal of media productions, such as the removal of all television viewing or a refusal to allow their child to play with Barbie dolls (Frank, 1999). Frank (1999) believes these steps to be drastic, and instead of cultivating culture-wise thinking skills, engenders feelings of resentment, envy, and alienation in girls on the edge of adolescence.

The extent to which the family transmits cultural messages about thinness and body shape, and the manner in which the family conveys these messages to family members, are crucial to understanding the processes associated with the production of

negative body images and eating dysfunction (Haworth-Hoepfner, 2000). Haworth-Hoepfner (2000), points out that proponents of a family perspective contend that individuals develop a normal or distorted body image in the context of family life, and therefore, believe the focus of investigation should be on family influences.

Eating disorders or body image concerns are thought to develop in the context of different family relationships and/or environments. Some such environments are: low cohesion in the family, less empathic, less emotionally supportive, less affectionate and warm, more neglectful, enmeshment, controlling, lack of support for autonomy, achievement oriented, and poorer communication (Thompson et al., 1999).

More specifically, a family environment that is less accepting and more critical, particularly of a child's appearance, could result in the adolescent's need to change herself through changing the body (Leon et al., 1997). In addition, a family environment that is chaotic or forms poor role boundaries may increase the need for the child or adolescent to seek control over her life through controlling the body (Leon et al., 1997). Frank (1991) also described family environmental influences, which are summarized below. He believes that family enmeshment and empathic failure are two issues in the development of eating dysfunction and body image concerns. He states that family enmeshment that focuses on issues of food, weight, appetite, and eating may explain why anorexic and bulimic women develop shame and guilt in relation to eating. Additionally, empathic failure may become exacerbated when the daughter develops an eating disorder, as her disturbing symptoms often provoke inappropriate intrusiveness from those around her. This exacerbation in turn results in further shame and guilt.



One common family environment that is believed to play a role body image and eating concern is a dysfunctional family environment. In a dysfunctional family (i.e. poor boundary issues, communication problems, rigid rules, perfectionist standards), the child may experience rejection from her parents because she does not measure up to the idealized image that the parents have, or lacks positively viewed family characteristics (McFarland & Baker-Baumann, 1990). This rejection occurs because the family may be fearful of the child putting the family at higher risk for exposure as a failure, resulting in the child's withdrawal from the family (McFarland & Baker-Baumann, 1990). This rejection of meeting a child's physical and emotion needs, and the eventual withdrawal, can be the basis for the development of self-shame and body dissatisfaction. Those children who grow up in a dysfunctional family system and withdraw from the family, are then more likely to be vulnerable to the media and fashion industries which promote the belief that we can feel happier inside and realize our purpose in life, if only we looked ideal on the outside (McFarland & Baker-Baumann, 1990).

Another family environment is one in which there is a history of psychopathology (e.g. diagnosis of an eating disorder or chemical dependency) among family members that influences the family's style of interacting (Reeves & Johnson, 1992). This style of interacting may contribute to eating concerns among its children. For instance, the development of an eating disorder in this type of environment is seen as an attempt by the family to maintain balance and avoid conflict that is often characteristic within the family's interaction (Reeves & Johnson, 1992).

Furthermore, family characteristics have been found among women with eating disorders or body image concerns. These family characteristics include rigidity,



enmeshment, over protectiveness, conflict avoidance, and poor conflict resolution (Minuchin, Rosman, & Barker, 1978). Family characteristics have been looked at both in terms of maternal and paternal characteristics; however, much more attention has focused on the role of the mother.

Mothers are perceived as the primary socialization agent who transmits messages to adolescents regarding their appearance and eating practices (McCabe & Ricciardelli, 2003). For example, Pike and Rodin (1991) found mothers of adolescent girls with disordered eating were more likely to report dieting behaviors and were more likely to believe that their daughters should lose weight and encourage them to diet. Additionally, maternal body image is believed to be a predictive factor in body and eating concern (Attie & Brooks-Gunn, 1989). Therefore, it is believed that through modeling and encouragement from their mothers, girls with eating and body image concerns, are more likely to be rewarded for engaging in extreme behaviors than girls who do not experience eating and body concern (Pike & Rodin, 1991). However, some studies have found no matching between mothers and their daughters on measures of either body image or eating behavior (Garfinkel, Garner, Rose, Darby, Brandes, O'Hanlon, & Walsh., 1983; Ogden & Elder, 1998). For example, Garfinkel et al. (1983) reported many similarities between parents of girls with anorexia and control parents when tested on measures of weight concern.

Additional maternal characteristics influencing body image dissatisfaction are those who are perceived as perfectionistic and controlling, where enmeshment is the norm, and in which issues of weight and appearance are prominent (Haworth-Hoepfner, 2000).

Fathers are also believed to play a role in the development of a negative body image; however, to a much less extreme than mothers. Characteristics of fathers in which body image issues emerge have been identified as fathers who are perceived as being passive, unloving, or abusive (Haworth-Hoepfner, 2000). While fathers are believed to influence their daughter's body dissatisfaction, it should be noted they have not been found to influence their eating practices, such as mothers do (Keel, Heatherton, Harden, & Hornig, 1997).

Webster and Palmer (2000) believe there is need for caution when considering observations of current family life with body image and eating disorders. These authors state that opinions and theories may involve the unwarranted assumption that current family problems were present before the onset of such issues. However, it could be that the disorder may have influenced the family, causing relationships within the family to become more distorted by the presence of the distressing illness, rather than the other way around (Webster & Palmer, 2000).

In regards to treatment intervention, it is important for mental health professionals to increase their awareness of the relationship between specific family dynamics and the development and maintenance of eating-disorders and body image dissatisfaction so appropriate interventions and referrals can be made (Reeves & Johnson, 1992).

Personal counseling in which family-of-origin dynamics are addressed may prove to be an appropriate intervention for individuals reporting eating disordered attitudes and behaviors (Reeves & Johnson, 1992). Referrals to sources that can provide education in the areas of communication skills and assertiveness training in relating to family members could also be valuable in encouraging these women to gain a sense of personal



power that they need in developing a healthy independence from their families (Reeves & Johnson, 1992). Another intervention Reeves and Johnson (1992) believe to be fruitful is referrals for family therapy that could foster the individual's personal growth in hopes of decreasing eating and body image issues.

There are a variety of family therapy approaches that have been developed specifically in the context of eating disorders. Two of the leading figures in family therapy for eating disorders are Minuchin and Selvini Palazzoli. These individuals observed specific characteristics within the families of individuals who had developed an eating disorder; leading to the development of specific family therapy paradigms (i.e. structural and strategic family therapy, Milan systems therapy). Both Minuchin and Selvini Palazzoli emphasize the closeness of the relationships within the family, the blurring of boundaries between generations, and a tendency to avoid disagreement and conflict (Dare & Eisler, 1997). As a result, both of their therapeutic strategies are aimed at changing those qualities of the family, which in turn are believed to help the individual struggling with body image and eating disorder issues.

Minuchin's structural family paradigm focuses on altering the dysfunctional state of the family, with the goal being to limit some patterns of family interaction believed to be dysfunctional, while encouraging other, more healthy patterns (Dare & Eisler, 1997). The premise behind this strategy is that as these issues are dealt with, the functional improvement within the family will diminish the processes that lead to the development of eating disorder symptoms, such as body image dissatisfaction.

The Milan family systems approach entails using a structured interview with the family to elicit information about the family system, while at the same time introducing a



new perspective regarding the interconnectedness of different aspects of family life (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). This allows the therapist to better understand the nature of the family organization and the purpose that the eating disorder symptoms serve in the context of the family system (Dare & Eisler, 1997).

The main difference between the structural family paradigm and the Milan family systems approach is that in the Milan approach, the therapist maintains a neutral position in working with the family. For instance, instead of making direct interventions, the therapist uses the structured interview to highlight family differences, which becomes new information for the family to process, thus encouraging them to challenge their beliefs about themselves and about their familial relationships (Dare & Eisler, 1997).

In conclusion, support for some of the preceding literature comes from a study by Haworth-Hoepfner (2000) on eating and body image issues and family influence. Interviews were carried out with 32 females on the topic of body image and eating concerns. Two groups formed the basis of analysis for this study: women with eating disorders, and women without diagnosed eating disorders. Analysis of interview transcripts revealed four common domains among those individuals with body image or eating concerns: (1) a critical family environment, (2) coercive parental control, (3) an unloving parent-child relationship, and (4) a main discourse on weight. Given these results, I chose for my study to look at the parental aspects of over control and protection and level of care, which have been two of the more commonly identified parental aspects in individuals with body image and eating concern.

Lastly, an additional study by Woodside, Bulik, Halmi, Fichter, Kaplan, Berrettini, Strober, Treasure, Lilienfeld, Klump, and Kaye (2002) examined temperament,

personality, psychological functioning, and eating-related pathology in parents of individuals presenting with body image concerns. The results of this study found that the most salient differences between mothers of females suffering from poor body image and mothers of female controls were greater perfectionism and higher levels of some aspects of eating disordered-type attitudes and behaviors. Given the results, Woodside et al. (2002) assert that it is conceivable that perfectionism is an environmentally transmitted trait that increases the liability to the development of body image dissatisfaction and distortion. This suggests that family environments and parental characteristics, particularly perfectionism, are connected variables that are important in the development of body image and eating concerns. Therefore, attention is now turned towards examining the internal risk factor of perfectionism, beginning with a discussion on how the family and perfectionism variables interact.

#### *Orientation for Success and Perfection*

According to Hamachek (1978), individuals who originate from early family environments of “non-approval” or “inconsistent approval” seek perfection as a means of avoiding disapproval and attaining acceptance. In addition, in a family environment of conditional positive approval, individuals learn that if they are to be loved, they cannot afford to be less than perfect, leading to their sense of self being defined in terms of performance standards (Mitzman, Slade, & Dewey, 1994).

In terms of parental influence, the most salient differences between mothers of individuals with eating and body image concerns and female controls were greater levels of perfectionism (Woodside et al., 2002). Woodside et al. (2002) believes their finding has several possible interpretations. First, they state it is conceivable that parental



perfectionism is an environmentally transmitted trait that a child learns through modeling. Second, they also believe that it is possible that perfectionist behaviors in a child could increase perfectionist tendencies in parents. Lastly, and what Woodside et al (2002) argues is most likely, perfectionism could be a genetically mediated personality trait that is transmitted through families and increases liability to the development of body image and eating concerns.

Perfectionism has been noted frequently as a key clinical feature of individuals with anorexia (Woodside et al., 2002). In addition, perfectionism is a personality style that has been described frequently as a central component of body image concerns, with several theorists hypothesizing a pathogenic role for perfectionistic tendencies in body image concerns and eating disorders (Casper, 1983; Hewitt, Flett, & Ediger, 1995).

While perfectionism contributes to these and other physical and psychological disorders and concerns, researchers often fail to discriminate adequately between normal (adaptive) and neurotic (maladaptive) perfectionism (Mitzman et al., 1994). Adaptive perfectionism is believed to be accompanied by a sense of satisfaction and increased self-esteem, where realistic targets are set by the individual who is motivated by the pleasure and rewards associated with success (Mitzman et al., 1994). This type of perfectionism can describe a set of characteristics that are viewed as being highly socially desirable, and appear to be adaptive to healthy psychological functioning (e.g. personal satisfaction, feelings of achievement, and high self-esteem).

However, perfectionism can also describe a tendency to set impossible personal standards, while simultaneously experiencing an intense need to avoid failure (Davis, 1997). This is termed maladaptive perfectionism and is characterized by excessively high



standards, where lapses or mistakes made by the individual are viewed as disastrous, driving the individual primarily by fear of failure and feeling that they should have done better (Mitzman et al., 1994). Therefore, it is at this point where perfectionist traits become maladaptive; resulting in the inability to derive satisfaction from almost any endeavor, such as feelings towards oneself and one's body shape. Davis (1997) demonstrated this point by showing that body image dissatisfaction is most pronounced when high personal strivings are set in the direction of goals that are out of reach of normal expectation, and when the individual experiences a strong fear of personal failure. Furthermore Davis (1997) concluded that the characteristics of body image concerns and eating disorders can be understood in the context of attitudes and behaviors that are driven by two combining forces, a rigid adherence to self-imposed, but typically unrealistic, body size aspirations, in conjunction with an anxiety about the real, or perceived, consequences of not achieving the task at hand (e.g. losing weight).

The distinction between adaptive and maladaptive perfectionism was also examined in a study by Ashby, Kottman, and Schoen (1998). Their results showed that individuals being treated for an eating disorder scored significantly higher than non-eating disordered individuals on the factor labeled Maladaptive Perfectionism, but not on the factor labeled Adaptive Perfectionism. This suggests that individuals with eating and body image concerns may be more perfectionist in maladaptive ways (e.g. over concern with making mistakes, anxiety about performance) than individuals without such concerns; however, individuals with eating and body image concerns do not seem to be more perfectionistic in adaptive ways (e.g. high personal standards, need for organization) (Ashby et al., 1998). In addition, Ashby et al. (1998) found a significant

correlation between the body dissatisfaction subscale of the Eating Disorder Inventory (EDI) and the factor labeled Maladaptive Perfectionism, indicating a positive relationship between maladaptive aspects of perfectionism and elevated levels of body dissatisfaction as defined by the EDI.

Traditionally, treatment of eating disordered individuals have included attempts to lower personal standards and help clients let go of a need for order and organization (Burns, 1980). However, recently the construct of maladaptive perfectionism has also been implicated, suggesting counselors working with this population might consider assisting individuals in the reduction of the maladaptive factors in perfectionism, rather than just concentrating on lowering personal standards and reducing the need for order and organization (Ashby et al., 1998).

One strategy for achieving this would be for counselors to help clients learn to reduce their anxiety about their performance and the discrepancy between their achievement and their own personal standards or the standards they perceive imposed on them by others (Ashby et al., 1998). In addition, it could be productive to work on acceptance of personal mistakes and the willingness to risk error and imperfect performance (Ashby et al., 1998).

Hewitt and Flett (1989) conceptualized perfectionism as a multidimensional construct that incorporates three different components: the need to appear perfect, the need to avoid appearing imperfect, and the need to avoid disclosure of imperfection. These three components are believed to play a major role in body image concerns. For example, because highly perfectionistic individuals have stringent evaluative criteria, falling only slightly short of a goal can be viewed as a failure. Therefore, individuals



may require themselves to meet stringent ideals regarding body and weight standards that will be impossible for the individual to measure up to, resulting in a feeling of failure and continual dissatisfaction of one's body shape.

In addition to this multidimensional look at perfectionism, researchers have associated individuals with eating and body image concerns with a character profile of achievement and success orientation, the drive for perfectionism, and low self-esteem (Ashby et al., 1998; Bastiani, Roa, Weltzin, & Kaye, 1995). Each of these three character profiles will be looked at in the following sections.

For success-oriented women, the achievement or experience of thinness may also be viewed as a personal accomplishment or emulation of higher social class (Jarry, 1998). Jarry (1998) states that a thin body image is viewed as a sense of accomplishment, which is described below. For eating disordered women or women who are dissatisfied with their body images and are in pursuit of an "ideal" body image, the body is used as the individual's confirmation that she is capable of accomplishment, which is the difficult task of enduring hunger and deprivation for prolonged periods of time. Such an individual may also use her pursuit of the "ideal" image to communicate to others her capacity for self-control and strength. The thin body becomes both the message and the medium by which she communicates her capacity for control and self-discipline. In this aspect, the body is used as a safe expression of personal value because it protects the person from the frightening prospect of having to actually demonstrate her value through regular accomplishments that she fears herself incapable of achieving.

Additionally, Slade (1982) argues that the desire to be perfect in an individual who experiences global dissatisfaction and chooses to interfere with food intake and body



weight, culminates in a need to establish order and total control over one's life and ultimately over one's body. Therefore, eating disorders are powerfully self-reinforcing in that the affected individuals experience feelings of success and control at times when they feel they have failed in other aspects of their lives (Mitzman et al., 1994).

Jarry (1998) also pointed out the issue of perfectionism within this phenomenon. He stated that perfectionism experienced by the individual, as demanded of the self by others, is related to concerns about appearance and disordered eating patterns. An example he used to illustrate this case is for the individual who doubts that she possesses the resources necessary to succeed. For these individuals who strive to be perfect in order to succeed, working at losing weight and attempting to become thin remains a simple task. While succeeding at other aspects of life are complex tasks, losing weight is seen as simple in that it lacks the complexity of those other life tasks, and once mastered, can be repeated indefinitely to ensure perfection and success. This was further supported by Bulik, Tozzi, Anderson, Mazzeo, Aggen, and Sullivan (2003) who demonstrated that the aspect of perfectionism, concern over mistakes and ability, was highly associated with the presence of body image concern and eating disorders.

Lastly, Jarry (1998) points to clinical experiences that suggest low self-esteem contributes to body image preoccupations in that feelings of low self-worth foster the reliance on the body as an element that is under the control of the individual and that offers the possibility of an experience of success. Davis et al. (2000) argue that as a general principle, perfectionistic individuals will tend to set themselves excessively high, and often unattainable, standards in whatever goals help them to achieve and to continue validating their self-esteem. This will be no less true where physical beauty is the main

source of self-regard. Therefore, working at losing weight has the advantage of providing the insecure individual with tangible proof of success; the diminishing numbers on the scale. While indices of success are usually more ambiguous and involve delayed gratification in other areas of life, a restrictive diet has the advantage of providing an immediate reward each time the individual steps on the scale and restores her self-worth. Jarry (1998) suggests that focusing her attention on weight loss as a strategy to experience success helps to protect the individual from her low appraisal of her capacity to do well.

In conclusion, since a lot of attention recently has focused on viewing perfectionism as a multidimensional construct, I am also taking this view in my study. When considering perfectionism in my study, I am using a self-report measure that consists of several different aspects of perfectionism.

#### *Gender-role*

Previous research and theory suggest that an individual's gender role will be related to his or her body image (Jackson, Sullivan, & Rostker, 1988), with one's gender-role orientation being proposed as an etiological factor in the development of body image dissatisfaction (Heinberg, 1996; Usmiani & Daniluk, 1997). For example, Cash et al. (1986) state that compared to men, women evaluate their bodies less favorably, express more dissatisfaction with their bodies, view physical appearance as more important, perceive a greater discrepancy between body image and body ideal, and are more likely to suffer from eating disorders associated with a negative and dissatisfied body image. In addition, evidence suggests that for boys and men, masculinity is related to body image



satisfaction ratings, while for girls and women, greater femininity is correlated with dissatisfaction with body image and concern with weight (Jackson et al., 1988; Kimlicka, Cross, & Tarnai, 1983).

A woman's preoccupation with a thin body has also been explained in terms of a woman's place in the social and political climate of our culture. Social pressures directly put women at risk for eating disorders and body image concerns because of the overemphasis on thinness as a primary component of female sexuality and identity (Cantrell & Ellis, 1991). For example, women endorsing the traditional sex-role stereotype who want to break away from this traditional stereotype may want to be attractive and thin because these attributes are associated with the more desirable female stereotype of being less submissive and more powerful (Jarry, 1998). The traditional stereotypic sex role identity for women seems then to compromise this desirable female stereotype by consisting of characteristics such as being seen as unassertive, dependent, submissive, low in self-esteem, and a focus on one's physical appearance (Martz et al., 1995).

What these two statements imply is that being a "traditional" female means you are both submissive and less powerful, as well as not as thin and attractive as the more desirable female counterpart who is more powerful. These characteristics may increase risk for psychological problems, such as eating disorders, that are associated with poor self-concept (Cantrell & Ellis, 1991). This is supported by the fact that clinical reports often have shown that female anorexic and bulimic patients are reported to represent the prototype of a traditional gender role orientation and to be adhering to self-views that are stereotypically feminine (Cantrell & Ellis, 1991; Martz et al. 1995).



There is also evidence that demonstrates women who have abandoned the stereotypical female role might also pursue thinness (Jarry, 1998). However, they may do so because they believe that a generous body size has been traditionally associated with the role of wife and mother, the very roles these women are attempting to expand.

To understand how gender-role may play an important part in the development of body image dissatisfaction and eating concerns, taking a closer look at gender-role orientation is essential. According to Bem's gender schema theory (Bem, 1981), gender-typed individuals (i.e. masculine males and feminine females) are more likely than non-gender-typed individuals (i.e. androgynous and undifferentiated females and males) to use gender as a dimension for encoding and organizing self-relevant and other-relevant information (Jackson et al., 1988). For example, research testing this gender-role schema theory has demonstrated that gender-typed persons are more likely to choose gender-appropriate behaviors, to avoid gender-inappropriate behavior, and to be influenced by the physical attractiveness of opposite-sex others than are non-gender-typed persons (Jackson et al., 1988). Additionally, previous research reports that because androgynous and undifferentiated individuals are not gender typed as their masculine- and feminine-typed counterparts are, and consequently do not process information about themselves on the basis of a gender schema that partitions the self-concept into either masculine or feminine categories, they are rather independent of external social pressures (Bem 1981; Bem 1977).

So how does this relate to body image and eating? Given the above work by Bem, androgynous and undifferentiated women are believed to possess specific characteristics that protect them and allow them to cope effectively with the different and conflicting

demands of masculine and feminine roles (Thornton, Leo, & Alberg, 1991). Root (1990) notes that these characteristics consist of having higher self-esteem and emotional stability, lower self-consciousness, and more of an emphasis on a healthy body than do gender-typed females. These characteristics are all believed to act as protective factors in regards to developing body image and eating concerns (Thornton et al., 1991). In my study I am using the Bem inventory to assess gender-role to test if certain characteristics are indeed protective in developing body image dissatisfaction.

In one study comparing females who differed in gender role (i.e. masculine, feminine, androgynous, or undifferentiated), Kimlicka et al. (1983) found that masculine and androgynous females were more satisfied with their body characteristics and sexuality than feminine and undifferentiated females. Jackson et al. (1988) also found that differences in the body image ratings of masculine and androgynous females, compared to feminine females, suggest that masculinity in females may be related to a more favorable body image. The proposition that masculinity in females contributes to a favorable body image also finds support in the results of a Kimlicka et al. (1983) study, who found that masculinity, but not femininity, was related to body image satisfaction.

However, Jackson et al. (1988) believe there should be caution in adopting these conclusions. For example, they report that while masculine females are more satisfied with their body images, they are also more desirous of changing aspects of their physiques than feminine females, although they did not rate their physiques as any less attractive than feminine females. One explanation for this finding is that the desire to change an aspect of physical appearance is not synonymous to dissatisfaction with that



aspect. Therefore, masculine females may be desirous of improving their physiques, which they already view quite favorably and with which they are well satisfied (Jackson et al. 1988).

That gender role is related to body image is evident in the support for the prediction that feminine females would evaluate their physical appearance less favorably than masculine and androgynous females (Jackson et al. 1988). However, feminine and androgynous females both consider their physical appearance to be equally important (Jackson et al. 1988), suggesting it is more the acceptance of cultural standards regarding the importance of appearance for women that differentiates why the gender-typed females are more likely to go on to develop eating and body image concerns.

Before examining the interaction of gender-role orientation and cultural variables, it is important to introduce and discuss the concepts of the wise woman and the superwoman (Steiner-Adair, 1986). Wise women are believed to reflect their recognition of the new societal values and expectations of autonomy, independence, and success for women; however, they combine this recognition with an ability to take a stand apart from these values and maintain conflicting and/or different values (Frank, 1999). On the other hand, the superwoman pattern represents the identification of the new cultural values of autonomy and success, and forms this identification with society's independent and autonomously successful "superwoman" as their own ideal (Frank, 1999). The superwoman concept seems to have arisen out of the conflicting sociocultural messages for women. On the one hand, women are inundated with pressures to conform to the current media images of female beauty, a task that is difficult, if not impossible to achieve. At the same time, society now places considerable emphasis on the virtues of



independence, intellectual freedom, and autonomy for women, both domestically and in the workplace (Davis, Dionne, & Lazarus, 1996). Therefore, the superwoman is the one who attempts to be all these things, attempting to please society and accepting these demands as ideal.

There is some evidence that women who adopt a superwoman ideal may be more vulnerable to eating disorders and body image concerns compared to those who reject the ideal (the “wise woman”) (Thornton et al., 1991). For example, the wise woman is able to critique the societal values and demands of girls, recognizing they may not be consistent with their own needs nor with their desires for self-fulfillment and self-satisfaction; whereas the superwoman identifies with the societal image and demands as her ideal (Frank, 1999). Having the resistance of the wise woman would, for example, provide females with a healthy skepticism through which media messages and/or cultural productions can be filtered, thus impeding the media’s impact on the psyche and offering protection against potentially harmful influences (Frank, 1999). Frank (1999) believes that this addresses the need for the acquisition of an internal process (rather than just or in addition to a family environment) that will operate as a media filter and that will result in an on going culture-wise consciousness. This is where one’s gender-role orientation may interact with and protect against eating and body image concerns.

When considering both gender role typing and the superwoman ideal, the distinction between gender-typed, androgynous, and undifferentiated women is apparently an important one. Among superwomen adherents, masculine- and feminine-typed women both presented greater potential for disordered eating relative to either androgynous or undifferentiated women; in fact, the latter two groups were comparable

to women who did not adhere to a superwomen ideal (Thornton et al. 1991). It is presumed that the non-adherents of the superwoman ideal are subject to less stress and anxiety as they are not striving to excel across many diverse roles and be all things to all people, but instead are prioritizing these roles and concentrating on a few for which success is of central importance (Steiner-Adair, 1986). However, this would not account for the reduced risk observed among androgynous and undifferentiated superwomen since, by definition, these individuals are not prioritizing either, but maintain a great many diverse roles of central importance (Thornton et al. 1991).

It would seem that the greater behavioral adaptability of the androgynous and undifferentiated superwomen enables them to deal with many diverse roles without experiencing an increased risk of disordered eating or body image dissatisfaction (Thornton et al. 1991). In contrast, gender-typed superwomen without this behavioral adaptability may be attempting to excel in an over abundance of roles or cross-typed roles for which they are not adequately prepared, subsequently, they may experience greater stress and anxiety, which contributes to their increased potential for eating and body image concerns (Thornton et al. 1991).

In addition to sociocultural messages, studies on adolescent development also suggest that familial relationships play an important part in gender-role identity formation (Usmiani & Daniluk, 1997). Based on parents' reactions to adolescent girls' self-evaluations, and on how girls are evaluated within their families, family members may influence body image and gender-role identity by providing the first set of significant external criteria against which girls learn to evaluate themselves as women, an evaluation that necessarily includes an assessment of their physical adequacy (Fisher, 1986). For



to women who did not adhere to a superwomen ideal (Thornton et al. 1991). It is presumed that the non-adherents of the superwoman ideal are subject to less stress and anxiety as they are not striving to excel across many diverse roles and be all things to all people, but instead are prioritizing these roles and concentrating on a few for which success is of central importance (Steiner-Adair, 1986). However, this would not account for the reduced risk observed among androgynous and undifferentiated superwomen since, by definition, these individuals are not prioritizing either, but maintain a great many diverse roles of central importance (Thornton et al. 1991).

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example, when making the transition from girls to women, mothers appear to serve as significant role models and sources of information and guidance for adolescent girls, regarding who they are as women, how they should feel and behave, and how their bodies measure up to the female gender-role identity (Usmiani & Daniluk, 1997). There is also evidence to suggest that mothers' perceptions of their femininity are related to their daughters' self-perceptions of their femininity (Jackson et al. 1988).

There has been research that has looked at how the gender-typed female is more vulnerable to the influence of stress, thus affecting their predisposition to developing eating and body image concerns. Therefore, attention is now turned to the influence of stress in developing body image dissatisfaction and/or an eating disorder.

### *Stress*

Martz et al. (1995) conducted one study to examine whether the Feminine Gender Role Stress Scale (FGRS; Gillespie & Eisler, 1992) discriminated between young women who were hospitalized with eating and body image pathology and women hospitalized with different diagnoses or non-hospitalized women. Each woman completed the FGRS. Results showed that self-reported gender role stress is significantly higher in women with eating and weight related concerns, suggesting that feminine gender role does indeed play a role in the development and/or maintenance of such concerns.

It is suggested that this disordered eating and body image pattern reflects women's response to the stress of the multiple pressures and conflicting demands placed on the female gender-role (Orbach, 1986). In a culture in which women's roles are complex and frequently conflicting, and the emphasis placed on appearance and thinness

results in unrealistic body image and body dissatisfaction, conditions exist for heightened chronic stress that may contribute to increased risk among women developing an eating disorder (Thornton et al. 1991).

Heilbrun, Jr. and Putter (1986) found that vulnerability to stress was found to be contingent upon the females' sensitivity to traditional role definitions for women and men. For example, they found that females sharing anorexic personality characteristics who were alert to traditional sex-role stereotypes were by far the most highly stressed group, standing in clearest contrast to females who think in traditional sex-role terms but do not report being troubled by feelings of ineffectiveness, perfectionistic needs, and interpersonal distrust, all characteristics of anorexic individuals. Subsequently, Heilbrun, Jr. and Putter (1986) conclude that the failure to distinguish between stress generated by a sense of incompatibility between career and marriage goals or by other uncontrollable features of the female role and stress associated with concern over her weight, leave women vulnerable to continued stress and continued dieting, even if her version of an ideal weight is reached.

Whereas the stress described above was in relation only to stress caused by the female gender role, the construct of stress here is described as the general discontent experienced as a result of other life events. Although a range of psychological factors have been implicated in eating disorder and body image complaints, many studies have suggested that psychological stress is associated strongly with disordered eating (Ball & Lee, 2000). For example, it is believed that stress levels may predict the development of eating and weight related concerns (Schmidt, Troop, & Treasure, 1999). In general,



although stress has been thought to play a role in the onset of these concerns, the nature and severity of these stresses has not been well established until recently (Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997).

Numerous studies over the last 20 to 30 years have been conducted, investigating the nature and strength of the link between psychological stress and health conditions, such as eating disorders (Cooper, Cooper, & Faragher, 1989). Although much of this research has addressed stress-related life events, some have also focused on stress as appraised by the individual, known as perceived stress (Groer, Carr, & Younger, 1993). In one such study by DeMarco, Li, Phillips, and McElroy (1998), global appraisals of stress were more closely associated with eating disorder symptoms than were negative life events, suggesting that perceived stress may have a greater impact on eating and body image concerns than negative life events. This idea was studied further with individuals diagnosed with body dysmorphic disorder. DeMarco et al. (1998) hypothesized that levels of perceived stress would be relatively high in these individuals. Their results supported this hypothesis, suggesting that patients with body dysmorphic disorder do in fact experience high levels of perceived stress, particularly for those individuals who were more delusional in their body image appraisals.

There are different models that have been proposed to explain the relationship between stress and eating or body image concerns. A cumulative stressor model suggests that individuals who experience a large number of relatively normative and/or non-normative stressors may be at risk for developing these concerns (Sharpe et al., 1997). These stressors may come from a variety of contexts, including puberty, family problems, peer problems, or academic challenges.



Another model is the traumatic life events model. According to this theory, unusually severe life stressors play a role in the development of eating and body image concerns as well (Sharpe et al., 1997). Examples of these traumatic events include sexual, physical, or psychological abuse.

The last model proposed by Sharpe et al. (1997) is the normative stressor model. This model proposes that individuals harboring eating and weight-related concerns do not necessarily differ in the number of objectively defined stressors than normal controls; rather, it is the individuals' perceptions of these events that are the critical factor with regard to the development of such concerns.

Research findings have mixed results on the role that stress plays in the development or maintenance of body image concerns. Due to such discrepancies, findings that suggest an association between stressful life events and such concerns are still disputed (Sharpe et al., 1997). Sharpe et al. (1997) believes that stress data differ due to different methods utilized for collection of data. These authors believe that researchers who utilize more unstructured assessment techniques that recognize the participants' appraisals of stressful events are more likely to find significant results than those who take less consideration of individuals' appraisals of stressful events.

In one study, Troop, Holbrey, Trowler, and Treasure (1994) found that clinical samples of individuals with eating and weight related concerns appear to experience higher levels of stress than control subjects. On the other hand, Sharpe et al. (1997) found only a subtle difference between clinical subjects diagnosed with eating pathology and the control group. This study further found that these subtle differences between groups were driven by disorder-specific events. For example, in the eating disordered sample,

the stress associated with living with these disorders (e.g. constant body dissatisfaction, constant hunger, pressure to seek help) was what differentiated between the two groups. Once these events were excluded from analysis, the group differences disappeared.

Stressful life events or difficulties are believed to precede the onset of eating disorders in 76% of cases (Schmidt et al., 1991) as cited by Troop et al. (1994). However, many of these events and/or difficulties fall within the normal range of experiences for young women; therefore, it is likely that other variables may mediate between stress and the onset of eating or body image concerns. One such factor believed to play a crucial role in mediating between stress and the development of such concerns is an individual's perception and capacity to cope with such stressors (Soukup, Beiler, & Terrell, 1990).

Coping refers to the "constantly changing thoughts and behaviors in which people engage in order to manage, tolerate, or reduce internal or external demands" (p. 158) (Troop et al., 1998). It is suggested that a deficit in coping skills or general problem-solving inadequacies may render eating-disordered individuals less able to deal effectively with stress and that the eating or body image concerns may be a manifestation of maladaptive coping styles (Soukup et al., 1990). Therefore, while the pressures experienced by an individual with eating and body image concerns appear capable of arousing and sustaining excessive levels of stress, maladaptive coping efforts to deal effectively with this stress may be just as important a factor (Heilbrun, Jr. & Putter, 1986). For example, women with eating pathology have been found to



demonstrate a reliance on emotion-focused or avoidance coping and have shown a reluctance to share or discuss problems with others (Shatford & Evans, 1986; Soukup et al., 1990; Troop et al., 1994).

Maladaptive coping strategies may stem from women internalizing the stress and blame they feel as a result of not measuring up to the thin ideal our society presents (Ball & Lee, 2002). Ball and Lee (2002) demonstrated this concept by showing that women who were currently engaging in disordered eating behaviors reported a significantly greater reliance on particular coping strategies, which tended to be characterized by an inward focus on the self, or by avoidance. Other researchers have found similar and consistent findings, suggesting that those individuals dealing with eating and body image concerns appear to use more maladaptive coping skills to handle stress (i.e. avoidance, cognitive rumination, pessimism) than a control population (Soukup et al., 1990; Troop et al., 1994; Troop et al., 1998).

Women who rely on these strategies may seek other means of reducing tension or stress. For those women who also experience high levels of body image dissatisfaction, engaging in disordered eating behaviors may be a way of dealing with this stress (Ball & Lee, 2002). Therefore, disordered eating may develop as an alternative coping mechanism in women who rely on self-focused coping strategies and who are stressed about their body weight (Ball & Lee, 2002). For my study, I looked at both the level of stress individuals perceived themselves to be under during the past year, as well as their assessment on their ability to cope with their level of stress.



### *Guilt and Shame*

Beyond being struck by a woman's dissatisfaction with their weight, Silberstein et al. (1987), have been impressed in their clinical and empirical work with another aspect of women's relationship to their bodies and weight: guilt and shame. Due to the fact that women are far more likely than men to feel dissatisfied with their weight, to diet, and to develop an eating disorder, Silberstein et al. (1987) wondered whether it is merely serendipitous that proneness to shame and guilt, and concerns with weight and eating, co-occur in women, or whether they are interrelated phenomena.

A recurring theme in the literature on eating disorders is the notion that shame or guilt (or both) are implicated in women's disordered eating patterns (Burney & Irwin, 2000). Given the realities of the female body shape relative to the culturally defined ideal, many women are bound to emerge from such comparisons with beliefs that their body shape is flawed. This belief may result in feelings of guilt and self-debasement (Thompson, Dinnel, & Dill, 2002). In the clinical literature on eating disorders, anecdotal accounts certainly exist in which guilt and shame in relation to disordered and dissatisfied body views or eating behaviors are apparent (Frank, 1991). However, before discussing this issue further, an explanation on what the concepts of guilt and shame are and the differences and similarities between the two constructs will be examined.

Guilt and shame are often confused, and historically the term guilt has been used loosely to refer to aspects of both emotions (Tangney, 1995), and the terms often have been used interchangeably (Burney & Irwin, 2000). However, while there are some similarities between these two emotions, there are several differences that set guilt and shame apart.

One difference is noted in what it is that causes the guilt and shame response. For example, guilt results from actually having done something wrong, feeling as though one has violated a moral or ethical code by breaking a rule or in some way violating their own beliefs or standards (McFarland & Baker-Baumann, 1990). Unlike guilt, shame can be the result of a nonmoral situation such as failure or defeat (Burney & Irwin, 2000). Shame results from an inherent sense of the self being flawed or defective; it's not whether one has done anything bad, it is that one is bad (McFarland & Baker-Baumann, 1990). Lewis (1987) agreed with this fundamental difference between shame and guilt. According to Lewis, shame arises from the self's negative evaluation of the entire self; that is, after much self-scrutiny the self perceives itself to be inadequate in some respect (e.g. worthless, incompetent, powerless). Guilt on the other hand, is said to arise from the self's negative evaluation of its behavior.

Another difference between shame and guilt is how each emotion leaves the individual feeling. The person who feels guilt, not only spends a lot of mental energy preoccupied by the wrongdoing, but also conjuring up schemes to make things right (McFarland & Baker-Baumann, 1990). Shame results in a different feeling; it may be too difficult to tolerate so the individual becomes temporarily befuddled in her thinking, tending to repress or deny the shaming experience (McFarland & Baker-Baumann, 1990).

McFarland and Baker-Baumann (1990) believe another way of examining the difference between guilt and shame is to look at the difference in the meaning of the words guiltless and shameless. They state that being guiltless is a desired state since it connotes innocence or freedom from blame; however, shameless refers to a deficit in



one's character. To be shameless is considered equal to having no sense of values or morals (McFarland & Baker-Baumann, 1990).

Burney and Irwin (2000) believe that in some situations guilt and shame can co-occur. They give the example that in a moral transgression, people may feel guilty for violating a standard of behavior, and at the same time they may be ashamed of their personal deficiency in this regard. Therefore, in this example, guilt focuses on the tension and regret for having done something wrong, and the experience of shame involves feeling like a bad person for having transgressed.

In addition to the difference between guilt and shame, they do share some important features. For example, both shame and guilt are self-conscious emotions; they involve self-referent processes that apply to some standard of the self or behavior (Lewis, 1992). In addition, shame and guilt are typically evoked by remarkably similar events (Burney & Irwin, 2000). Lastly, both emotions typically involve internal attributions for negative self-relevant events (Lewis, 1987).

Having an understanding of what shame and guilt are and the differences between the two constructs helps us conceptualize how these two concepts play a role in eating and body image concerns. However, there are differing opinions as to the exact role guilt and shame play when it comes to eating disturbances and body image issues. Whereas some see proneness to shame and guilt as causal factors in the psychodynamics of eating disorders, others view these affects more as consequences of having an eating disorder (Burney & Irwin, 2000). Burney and Irwin (2000) believe that if eating-disordered shame and eating-disordered guilt are taken primarily to be consequences of an eating disorder, then these facets of self-conscious affect would seem to throw more light on the nature of



eating-disordered symptoms than on the etiology of eating disorders. When it comes specifically to the issue of etiology of eating and body image concerns, shame has been implicated more. For example, typically anorexics have such a high emotional investment in achieving a thin body that they fail to recognize the severity of their emaciation. In this unrelenting pursuit of thinness a disturbance of body image is a core feature (Williamson, Barker, & Norris, 1993). There is some suggestion that this disturbance is linked to the affects of shame and guilt. In observing that shame was one of the predominant affects in their clinical sample of anorexic patients, Casper, Offer, and Ostrov (1981) argue that feelings of shame about the perceived shape and size of the body inspire the pursuit of a thin body. Due to the differing opinions on the role of shame and guilt in eating and body image issues, a deeper look at each construct in relation to these concerns is warranted.

Some believe that women's ideal body image is not an individualized creation but rather the product of a societal prescription (Silberstein et al., 1987). Shame theorists further postulate that shame can be generated when the individual falls short of her idealized version of herself that has been created, with the ideal versus the real image going beyond the inner self and including the body (McFarland & Baker-Baumann, 1990). Consequently, when the ideal self-image fails to compare to the internalized ideal, body dissatisfaction and shame occur. In shame, the self feels humiliated and the entire self is the object of denigration; the ashamed person understands herself to be bad (Silberstein et al., 1987). Shame in relation to this construct implies that the defect (her body) is inherent in her character; body shame has moved the feeling to the outer, more exposed self, the shell of the defective inner self (McFarland & Baker-Baumann, 1990).

In this sense, being fat comes to symbolize a failure to achieve, and the sense of shame becomes entwined with the fleshy body, believing itself to reveal a defective, needy inner self, a self that is weak, dependent, and out of control (McFarland & Baker-Baumann, 1990). As a result, the heavy body absorbs the inner shame and the individual begins to develop a belief system that says, if only I could lose weight, I would be in control, successful, and happy; body shame becomes the receptacle for self-shame (McFarland & Baker-Baumann, 1990). Therefore, if feeling fat causes a woman to feel shame and hence to be inadequate and worthy of self-denigration, then feeling thin holds the promise of self and other-acceptance (Silberstein et al., 1987).

As a result of the belief that thinness symbolizes power, independence and control, and that fatness symbolizes weakness, dependence, and lack of control, women fall victim to an addictive pride/shame cycle, where achieving thinness is worthy of pride and being fat is shameful (McFarland & Baker-Baumann, 1990). This is enhanced by cultural assumptions that individuals can control their weight and choose the weight they want to be (Noll & Fredrickson, 1998). As a result, dieting is clearly one of the primary strategies to cope with the shame of fatness (Silberstein et al., 1987), promising women relief from the body shame arising from dissatisfaction with body size (Noll & Fredrickson, 1998).

Exercise is another weight loss effort that is used as an attempt to reduce the experience of shame and dissatisfaction with one's body. However, these efforts can also trap women in the pride/shame cycle. For some women, exercise becomes as compulsive and enslaving a regimen as dieting and thus creates its own psychological hazards, while other women find themselves unable to sustain the zealous commitment to exercise



programs (Silberstein et al., 1987). Therefore, as these women swing on and off exercise regimens, much as they do with diets, a similar self-denigration process and pride/shame cycle begins (Silberstein et al., 1987). Consequently, weight loss practices such as dieting and exercise may amplify the experience of body shame rather than alleviate it for these women. In and of themselves, these weight-loss practices lead women to pay more attention to weight and shape, which can heighten and/or increase the frequency of their awareness of their failure to meet physical ideals (Noll & Fredrickson, 1998). This feeling of now further failure again begins and deepens the vicious cycle, in which failure to meet body ideals leads to shame.

In regards to treatment approaches, there are mixed results concerning the effectiveness of exercise programs in the treatment of eating disorders and body image disturbance. For instance, Fisher and Thompson (1994) examined cognitive-behavioral techniques versus exercise therapies for body image disturbance. Their results revealed roughly equivalent positive benefits of the psychologically based treatment and the exercise intervention, with significant treatment effects being found for measures of body image anxiety, body dissatisfaction, and cognitive-behavioral aspects of body image. However, two of these effects were marginal ( $p = .06$ ). This is in contrast to the substantial treatment effects that were found in other exercise outcome studies (Butters & Cash, 1987; Rosen, Cado, Silberg, Srebnik, & Wendt 1990). Despite the debatable level of clinical significance of such interventions, these studies do offer some promise for the development of fitness-based interventions, particularly if they augment a psychologically based treatment.



However, Fisher and Thompson (1994) argue that still much work needs to be done before this type of intervention can be offered without any reservation. For instance, implementation of an exercise program as a treatment for body image disturbance may be considered by some clinicians as problematic because of the possibility of validating the client's disparagement about her appearance (Fisher & Thompson, 1994). Thus, it is important for clinicians to consider the possible reinforcement of negative self-images or sociocultural biases toward thinness via the implementation of a fitness program (Fisher & Thompson, 1994).

Shame also plays a role in eating pathology and body image dissatisfaction by looking at how these women determine their self-worth. For example, some women determine their self-worth, whether they are good or bad, by if and what they have eaten and by how much they weigh (McFarland & Baker-Baumann, 1990). McFarland and Baker-Baumann (1990) state these women view themselves as "good" if they abstain from certain foods, which are viewed as "bad," while on the other hand, see themselves as bad when they give in to desires and are unable to control eating those foods that have been designated as bad. As a result, not only is self-definition rigidly connected to external appearance, but also to the belief that if anything goes wrong with these attempts or life in general, it is the fault of our bodies (McFarland & Baker-Baumann, 1990).

Treating shame when working with body image dissatisfaction is believed to be extremely valuable. In particular, it is believed to be particularly beneficial to help clients identify and articulate the shame that surrounds their weight and body image; given that shame is such a powerful state, it is a profound relief to have it defined and labeled for these clients (Silberstein et al., 1987). Therefore, it is important for therapists to

recognize and manage their own feelings of shame about weight so that they do not subtly communicate to clients that this is a topic to be avoided, or convey a message that may amplify the woman's shame (Silberstein et al., 1987).

One intervention to help individuals overcome their sense of shame is encouraging clients to look at the ideal against which they have been measuring themselves and exploring the physiological as well as psychological obstacles that interfere with their efforts to attain that ideal (Silberstein et al., 1987). Educational strategies that focus on clients changing their body ideal in order to reduce their sense of shame appear to be one useful strategy to achieve this.

Lastly, group therapy is believed to be useful in the reduction of shame-based emotions surrounding eating and body image issues. For example, one of the advantages of seeing this population in group treatment is that they can experience the additional relief of discovering that they are not alone, thus helping to dissipate some of the shame experienced by individuals about their weight (Silberstein et al., 1987).

In contrast to all the literature on shame with eating and body image issues, much less literature has focused exclusively on the role of guilt. In terms of eating disorders, Goodsitt (1985) suggests that anorexics may feel guilty about the "indulgent" act of eating, and this serves to exacerbate feelings of self-negation. In addition, Fairburn (1981) proposes that bulimics' episodes of overeating are marked by a profound sense of loss of control and evokes feelings of guilt and self-disgust.

In the context of eating pathology and body image issues, guilt is considered generally less problematic than shame because in guilt, only a specific behavior (rather than the entire self) is condemned, and as a consequence, guilt does not strike at the



person's core identity (Burney & Irwin, 2000). Although feelings of guilt are painful, the self "remains intact" (Tangney, Burggraf, & Wagner, 1995). Further, guilt allows the individual to experience remorse and to make apologies, and hence guilt is readily more resolved than are feelings of shame (Tangney, 1995).

The inherent difference between shame and guilt in relation to body image and eating concerns was also studied by Sanftner, Barlow, Marschall, and Tangney, (1995). Sanftner et al. (1995) argued that women with eating-disordered behavior would be more inclined to feel bad about themselves (a shame-related experience) in relation to their bodies and their eating difficulties than they do about their behaviors (a characteristic more consistent with guilt). Thus, although both shame and guilt may be implicated, the former would be expected to be more crucial than the latter. Using a nonclinical sample of undergraduate women, the authors found that shame proneness was positively related to the severity of a wide range of eating disturbances (including body image dissatisfaction), whereas guilt proneness tended to be negatively and less strongly related to the severity of such symptoms. Sanftner et al. (1995) suggested the latter findings might stem from the fact that guilt tends to motivate reparation. That is, if guilt-prone people are inclined to resolve their conflicts through reparative action, they will not develop such psychopathology as an eating disorder, and to this extent, guilt proneness is actually a protection against eating-disordered symptomatology.

However, a more recent investigation failed to replicate the findings by Sanftner et al. (1995) of a negative relationship between guilt and eating-disordered symptomatology. In a study of female undergraduates, Bybee, Zigler, Berliner, and Merisca (1996) found eating disturbances were positively related to guilt feelings over



eating and exercise, but were unrelated to global proneness to guilt. These authors' findings lent support to the assumption by Frank (1991) that investigation of the self-conscious affects underlying eating disorders should take into account distinctions between proneness to these affects in a global sense and proneness to the affects specifically in eating-related contexts.

As stated above, the concept of guilt in relation to eating disorders and body image was also tested by Frank (1991). He tested 400 female undergraduate students on eating attitudes, depression, and shame and guilt. His results suggest that women with eating-disorder symptoms experience significantly higher levels of shame and guilt in relation to eating when compared to a depressed and a normal control population. Subsequently, his hypothesis was supported that the existence of eating-disorder symptomatology causes more shame and guilt in relation to eating than in the global experiences of shame and guilt.

Burney and Irwin (2000) also investigated shame and guilt among women who have eating disturbances. These authors examined the question of whether or not shame is a more prominent emotion than guilt among women with body image and eating concerns, and whether eating disordered symptomatology is predicted best by a global propensity for shame, by shame concerned with the specific context of eating, or by bodily shame. Burney and Irwin's (2000) results found that the severity of eating-disordered symptomatology is related not to any global proneness to shame or guilt, but rather to shame and guilt in eating contexts and to shame about the body. Their results also suggest that eating-disordered women tend both to condemn her disturbed eating behavior (guilt) and to condemn her own inadequacy in this regard (shame). However,

eating-associated shame did emerge as a substantially more important consideration than eating-associated guilt. In regards to my study, I chose to look at both guilt and shame separately to assess the different influences they have on body image dissatisfaction.

#### Summary and Purpose

The preponderance of evidence suggests that body image and weight-related concerns result from, or tend to be maintained by, a variety of sociocultural, family, personality, and cognitive variables. However, the specific nature of the interaction and relative contribution of these variables has not yet been identified fully. For example, it is believed by some that the media predisposes individuals to eating and body image concerns. Then when other factors such as family and/or peers reinforce these messages, and they occur in a context of low self-esteem, a poorly developed body image and weight related concerns could develop (Thompson & Heinberg, 1999).

The purpose of this paper is to examine the specific nature of the interaction and contribution of variables related to body image in a nonclinical population. Given the literature reviewed above, it is evident that each variable interacts with one another; therefore, this paper will attempt to address the specific path and contribution each variable has on body image dissatisfaction. A nonclinical population is being assessed due to the relatively universal lack of attention this group has received when studying body image concerns, even though normal control groups have consistently identified dissatisfaction with body image as well as clinical populations. In this study, six variables were analyzed: sociocultural (media) influences, family characteristics, perfectionism, gender-role, stress, shame, and guilt. These variables were analyzed in terms of how they contribute and interact with one another to yield one's view of her



body image and level of body image satisfaction. More specifically, family and sociocultural influences are seen as contextual factors (exogenous variables) in the proposed path analysis, whereas perfectionism, gender-role identity, guilt, shame and stress are the mediating factors (endogenous variables) that contribute to the final variable of body image. More specifically, family and media influences are viewed as the strongest path variables, therefore only having an effect on the other variables, rather than also being affected by the other variables. The path model hypothesizes that all variables interact and contribute to one another to yield different relative contributions to body image dissatisfaction.



## CHAPTER III

### METHOD

#### Participants

The participants were 226 undergraduate and graduate students enrolled at a university in the Midwest. Of the participants, 174 were recruited through a class in which they were enrolled (e.g. Introduction to Sociology, Nutrition and Dietetics, as well as beginning graduate courses in the Department of Counseling). The remaining 49 participants were recruited through a sorority at the university. All students who participated did so voluntarily, and no reimbursement or reinforcement was given for participation.

In order to participate, individuals needed to be females who were at least 18 years of age. In addition, this study looked at a nonclinical population, therefore, individuals who indicated they were currently being treated for an eating disorder were eliminated (n=3).

The mean age for the final participant pool (N=223) was 20.75 years. The ages ranged from 18 to 47 with a standard deviation of 3.85. Education demographics reveal that 32.7% were first year students (n=73), 30% were second year students (n=67), 15.7% were third year students (n=35), 6.3% were fourth year students (n=14), and 15.2% were graduate students (n=34). In addition, cultural demographics reveal 1.3% were Native American (n=3), .4% were African American (n=1), 1.8% were Asian American/Pacific

Islander (n=4), 92.4% were Caucasian (n=206), .9% were Hispanic American (n=2), 2.7% identified themselves as Other (n=6) and one individual did not disclose her ethnicity.

## Materials

### *Demographics Form*

Each participant completed a brief demographics questionnaire that asked her age, year in school, ethnicity, and if they have had prior treatment for an eating disorder.

### *Multidimensional Body Self-Relations Questionnaire (MBSRQ)*

The Multidimensional Body-Self Relations Questionnaire (MBSRQ; Brown, Cash, & Mikulka, 1990) is designed to measure attitudinal aspects towards one's body image. As defined by Cash and Pruzinsky (1990), body image is conceived as one's attitudinal disposition towards their physical self. Attitudes such as affective/evaluative, cognitive/attentional and behavioral are examined with regards to one's disposition. The physical self includes one's aesthetic view of one's physical size and appearance, as well as their attitudes towards their fitness, health, and illness.

The MBSRQ is comprised of 69 self-report items and consists of seven factor subscales and three special multi-item subscales. Cash (1994) describes the seven factor subscales as: Appearance Evaluation, Appearance Orientation, Fitness Evaluation, Fitness Orientation, Health Evaluation, Health Orientation, and Illness Orientation. The three multi-item subscales are: Body-Area Satisfaction, Overweight Preoccupation, and Self Weight Classification. Using a five-point response format (5=definitely agree to 1=definitely disagree), the MBSRQ consists of items that reflect a participant's attitude



towards their semantic domains of appearance, fitness, and health, with each of these domains consisting of two composite subscales of evaluation and orientation (Brown et al., 1990).

Given this study is looking only at body image and how satisfied or dissatisfied one is with her image, only the Appearance Evaluation and Body-Area Satisfaction subscales were used in the analysis, although the entire MBSRQ was administered for reliability and validity purposes.

The Appearance Evaluation subscale is a 7-item scale that describes feelings of physical attractiveness or unattractiveness, as well as satisfaction or dissatisfaction with how one looks. High scores indicate that the individual feels mostly positive and satisfied with her appearance, and low scores indicate a general unhappiness or dissatisfaction with her physical appearance. In the context of the entire instrument, this subscale has a Cronbach's Alpha of .88 and a Test-Retest reliability of .91. Examples of items on this subscale are: "My body is sexually appealing" and "I am unattractive."

The Body-Areas Satisfaction Scale (BASS) is a 9-item scale that measures satisfaction or dissatisfaction with various parts of one's body (e.g. lower torso, arms, face, etc.). High scores on this subscale would represent individuals who are generally comfortable with most areas of their body, while low scores indicate a dissatisfaction with the size or appearance of several areas of their body. Cronbach's Alpha for this subscale is .73 and the Test-Retest reliability is .74.

Analysis was done to determine the appropriateness of combining these two subscales to form one observed variable of body image satisfaction. A bivariate correlation was ran and yielded a strong positive correlation ( $r = .77$ ) between the two



subscales. In addition, the hypothesized path model was run using each subscale as the body image variable separately. This analysis produced almost identical results between the Appearance Evaluation subscale (chi-square/*df* = 1.7, CFI = .99, GFI = .99, RMSEA = .06) and the Body-Areas Satisfaction Scale (chi-square/*df* = 1.9, CFI = .99, GFI = .99, RMSEA = .06). Given these results, and the fact that these two subscales both measure general satisfaction or dissatisfaction regarding appearance and use the same scoring method, these two subscales were combined to form one endogenous variable of body image.

#### *Parental Bonding Inventory (PBI)*

The PBI (Parker, Tur'ling, & Brown, 1979) was used to assess parental characteristics towards the child, as viewed by the child, as well as the parent-child bond. This was done based on the two scales of the PBI, which measure care and overprotection. These scales are scored separately for mothers and fathers using 25 items that are rated on a 4-point Likert scale (0 = very unlike one's parent to 3 = very like one's parent). There are 12 items that make up the Care scale, which combine for a maximum score of 36. High scores on this subscale indicate respondents view their parents as being more caring. This scale asks participants to respond to items such as "spoke to me in a warm and friendly voice" and "seemed emotionally cold to me" (Paker et al., 1979). Thirteen items comprise the Overprotection scale, with a total maximum score of 39. High scores on this subscale indicate respondents view their parents as being less overprotective. Items on this scale were "tried to control everything I did" and "invaded my privacy" (Parker et al., 1979). Directions instruct participants to rate each item based on their relationship with their mother and father separately for the first 16 years of life.

Reliability estimates indicate test-retest at a three-week interval to be .76 for the Care scale and .63 for the Overprotection scale, while split-half reliability for the Care scale is .88 and .74 for the Overprotection scale. Concurrent validity was determined by correlating ratings from independent judges, with .77 correlation for parental care and .50 correlation for overprotection. The independent judges were two of the test developers with inter-rater reliability correlations of .85 and .69 for the Care and Overprotection scales, respectively (Parker et al., 1979). One hundred and sixty-three students were tested over a decade to determine the test-retest reliability over an extended period of time. The mean correlation coefficients between the first two testing points at a five-year interval was .74, between five and ten years was .77, and at ten years was .65. As a result, the authors concluded that “the PBI is a highly reliable measure over an extended period, supporting its claim to be accurate measure of perceived parenting, and so useful in quantifying any parental risk to subsequent psychiatric disorder in childhood” (Wilhelm & Parker, 1990, 2002).

#### *Frost Multidimensional Perfectionism Scale (FMPS)*

The FMPS (Frost, Marten, Lahart, & Rosenblate, 1990) is a 35-item multidimensional measure of perfectionism that provides a total perfectionism score in addition to distinguishing between six factors of perfectionism, including: Personal Standards (PS), Concern over Mistakes (CM), Parental Expectations (PE), Parental Criticisms (PC), Doubting of Actions (DA), and Organization (O) (Frost et al., 1990). Alpha coefficients for each subscale range from .77 to .93. Example questions for each of the FMPS (Frost et al., 1990) subscales include: “I should be upset if I make a mistake” (CM), “I have higher goals than most people” (PS), “Only outstanding performance is



good enough in my family” (PE), “As a child, I was punished for doing things less than perfect” (PC), “It takes me a long time to do something right” (DA), and “Neatness is very important to me” (O). These statements are rated on a 5-point scale, ranging from “strongly agree” to “strongly disagree.”

The FMPS was chosen for this study because it is well supported in the literature, as well as having strong inter-item reliability (total scale = .90) and validity. Concurrent validity was determined by significant correlations in the expected direction between full and sub-scale FMPS scores and the Brief Symptom Inventory (BSI), the Situational Guilt Scale (SGS), the Maudsley Obsessive-Compulsive Inventory (MOCI), and the Everyday Checking Behavior Scale (ECBS; Frost et al., 1990).

#### *Bem Sex Role Inventory – Short Form (BSRI-SF)*

The BSRI-SF (Bem, 1981) is a 30-item, self-administered measure of gender role identity, which asks respondents to rate themselves on a 5-point Likert-type scale, on traits that are stereotypically associated with “femininity” and “masculinity” in our culture. Two subscales make up the BSRI-SF; masculinity and femininity, with ten items for each subscale. Ten items act as filler items that are considered to be gender-neutral characteristics. Scores can range from 5 to 50 on each subscale, with the masculinity and femininity reported means being 30 and 32, respectively. The masculinity and femininity subscales can be used in combination to place individuals in the following categories: masculine, feminine, androgynous, and undifferentiated. Higher scores indicate greater self-endorsement of the characteristics. This study initially used the femininity and masculinity subscales in the hypothesized path model. Internal consistency and reliability coefficient alphas of .75 and .87 are reported for female respondents.



### *Perceived Stress Scale (PSS)*

The Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) is a 10-item self-report measure designed to assess the degree to which situations in one's life are appraised as stressful. It includes items designed to assess the degree to which individuals find their lives to be unpredictable, uncontrollable, and overloaded, and it includes a number of items related to current levels of experienced stress. Respondents answer each statement by indicating how often during the previous year (on a 5-point scale ranging from 0=never to 4=very often) they have felt or thought in the way indicated by the statement. Scores range from 0 to 40, with high scores indicating a greater level of perceived stress. Coefficient alpha reliability for the PSS is .85, and two-day test-retest reliability is also .85.

### *Sociocultural Attitudes Towards Appearance Scale – 3 (SATAQ-3)*

The Sociocultural Attitudes Towards Appearance Scale – 3 (SATAQ-3; Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004) is a 30-item self-report measure that assesses a number of components related to multimedia and body image. This instrument focuses on such components as media consumption, media pressure, internalization of media-communicated ideals, and media messages regarding athleticism and sports. These components make up the four subscales of the SATAQ-3: Internalization-General (nine items), Information (nine items), Pressures (seven items), and Internalization-Athletic (five items). Respondents rate each item on a five-point Likert scale (1=definitely disagree to 5=definitely agree).

The Internalization-General subscale has a Cronbach alpha of .96. Items on this scale include: "I would like my body to look like the models who appear in magazines"

and “I compare my appearance to the appearance of TV and movie stars.” The Information subscale has an alpha of .96. Examples of items on this scale are: “TV programs are an important source of information about fashion and ‘being attractive’” and “Pictures in magazines are an important source of information about fashion and ‘being attractive.’” The Pressures subscale has an internal consistency of .92 and includes such items as “I’ve felt pressure from TV or magazines to lose weight” and “I’ve felt pressure from TV or magazines to have a perfect body.” The Internalization-Athletic subscale has a Cronbach alpha of .95. Items on this scale include: “I wish I looked as athletic as sports stars” and I compare my body to that of people in ‘good shape.’” The SATAQ-3 as a total score measure has a Cronbach alpha of .96. The SATAQ-3 also shows good convergent validity with the Eating Disorder Inventory (EDI), with validity scores being .57 and .49 for the EDI- Drive for Thinness subscale and EDI-Body Dissatisfaction subscale, respectively.

#### *Body Image Guilt and Shame Scale (BIGSS)*

The Body Image Guilt and Shame Scale (BIGSS; Thompson, Dinnel, & Dill, 2002) is a specific body-related, scenario-based measure that indicates proneness to shame and proneness to guilt about one’s body and body-related behaviors. The structure of the scale (the response alternative and scenarios) is modeled on the TOSCA, where proneness to guilt is operationalized as a behavioral response and proneness to shame is operationalized as an emotional response.

Respondents are presented with a series of 15 items followed by four response options that they rate on a five-point scale (1=not likely to 5=very likely). A sample scenario from the BIGSS is “You find that your clothes from last summer are very tight



around your waist,” followed by four response options. For this item, the response options are: “You would feel undisciplined and overweight” (shame response), “You would go out and buy a six-month membership to a gym” (guilt response), “You would think: Well, it’s time to buy some new clothes anyway” (detachment), and “You would think: I’ve been very busy over the last year, with no time to exercise” (externalization/rationalization). Each of the four response options is given a rating. The shame and guilt response options are the only two response options that are scored, with externalization/rationalization and detachment serving as filler items. These response options are randomized across the 15 items.

Internal consistency for the BIGSS is reported at .88 and .90 for the guilt and shame subscales, respectively. Additionally, the guilt and shame subscales show moderate construct validity when compared with the guilt and shame subscales of the TOSCA, with the guilt scales correlated at .48 and the shame scales correlated at .41.

#### Design and Procedure

The participants were given a consent form that describes the study as measuring factors that may or may not influence image satisfaction. After being informed that they could discontinue participation at any time and then signing the consent form, participants were administered the survey packet consisting of the seven measures, which were randomly placed in the packets, and one demographics form. A brief introduction was given to participants regarding the various instruments in the survey packet prior to individuals beginning the study. All survey packets were administered in a group setting. Once participants completed the packet of questionnaires, contact information for the principal investigator and the campus counseling center were distributed in case the

participants had any subsequent questions or concerns pertaining to their involvement in the study.

### Data Analysis

Data analysis consisted of bivariate correlations for each variable measured in the study. In addition, a path analysis was conducted using AMOS 4.0 to assess the proposed fit of the hypothesized path diagram. The path diagram followed the recommended procedure of establishing a model that is grounded in theory regarding the causal relationships among a set of variables. The path analysis in this study provided estimates of the magnitude of the hypothesized effects, with the estimates obtained conditional on the model being correct. In addition, analyses were conducted to test whether my hypothesized model was consistent with the observed data.

In my path model, I am hypothesizing that the endogenous variables of perfectionism, gender-role, stress, shame, and guilt will act as mediating influences between the two exogenous variables and body image.



## CHAPTER IV

### RESULTS

#### Descriptive Statistics

Means and standard deviations for the 12 observed variables are shown in Table 1. The PBI, SATAQ-3, FMPS, PSS, and MBSRQ are all within one standard deviation of the mean, based on reported norms (Parker et al., 1979; Cusumano & Thompson, 2003; Frost et al., 1990; Cohen et al., 1983; Cash et al., 1994). However, the BSRI masculine and feminine subscales are both significantly higher than the normed means, indicating participants identified strongly with characteristics listed. This implies a majority of participants scored highly on both the masculine and feminine subscales, indicating that participants identified themselves as androgynous rather than masculine or feminine. In addition, while the shame and guilt scores are roughly at the midpoint for range of scores on these two scales, the large standard deviation should be noted, given the spread of scores is only 60 points. This appears to imply that respondents tended to be either quite low on guilt and shame characteristics or quite high on these characteristics. After examining response patterns, this was supported given respondents typically rated guilt and shame items with either a one (not likely to have that given reaction) or a five (very likely to have given reaction).

Table 1. Means and Standard Deviations for 12 Measured Variables.

	M	SD
1. Pbimop	27.74	6.77
2. Pbimcare	31.18	7.92
3. Pbifop	28.60	5.81
4. Pbifcare	28.75	7.92
5. Media	92.28	21.29
6. Perfection	99.53	16.51
7. Bemfem	38.90	3.38
8. Bemmas	35.96	4.19
9. Shame	40.98	14.49
10. Guilt	43.60	13.43
11. Stress	18.41	6.08
12. Body Image	51.62	9.51

*Note.* N=223. Pbimop = Mother's over-protection score on PBI, Pbimcare = Mother's care score on PBI, Pbifop = Father's over-protection score on PBI, Pbifcare = Father's care score on PBI, Bemfem = Feminine score on BSRI, Bemmas = Masculine score on BSRI.

Bivariate correlations are presented for each of the 12 measured variables in the path analysis in Table 2. What is interesting to note here is that the only variables not significantly correlated with body image are the two parental overprotection variables as measured by the PBI. On the other hand, media influences, shame, and stress are the most highly correlated with body image. Other strong correlations of note are between guilt and shame, media influences and shame, and perfectionism and stress. Surprisingly, family characteristics of overprotection and care correlated with very few variables other than with themselves. In addition, masculinity and femininity as measured by the BSRI both only showed correlations with body image, while masculinity negatively correlated with shame and stress, and femininity correlated with father and mother ratings of care.



Table 2. Bivariate Correlations for 12 Measured Variables.

	1	2	3	4	5	6	7	8	9	10	11	12
1. Pbimop	-	.43**	.72**	.33**	.01	-.36**	.05	.03	-.03	-.07	-.16*	.05
2. Pbimcare		-	.31**	.61**	-.04	-.33**	.21**	.04	-.05	.02	-.26**	.17**
3. Pbifop			-	.33**	-.02	-.30**	.00	.04	-.03	-.09	-.21**	.09
4. Pbifcare				-	-.03	-.24**	.21**	.08	-.06	.03	-.26**	.22**
5. Media					-	.32**	.08	-.09	.52**	.34**	.35**	-.44**
6. Perfection						-	-.09	.02	.26**	.18**	.44**	-.27**
7. Bemfem							-	.22**	.02	.05	-.12	.23**
8. Bemmas								-	-.24**	.00	-.14*	.32**
9. Shame									-	.55**	.38**	-.50**
10. Guilt										-	.10	-.19**
11. Stress											-	-.47**
12. Body Image												-

Note. \* $p < .05$ . \*\* $p < .01$ . N=223. Pbimop = Mother's over-protection score on PBI, Pbimcare = Mother's care score on PBI, Pbifop = Father's over-protection score on PBI, Pbifcare = Father's care score on PBI, Bemfem = Feminine score on BSRI, Bemmas = Masculine score on BSRI.

#### Path Model

The hypothesized model, which is presented in Figure 1 with standardized regression weights, was used to predict body image dissatisfaction tested by several paths. The exogenous (contextual) variables, which included family characteristics and media influences, in the model were allowed to covary, with multiple paths through the five endogenous (mediating) variables.

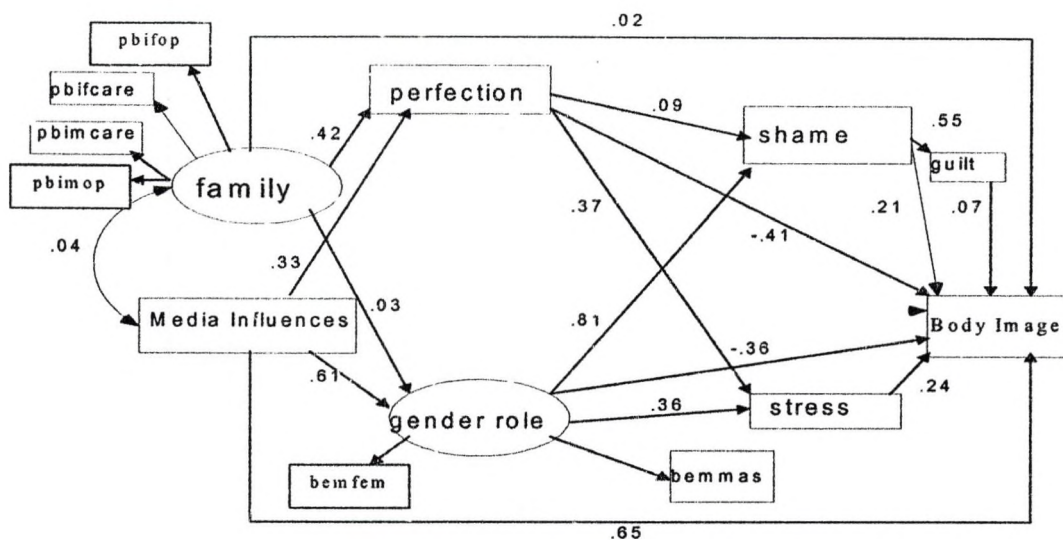


Figure 1. Original Path Model. N = 223. Pbmcare = PBI mother care; Pbficare = PBI father care; Pbmop = PBI mother overprotection score; Pbfop = PBI father overprotection score; bemmas = BSRI masculine score; bemfem = BSRI feminine score.

Adequacy of model fit was determined by using a variety of goodness-of-fit measures, including the chi-square test, the comparative fit index (CFI), the goodness-of-fit index (GFI), and the root-mean-square error of approximation (RMSEA). According to Loehlin (1998), the CFI and RMSEA are the preferred goodness-of-fit indexes by which to assess model fit.

If a model provides adequate fit, a small, nonsignificant chi-square value and a chi-square:*df* ratio less than 2 are expected. Values for the CFI and GFI indexes range from 0 to 1, with models having values above .90 traditionally being considered models with good fit (Loehlin, 1998); however, values of .95 and higher are suggested today as the baseline to assess model fit (Flores & O'Brien, 2002). The CFI is suggested to be used in conjunction with the RMSEA. Smaller RMSEA values indicate a better fit; researchers have suggested that a value smaller than .08 is an "acceptable" fit, and smaller than .06 is a "good" fit (Hu & Bentler, 1999). Hu and Bentler (1999) recommend



joint criteria to minimize the dual threats of rejecting the right model and retaining the wrong model. Specifically, a model can be retained if the CFI is .96 and the RMSEA is  $\leq$  .06. See Table 3 for a summary of the goodness-of-fit indices for the hypothesize body image model.

Table 3. Goodness-of-Fit Summary for Hypothesized Model.

Index	Model 1
Chi-square	161.9
<i>df</i>	43
Chi-square/ <i>df</i>	3.77
CFI	.98
GFI	.98
RMSEA	.11

*Note.* N=223. CFI = comparative fit index; GFI = goodness-of-fit index; RMSEA = root-mean-square error of approximation.

The chi-square/*df* statistic for the model predicting body image dissatisfaction was greater than two, suggesting a poor fit. In addition, other indexes were studied.

Examination of the CFI, GFI, and RMSEA indexes implied that the data fit the model poorly, indicating that the fit between the data and the model could be improved. As a result, the model was rejected.

It is rare that a model fits well at first; therefore, additional modification is often required to obtain a better fitting model. Prior to testing a new model, standardized regression weight and bivariate correlations were reviewed to assess if any points surfaced that were theoretically meaningful in order to refine the hypothesized model. From this analysis, a few details emerged. First, there was an extremely low regression weight from the exogenous variable of family characteristics and the endogenous variable

gender-role. This is consistent with the literature that suggests gender-role is more innate and influenced more by life experiences, rather than being influenced by family (Bem, 1981; Rierdan & Koff, 1985; Attie & Brooks-Gunn, 1989; Golub, 1992; Heinberg, 1996; Usmiani & Daniluk, 1997).

In addition there was an extremely low correlation between overprotection subscales on the PBI to body image, whereas the care subscales were higher and significant at the .05 level. This point is also consistent with theory that suggests it is more parental characteristics of enmeshment, being distant, unloving or uncaring, that play a role in body image dissatisfaction rather than being overprotective (Frank 1991; Leon et al., 1997; Thompson et al., 1999).

Lastly, the feminine score on the BSRI showed to be less correlated to body image than the masculine score. This aspect gets into the issue of the validity of the BSRI characterization of masculinity and femininity and the appropriateness of this distinction in today's society (this will be addressed further in the discussion).

As a result, the overprotection subscales and the feminine scale were removed from the path model, as well as the path from family to gender-role. The modified path model is shown in Figure 2 with standardized regression weights.



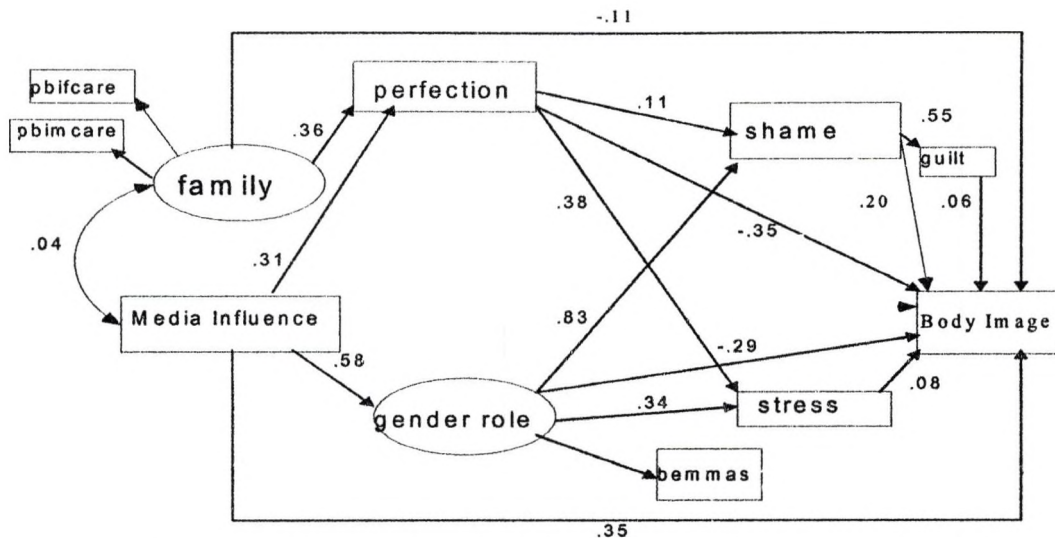


Figure 2. Modified Path Model. N = 223. Pbmcare = PBI mother care score; Pbficare = PBI father care score; bemmas = BSRI masculine score.

The model was rerun with these changes, and the fit indexes indicated a superior fit to the data. Table 4 presents a summary of the fit indexes for the initial hypothesized model and the revised model predicting body image dissatisfaction.

Table 4. Goodness-of-Fit Summary.

Index	Model 1	Model 2
Chi-square	161.9	30.7
<i>df</i>	43	17
Chi-square/ <i>df</i>	3.77	1.81
CFI	.98	.998
GFI	.98	.995
RMSEA	.11	.06

Note. N=223. CFI = comparative fit index; GFI = goodness-of-fit index; RMSEA = root-mean-square error of approximation.

Comparing the goodness-of-fit indices, improvements were made among all four (chi-square/*df*, CFI, GFI, and RMSEA). Furthermore, the revised model met Hu and Bentler's (1999) recommended criteria for model acceptance. As a result, the modified model appears to be a more appropriate fit with the data than my original hypothesized model.

There are several aspects that require further discussion when looking at the standardized regression weights in the final model (Figure 2). First, the contextual variable of media influences does indeed appear to be a strong link to body image dissatisfaction (.35). However, the family variable, which was hypothesized to also play a role in body image dissatisfaction as a contextual variable, did not demonstrate much unique variance to body image (-.11). The family influence however, shows an indirect effect on body image, as family uniquely contributes to perfectionism (.36), and perfectionism in turn uniquely contributes to body image (-.35), although in the negative direction, indicating perfectionism is somewhat of a protective factor against body image dissatisfaction. The media influences also indicate an indirect effect mediated through perfectionism (.31), and even more so through gender-role (.58). What is interesting to note here however, is that both perfectionism and gender-role act as mediating influences in the negative direction, suggesting both are protective factors between media influences and developing body image dissatisfaction.

Second, the gender-role variable demonstrates some interesting findings. Gender-role identity shows to be a protective factor in the development of body image dissatisfaction (-.29); however, it has a significant direct effect to shame (.83). This is noteworthy given that shame has a moderate direct effect to body image (.20), and as a



result, one would expect gender-role to also be a protective factor in the development of shame, as well as body image.

Lastly, the variables of guilt and stress demonstrate a redundancy effect to body image dissatisfaction, meaning little remaining variance is accounted for by these two variables to body image dissatisfaction (.06 and .08, respectively) after prior variables in the path have been taken into consideration.

## CHAPTER V

### DISCUSSION

The present study tested a path model using family and media influences as exogenous variables and perfectionism, gender-role identity, stress, shame, and guilt as mediating endogenous variables to the end endogenous variable, body image dissatisfaction.

#### Hypothesized Model

My original hypothesized path model used media and family influences as correlated exogenous variables for several reasons. First, considering the media variable, it has been argued that body image is formed to a degree as a function of the culturally defined images of a desirable female body and appearance, with the media being credited as the greatest influence in the contribution to body image dissatisfaction. Second, the media's influence is considered a dangerous risk factor given the evidence that the current cultural standard of thinness is an illusion, and without resorting to extremely maladaptive behaviors, nearly impossible to achieve for the average woman. Third, the family influence also is cited as one of the strongest influences in body image and eating disorders. The influence of these variables has been identified by Frank (1999) who discusses the correlated effect between media and family, stating that parents need to be "culture-wise" in their parenting. Culture-wise parenting refers to parents who are able to view the sociocultural environment with a critical perspective, thereby acting as a

formidable influence and transmitting healthier cultural messages about thinness and body shape. Given these theoretical underpinnings, I hypothesized that family and media influences would be the strongest exogenous variables (the contextual variables), therefore only having an effect on the other variables, rather than also being affected by the other variables. While the media influence variable was supported as an exogenous variable in the path analysis, the family influence variable was only partially supported. The care subscales of family influence were supported as comprising this variable, while the overprotection subscale was not.

From the exogenous variables, I hypothesized several paths in my original model. I placed the variables of perfectionism and gender-role next, as they appeared in the literature to be more influential in body image development than did shame, guilt, or stress. I hypothesized a direct path from media influences to both perfectionism and gender-role. My rationale for the path from media influences to perfectionism comes from the literature that suggests women often internalize these unrealistic images of body shape and size in the media. For example, Usmiani and Daniluk (1997) argued that body image is formed to a degree as a function of the culturally defined images, and therefore, one's body satisfaction may be influenced by the degree to which he or she internalizes and believes they meet those cultural standards. The print media and television advertising have been powerful sources in creating an unrealistic cultural standard for women to compare themselves. This social comparison process is seen as a possible mechanism that connects media exposure or pressures to the development of heightened internalization of media values (Thompson & Heinberg, 1999). As a result, I hypothesized that media influences would have a direct effect on perfectionism,



suggesting that the more an individual internalizes these cultural standards, the more likely they will endorse perfectionistic tendencies to meet this standard. This hypothesized path was supported.

I also hypothesized a path from media influences to gender-role. Gender-role is believed to develop primarily in adolescence during puberty. As a result, influences that occur during this stage in one's life can have an effect on one's gender-role development. McCabe and Ricciardelli (2001) stated that during adolescence, peers are perceived to pressure girls to move closer to the societal ideal of extreme thinness, but the same pressure was not seen to be operating on boys to encourage them to increase muscle size or shape. In addition, Garner and his colleagues (1980) documented that over the past few decades, thinness has become a central feature in the definition of feminine beauty. Therefore, I concluded that as a result of given cultural and media pressures, there would be a direct path between media influences and gender-role identity, which was supported in the path analysis.

My hypothesized model also had direct paths from the exogenous family variable to both perfectionism and gender-role. There has been strong support in the literature that suggests parental influence, particularly from mothers, is connected to increased perfectionism in their children. For example, Woodside et al. (2002) examined a variety of characteristics in parents of individuals presenting with body image and eating disordered concerns. Their results showed that the most salient difference between mothers of controls and mothers of individuals presenting with body image and eating disorder symptoms was greater levels of perfectionism. These authors concluded from their results that perfectionism is likely to be both an environmentally transmitted trait a

child learns through modeling, as well as a genetically mediated personality trait. In addition, Hamachek (1978) stated that individuals who originate from early family environments that are disapproving and unloving seek perfection as a means of avoiding their parents' disapproval and attaining their acceptance. The above conclusions support my hypothesis of a direct effect from family influences to perfectionism. This hypothesized path was supported.

My hypothesized path from family influences to gender-role was less supported in the literature and was a relationship I proposed based on the overall theory of body image. Usmiani and Daniluk (1997) are two researchers who do discuss a direct link between family influence and gender-role development, stating that during adolescent development, familial relationships play an important role in gender-role identity formation. They suggest that based on parents' reactions to adolescent girls' self-evaluations, and on how girls are evaluated within their families, family members may influence gender-role identity by providing the first set of significant external criteria against which girls learn to evaluate themselves as women. In addition, they state that mothers appear to serve as significant role models and sources of guidance for adolescent girls regarding who they are as women and how they measure up to the female gender-role identity. Furthermore, the gender-role literature implies that women who endorse such characteristics as being unassertive, dependent, submissive, and focusing on one's physical appearance, put these women at increased risk for developing body image and eating disorder issues (Cantrell & Ellis, 1991). Therefore I implied a link between Usmiani and Daniluk's work, that suggests mothers are role models in their daughters gender-role identity, and Cantrell and Ellis's work, hypothesizing that these



characteristics are developed and learned through family influence and modeling.

However, this hypothesis was not supported.

There were several paths that were also hypothesized based on theory stemming from the perfectionism and gender-role variables. Both perfectionism and gender-role were hypothesized to have a direct effect on shame, stress, and body image. I will briefly touch on the rationale for each of these paths.

In regards to the path between perfectionism and body image, perfectionism has been noted frequently as a key clinical feature and personality style as a central component of body image concerns and eating disorders (Woodside et al., 2002). Theory argues that the desire to be perfect in an individual can interfere with food intake and body weight, culminating in a need to establish order and control over one's body. Many researchers have suggested that individuals who strive to be perfect use this perfectionistic tendency to gain control and succeed at losing weight, while other aspects of their lives may be out of their control. Therefore, while succeeding at other aspects of life may be difficult, losing weight is seen as simple, and once mastered, can be repeated indefinitely to ensure perfection and success. This viewpoint indicates it is a maladaptive form of perfectionism that relates to body image dissatisfaction. The hypothesized path from perfectionism to body image was supported.

Perfectionism is also tied to shame and stress as mediating influences to body image dissatisfaction. As a result, I hypothesized two indirect paths from perfectionism to body image through shame and stress. Literature on perfectionism notes a difference between two aspects of perfectionism; maladaptive and adaptive perfectionism. Maladaptive perfectionism is characterized by excessively high standards, where lapses



or mistakes made by the individual are viewed as disastrous, driving the individual primarily by fear of failure. Davis (1997) demonstrated this point by showing that body image dissatisfaction is most pronounced when high personal strivings are set in the direction of goals that are out of reach of normal expectation, and when the individual experiences a strong fear of personal failure. These two combining forces set up the perfectionistic individual to feel shame and stress. For example, a rigid adherence to self-imposed, but typically unrealistic goals (i.e. body size aspirations), leads an individual to experience shame when these goals are not obtained. Additionally, the pressures from these high personal strivings lead to feelings of stress and anxiety regarding the likely forthcoming failure (i.e. losing weight). Both hypothesized paths from perfectionism to shame and perfectionism to stress were supported.

Gender-role theory also shows support for my hypothesis of a direct path from gender-role identity to body image. Specifically, gender-role orientation has been proposed as an etiological factor in the development of body image dissatisfaction (Heinberg, 1996; Usmiani & Daniluk, 1997). For example, Cash et al. (1986) stated that women, compared to men, evaluate their bodies less favorably, express more dissatisfaction with their bodies, view physical appearance as more important, perceive a greater discrepancy between body image and body ideal, and are more likely to suffer from eating disorders associated with a negative and dissatisfied body image. This direct path between gender-role identity and body image was supported by the path analysis. More specifically, the notion of having a "masculine" gender-identity appears to be a rather strong protective factor in the development of body image dissatisfaction.

Like perfectionism, gender-role is also indirectly tied to body image through direct effects on shame and stress. For example, a woman's preoccupation with a thin body has been explained in terms of a woman's place in the social and political climate of our culture. Social pressures are believed to directly put women at risk for eating disorders and body image concerns because of the overemphasis on thinness as a primary component of female identity (Cantrell & Ellis, 1991). Additionally, these pressures have been discussed in terms of the superwoman ideal (Frank, 1999). The superwoman ideal places conflicting messages and pressures on women. On the one hand, women are inundated with pressures to conform to the current media images of female beauty, while at the same time, also being pressured to be independent, intellectual, and autonomous, both domestically and in the workplace. These pressures, like with perfectionism, leave women susceptible to experiencing great levels of shame and stress if they feel they do not measure up. Additionally, these hypothesized paths were supported.

The last three endogenous variables (stress, shame, and guilt) in my hypothesized path model act primarily as effects of the prior variables in the model, with each variable also having a direct path to body image. Each of these three variables has been shown to have some relationship to body image, supporting my hypothesized paths from each variable to body image, with all of these paths being supported by the path analysis.

Stress has been suggested by many studies to be associated with disordered eating, with some theorists proposing that stress level may predict the development of eating and weight related concerns (Schmidt et al., 1999). In addition, DeMarco et al. (1998) demonstrated that global appraisals of stress were more closely associated with eating disorders and body image dissatisfaction than were negative life events, suggesting



that perceived stress may have a greater impact on such concerns than do negative life events. However, research findings have mixed results on the role that stress plays in the development or maintenance of body image concerns. Due to these discrepancies, findings that suggest an association between stressful life events and such concerns are still disputed.

Shame and guilt are also demonstrated in the literature to play a role in body image dissatisfaction, supporting my claim of a direct path between both shame and guilt and body image. However, when it comes specifically to the issue of etiology of body image concerns, shame has been implicated more. This was my justification for including shame as a major endogenous variable with other variables in the model, as opposed to guilt, which is only associated with shame. Shame theorists postulate that shame can be generated when the individual falls short of her idealized version of herself that has been created, with the ideal versus the real image going beyond the inner self and including the body (McFarland & Baker-Baumann, 1990). Consequently, when the ideal self-image fails to compare to the internalized ideal, body dissatisfaction and shame occur. In shame, the self feels humiliated and the entire self is the object of denigration; the ashamed person understands herself to be bad. Shame in relation to body image implies that the defect (her body) is inherent in her character; body shame has moved the feeling to the outer, more exposed self (McFarland & Baker-Baumann, 1990).

In contrast to all the literature on shame with eating and body image issues, much less literature has focused exclusively on the role of guilt. In addition, guilt is considered generally to be less problematic than shame because in the experience of guilt, only a specific behavior (rather than the entire self) is condemned, and as a consequence, guilt

does not strike at the person's core identity (Burney & Irwin, 2000). As a result, I hypothesized guilt to be an outside influence on body image, influenced primarily by its correlated counterpart, shame.

Although several of the predicted paths were in fact supported in the path analysis, an overall good fit was not found for my original hypothesized model. Therefore, based on observation of the obtained regression weights and the theoretically driven predictions, a number of modifications were made to the hypothesized model, ultimately resulting in a model that did adequately fit the data. These modifications will be discussed below.

#### Changes to the Hypothesized Model

One modification that was made to the hypothesized path model was removing the parental overprotection subscales and leaving only the care subscales. The overprotection subscale on the PBI asks participants to rate their mother and father separately on such items as "Invaded my privacy" and "Gave me as much freedom as I wanted." Such characteristics have not been as highly endorsed in the theoretical literature. On the other hand, characteristics that comprise the care subscale of the PBI, which include: "Seemed emotionally cold to me" and "Made me feel I wasn't wanted," are commonly endorsed in the literature as playing a role in the development of body image dissatisfaction and eating disorders. For example, some frequently cited environments or parental characteristics are: low cohesion in the family, less empathic, less emotionally supportive, less affectionate and warm, more neglectful, and enmeshment (Thompson et al., 1999).



Frank (1991) looked particularly at family enmeshment and empathetic failure. He states that family enmeshment that focuses on issues of food, weight, appetite, and eating may explain why anorexic and bulimic women develop shame and guilt in relation to eating. Additionally, empathetic failure may become exacerbated when the daughter develops an eating disorder, as her disturbing symptoms often provoke inappropriate intrusiveness from those around her. This exacerbation in turn results in further shame and guilt.

In addition, a family environment that is less accepting and more critical, particularly of a child's appearance, could result in the adolescent's need to change herself through changing the body (Leon et al., 1997). All of these characteristics are repeatedly discussed as being influential in the body image literature, and are also the characteristics that make up the care subscale on the PBI, while characteristics on the overprotection subscale are much less cited. As a result, there appeared to be a theoretical justification for removing the overprotection scales.

A second change that was made to the hypothesized path model was removing the BSRI femininity scale. The justification for this came after reviewing several articles that reassessed the usefulness of the masculinity and femininity scales on the BSRI. Several theorists have begun to question the usefulness of this scale in regards to how it categorizes masculinity and femininity. Auster and Ohm (2000) point out that in the nearly three decades since the BSRI was developed, women's roles in American society have changed in a variety of ways. One of the most notable changes has been the involvement of women in the workforce, especially married women and married women

with children. In addition, women's educational achievement and employment in previously male-dominated fields has begun to expand.

Given all this, it appears that the assumption underlying the development of the BSRI, that so-called masculine traits and feminine traits are mutually exclusive (e.g. if independent is considered masculine by a man in his definition of self, then it cannot be considered feminine by a woman in her definition of self), is an erroneous assumption (Hoffman & Borders, 2001).

As a result of this review of the literature on the BSRI, I concluded that many of the "masculine" traits are traits that are now more gender-neutral in today's society and would be endorsed more by females (particularly females in this sample who are all attending college) than the "feminine" traits. For example, traits on the BSRI such as: "independent," "self-reliant," "assertive," and "have leadership abilities" are now more commonly held by females as well as males, while characteristics such as "yielding," "shy," and "flatterable" are less characteristic of females in today's society. Therefore, I am taking the stance that the "masculine" subscale on the BSRI represents an equally adequate, if not a better, picture of the female gender-role in today's culture as does the "feminine" subscale. This will be discussed further under the limitations of this study.

In addition to these critiques of the BSRI, points made earlier from McCabe and Ricciardelli (2001) and Garner et al. (1980) show justification for only using the masculine subscale in this study. The work by these authors suggest that taking on more masculine characteristics as opposed to feminine characteristics could protect oneself from feeling pressured to live up to the cultural definition of feminine beauty. This is also supported by several researchers who have found that masculinity in females is related to



more favorable body image (Jackson et al., 1988; Cross & Tarnai, 1983; Kimlicka et al., 1983).

The third and final change that was made to the path model was removing the direct path from family influence to gender-role identity. As was stated prior, this path was not supported by as much theory as my other hypothesized paths; therefore, it is not surprising that this path provided a poor fit.

Gender-role has been suggested to be influenced more by innate factors, such as puberty, or cultural influences, such as cultural definitions and expectations of femininity, rather than parental influence. For example, puberty and maturational timing, as well as negative verbal commentary and teasing from peers are suggested to play an influential role in gender-role identity (Heinberg, 1996). Puberty and the beginning of menses have been identified as a pivotal event around which a young girl's attention turns to her developing body and the distinction between maleness and femaleness becomes more apparent (Rierdan & Koff, 1985). Some theorists suggest that this developmental transition in the female life cycle produces a sense of discontinuity in a girl's psychological self-structure, requiring reorganization and reintegration of these changes in terms of her gender-role identity (Attie & Brooks-Gunn, 1989). The reorganization of a girl's gender-role identity at this stage in development appears to be in the direction of greater feminine differentiation (Golub, 1992). This is evidenced by increased attempts for girls to differentiate themselves from boys in personality and appearance (Usmiani & Daniluk, 1997). Therefore, the development of gender-role identity appears to include the crucial task of integrating physical changes with societal expectations of gender appropriate behavior and appearance (Bem, 1981). The above discussion leads to the

argument that there are stronger factors in the development of gender-role than family influences, supporting my decision to drop the hypothesized path between family and gender-role.

### Identified Model

The final path model demonstrated several important findings, some of which were expected and others that were not. The following is a list of the major findings in this path analysis.

1. As expected, the cultural variable of media influence showed a direct path to body image, suggesting that the more one internalizes media messages and the more importance one places on these messages, the more likely they are to be dissatisfied with their body image. Furthermore, a moderate amount of the effect of the media influence variable on body image dissatisfaction is explained through the mediating effects of gender-role.

2. While the negative direction of family influence to body image dissatisfaction was expected (the more care and love from parents, the less dissatisfied with body image), the low regression weight was not expected. This indicates that family influence, at least in terms of characteristics associated with care as measured by the PBI, is not that strong of an influence on body image dissatisfaction. The path model also indicates that most of the effects of family influence on body image are explained through the mediating effects of perfectionism

3. Perfectionism did show a direct effect on body image dissatisfaction; however, this effect was in the negative direction. This initially seemed to contradict a vast majority of the current literature. However, after reviewing items and subscales of the



FMPS, which was used to measure levels of perfectionism, it appears that four of the six subscales of the FMPS (i.e. Concern over Mistakes, Personal Standards, Doubt over Actions, and Organization) may actually measure perfectionism on an adaptive-maladaptive continuum. Results of this scale indicate individuals scored more on the adaptive end of the continuum for these subscales. Therefore, these results suggest that adaptive perfectionism is a protective factor against developing body image dissatisfaction. In other words, the more adaptive perfectionist tendencies one possesses, the less likely they are to develop a dissatisfied body image.

4. Gender-role identity (specifically “masculine” identity) also shows a moderate direct effect on body image dissatisfaction in the negative direction. This result was expected as it is consistent with findings that demonstrate females endorsing more “masculine” traits as measured on the BSRI, are less likely to be dissatisfied with their bodies.

5. The variable shame suggests a low to moderate direct effect on body image, while stress and guilt show very low direct effects on body image dissatisfaction. This could initially appear to be a contradiction to the literature that suggests all three are linked to body image concerns; however, given this is a path analysis what it demonstrates is that these three variables are redundant to body image dissatisfaction and do not add any unique contribution when the other variables have already been taken into consideration. In other words, the prior four variables already explained a significant amount of the variance in the final body image dissatisfaction variable.

In addition to the results rendered from the path analysis, bivariate correlations were also examined among the variables assessed in this study. The following is a list of the major bivariate correlation findings.

1. Family influence was measured by assessing maternal and paternal overprotection and care. Results demonstrated that there is very little correlation between overprotection factors and body image development, regardless of the sex of the parent. In fact, this overprotection variable was the only variable not significantly correlated with body image. On the other hand, both maternal and paternal levels of care implied significant correlations at the .01 level. Therefore, characteristics such as feeling loved, cared for, and understood by both parents demonstrate significant relationships to body image development.

2. All four family variables that were used to assess family influence showed significant negative correlations with perfectionism. This supports the assumption of a strong link between parental influence and perfectionism.

3. Media influence was correlated to perfectionism, shame, guilt, stress, and body image, all in the expected direction. This is expected given the strong influence and pressures of current media images. However, what was surprising was that media influence was not correlated with either the feminine or masculine gender-role identity. This is in contrast to the path analysis that showed a strong direct path from media influences to gender-role. Also surprising, was that media influences was third in strength of correlation to body image behind shame and stress. One would have expected this to be a bit higher given the vast array of theory on sociocultural messages and body image.



4. Perfectionism, shame, and stress show significant positive correlations with one another, indicating greater levels of one of the variables are linked to greater levels of the other two variables.

5. Shame, not surprisingly, showed a high positive correlation to guilt. In addition, shame demonstrated the highest correlation to body image, while guilt was one of the lowest. This is consistent with the literature that suggests shame is a much stronger influence in the maintenance and development of body image than is guilt. This finding suggests that had shame been entered into the path analysis at an earlier stage, it likely would have demonstrated a strong direct path to body image; however, the other variables had already accounted for much of the unique variance associated with shame in the path model.

6. Finally, stress shows the second highest correlation to body image. This study measured stress as perceived stress from the individual. Therefore, it supports previous research suggesting perceived stress is a better indicator of body image concern than is stress caused by negative life events (DeMarco et al., 1998). Like with shame, the high correlation of stress indicates it too likely would have shown a strong direct path to body image had it been entered into the path earlier.

The path analysis tested variables that have been suggested as being influential in the development of body image dissatisfaction and eating disorders in a clinical population. This study's purpose was to test not only the hypothesized path model with these variables, but also to demonstrate whether or not these variables have similar influence in a nonclinical population. Overall, the findings support the hypothesis that the factors that are influential in the development of body image dissatisfaction in a clinical

population are similar in a nonclinical population, leaving these women susceptible to developing an eating disorder.

Despite a large amount of support for this hypothesis, some findings were incongruent with what has been suggested in the literature regarding clinical populations and body image dissatisfaction. Most notably was the lack of findings with family influence and body image. There has been much research that has focused on the role of parental characteristics in developing an eating disorder and body image concerns (e.g. fathers who are unloving and distant, mothers who are uncaring, harsh or critical). Despite this prior work, this was not supported when studying a nonclinical population. This highlights the notion that these familial characteristics have more of a relationship to clinical populations who suffer from an eating disorder, rather than to a nonclinical population who endorses body image dissatisfaction.

The second finding that was incongruent with eating disorder and body image research was the lower correlation between guilt and body image dissatisfaction. While shame has emerged as the more dominant emotion in the shame/guilt debate, guilt is still considered to have a powerful relationship to eating disorders and body image concern. However, the results of this study demonstrate a low negative correlation between guilt and body image, suggesting guilt is not as prominent in a nonclinical population.

In conclusion to this section, preventing any disorder or symptom involves identifying the pathogenic factors that put individuals at risk for developing such a disorder. In the case of this research, I was hoping to expand on prior research, and add new information, regarding the pathogenic factors in body image dissatisfaction. My aim here was to identify the magnitude and directions of certain factors as they relate to body



image dissatisfaction. This research is important given the plethora of research that suggests body image dissatisfaction is one of the leading, if not the leading, etiological factor in the development of an eating disorder.

Body image is suggested to be a multi-dimensional and complex construct, involving a variety of internal and external factors. Despite research that has already been carried out, a comprehensive review of these various factors regarding body image dissatisfaction has not been conducted. Therefore, this study's purpose was to offer new insight regarding the multidimensional aspects of body image, which I believe has been accomplished.

The findings of the current study highlight the importance of the interactions between several of the contributing factors. Specifically, the identified model highlights the importance of media messages and the influence they may have on females in today's society. One of the strongest links to body image is the direct path of media influence, as well as the indirect path of media influence through gender-role. That the masculine gender-role shows to be a protective factor to body image is particularly noteworthy. Furthermore, the findings of the current study highlight that family influence appears to be an indirect influence on body image, specifically through perfectionism (namely adaptive perfectionism). The lack of findings for family influence and overall perfectionism in both the path analysis and bivariate correlations suggest that these variables may be more uniquely contributed to eating disorders, rather than to body image. Lastly, the current study points out the strong correlations between shame and body image, as well as stress and body image. Therefore, these two constructs continue to be well supported as having a strong relationship to both eating disorders and body

image. Overall, this study demonstrated several important findings, with media influence, shame, and stress suggesting the strongest links to body image dissatisfaction. Having this information will help practitioners work from a preventative standpoint regarding body image concerns and the development of an eating disorder.

#### Limitations

There are some limitations for this study given the nature of survey research and some of the instruments used. Among the limitations is sample size. Sample size for conducting path analysis is recommended to be between at least 200 and 300 participants, depending on the number of variables. Given the number of variables I have in this study, my sample size (N=223) may be considered somewhat low. Another limitation in this study concerning my sample is homogeneity. As was discussed earlier, my sample was primarily Caucasian (92.4%), with approximately 75% of my sample being between the ages of 18 and 21. Therefore, the generalizability of this study is questionable, as participants were not diverse in age or race. Consequently, the results of this study should be applied with caution to populations that are not Caucasian and of traditional college age.

There are also limitations to this study regarding two of the instruments used. First, the PBI is a possible limitation to this study. The PBI asks participants to rate both a mother and a father on given characteristics in their first 16 years of life. Two issues arise from this instrument. One is that individuals may not have been raised in the traditional family context suggested by the PBI, leaving participants unsure how to proceed in responding to this inventory. Six participants indicated they did not know their father growing up and so this information was left blank. This may be a confounding



variable that was not taken into consideration. Second, the PBI is assessing the first 16 years of life. In hindsight, I may have wanted to choose an instrument that measured primary caretaker(s) characteristics throughout one's life, rather than focusing only on the first 16 years. This would have been appropriate given that some believe certain family dynamics may emerge as a result of an individuals' struggle with body image or eating disorders, rather than vice versa (Webster & Palmer, 2000).

Another limitation regarding the PBI is that in hindsight, the PBI was not truly measuring family influence as it was intended to be measured. When initially setting up the path model, family influence was conceptualized not only as parental characteristics, but also as the parent's role in communicating certain messages related to media images of females and the media's idea of what is considered beautiful. More specifically, what I was hoping to tap into was the impact parents can have on their children by either criticizing or endorsing media messages, and the effect these specific messages had to future development of body image dissatisfaction. However, by using the PBI, only parental characteristics was assessed, rather than the additional, and perhaps more important, aspect of family influence; the messages that are communicated from parents regarding media pressures.

Another instrument that is a possible limitation to this study is the BSRI. Although remnants of the traditional gender role expectations for women remain a part of today's society, many societal changes have occurred for women since the time of the original development of the BSRI. This may explain in part why the masculinity scale of the BSRI fit well with the observed data and showed to be a protective factor against developing body image dissatisfaction. Prior literature has suggested that androgyny

(defined as high scores on both masculine and feminine characteristics) would have been a better approach in this study as the gender-role variable. For instance, Bem and Lenney (1976) state that androgynous individuals do not feel constrained to behave in ways associated with only masculine or feminine gender roles, therefore demonstrating greater flexibility and adaptability. This, along with prior literature discussed, seems to suggest that androgyny would serve as a better protective factor than the "masculinity" subscale of the BSRI. However, an alternative model was tested using androgyny as the gender-role variable and was not supported by goodness-of-fit indices ( $\chi^2/df = 7.63$ ; CFI = .979; GFI = .976; RMSEA = .173). This shows further support for using the "masculinity" subscale in the path analysis.

## Implications

### *Practice Implications*

Implications for this study pertain primarily to practice. This study was meant to address the prevention of eating disorders by looking at one of the leading factors in the development of an eating disorder; body image dissatisfaction. Body image research has examined the subjective perceptions of, and attitudes towards, the size and shape of one's body and have found that body dissatisfaction (even after controlling for weight) is one of the strongest predictors of disordered eating in clinical and nonclinical populations (Davis et al., 2000; Rosen, 1996). Therefore, this study looked at various factors contributing to body image dissatisfaction, as a means of intervening earlier in the development of eating disorders by recognizing what variables contribute (and in what way they contribute) to body image dissatisfaction. For example, if the internalization of media messages or issues of perfectionism are treated earlier, this may decrease the



chance of one becoming dissatisfied with her body, therefore lowering her chances of going on to develop an eating disorder. There are several practical implications as a result of this research.

First, one of the most common errors psychologists can make in working with individuals with eating disorders is ignoring the issue of body image. This has been argued as early as 1962 when Bruch stated that successful treatment of eating disorder symptomatology without a corrective change in body image would likely be short lived. Therefore, one of the essential roles for psychologists is to be cognizant of the function body image concerns play in the development of increased harm, such as eating disorders.

Psychologists should be responsible for having a basic understanding not only of the role of body image, but also the underlying factors, such as the ones discussed in this study, that contribute to body image dissatisfaction. Having this knowledge will hopefully help equip psychologists to better identify who is at risk for the later development of an eating disorder. If this is the case, then psychologists could work from a preventative standpoint with vulnerable groups regarding the development of eating disorders and could help improve treatment procedures for short and long-term outcomes.

Second, psychologists need to be aware of his or her ability to convey a message that may amplify the woman's shame, such as communicating that issues of body image seem trivial or vain. Amplifying an individual's level of shame can lead to greater body image dissatisfaction, given the results of this study that demonstrate a strong positive correlation between shame and body image dissatisfaction. In addition, psychologists may misread the issue and identify a lack of will power to stick to a diet and lose weight

as the presenting issue, therefore citing a female client's decision to go on and stick to a diet as a reflection of her improved mental health (Silberstein et al., 1987). However, this should no longer be the appropriate role for psychologists to take. Rather, psychologists should emphasize with clients that while they may not be responsible for their body image struggles, that they are responsible for taking on the challenge of developing a healthy solution. One such solution is encouraging clients to be deliberate about being in situations where body acceptance is more important than body perfection (Kearney-Cooke & Striegel-Moore, 1997). Size acceptance is a critical topic to discuss and encourage for clients, which could result in fewer feelings of shame, guilt, or stress, particularly towards one's body. As a result, one could begin to accept her shape and size.

Lastly, it is evident that body image dissatisfaction is likely developed during adolescence. Therefore, knowledge gained from this study in regards to certain variables could be incorporated into a psychoeducational program during junior high school as an attempt for early intervention. For instance, during the course of a health education class, one of the topics discussed could be body image. This psychoeducational approach could include taking a critical look at media messages, or talking about shame, guilt, stress, and perfectionism tendencies and helpful ways to reduce or cope with such characteristics or behaviors.

#### *Research Implications*

There are also implications in regards to future research in this area. First, the literature on body image primarily consists of looking at body image alone (as a multidimensional construct) or looking at body image with one other variable. As a result, instruments that are used to measure body image lack sufficient dimensions to



grasp an overall picture of the individual's body image and where his or her particular struggles are that add to feeling dissatisfied. This leads to lengthy assessment procedures to assess a client's body image or eating disorder symptoms along with what factors contributed to these concerns. Therefore, future research could include using the results of this study to design a new body image dissatisfaction questionnaire that assesses not only body image dissatisfaction, but also a broad range of factors that may be contributing to this dissatisfaction.

In relation to the development of a new questionnaire, researchers seemed to have missed the boat regarding the parental impact on their children regarding media messages about female beauty. Future research could take a closer look at how much of a protective factor parents can be in the development of body image dissatisfaction when media messages are critiqued and criticized. There is no questionnaire currently available that taps into this aspect of parental influence on body image dissatisfaction, despite the fact that it has been heavily discussed in the literature (i.e. culture-wise parenting).

Third, future research would include expanding this study to gather a more diverse participant pool. This research would be beneficial in knowing the generalizability of the results and if these results could be used when working with clients of different ethnicities and ages.

Lastly, future research should be encouraged to look more at the male population when studying body image. A similar study such as the one conducted here could be carried out with a male population so that psychologists could be aware of the differences between genders.

### *Theory Implications*

Based on the results of this study, there are also implications to the theory on body image dissatisfaction. The first implication regards the issue to gender-role identity. As was discussed in the limitation section, there are questions on the validity of the BSRI distinction between "masculine" and "feminine." Theory on gender-role, particularly as it relates to body image, should start to incorporate the shift that has occurred in today's society regarding the role of women. Empowering women is now a crucial aspect in many treatment approaches with women, as well as in the everyday lives of women. Empowering women means women becoming more self-reliant, assertive, and independent, the very characteristics that are viewed as only being "masculine" on the BSRI. Given these "masculine" characteristics demonstrated a protective quality on body image dissatisfaction, empowerment and encouraging women to strive towards these characteristics may lead to developing healthier body images.

A second implication in regards to theory involves the role of perfectionism in body image. Current theory states that perfectionism is a strong influence in the development of body image dissatisfaction, as well as eating disorders. However, the distinction is rarely made between the different aspects of perfectionism (i.e. maladaptive versus adaptive). It is important for theory to start incorporating this viewpoint given that perfectionism is often viewed as a multidimensional construct, yet the different dimensions are rarely viewed separately. This study provides beginning work in the area of adaptive perfectionism as it relates to body image. The FMPS, as a function of some of its subscales, appears to measure the construct of adaptive perfectionism (i.e. "I am a neat person," "Organization is very important to me," "I am very good at focusing my



efforts on obtaining a goal"). Therefore, theory should not only be looking at maladaptive perfectionism as it relates to the *development* of an eating disorder, but also adaptive perfectionism as it relates to the *prevention* of an eating disorder.

Third, theory related to family influence on body image dissatisfaction could be expanded. Current theory includes discussion on limited family characteristics and family environments. Future theory and research should look at broadening the family influence to include other possible environments or characteristics, particularly looking closer at the father's role, given that much of the theory is based on the mother's influence. Family theory should also begin to incorporate nontraditional family environments as well (i.e. single parent, grandparent, same-sex households), rather than focusing solely on mother/father households. Lastly, as mentioned prior, family theory should continue to expand upon the notion of culture-wise parenting and the influence parents can have in how they convey specific messages to their children regarding media messages of female beauty.

The last implications relate to the two variables that demonstrated the strongest correlations to body image, shame and stress. The current research supports the claim that shame does in fact play a more crucial role in body image development and maintenance than does guilt. As a result, shame theory could begin to develop shame-based approaches to treatment of body image and expanding the role shame plays in this arena rather than continuing to argue the debate between shame and guilt.

Lastly, perceived stress has been suggested as being the most influential form of stress in the development and maintenance of body image dissatisfaction and eating disorders. The current research supports this theory. As a result, stress and body image

theory is right in looking at coping strategies and should be taken one step further to discuss the ramifications of having unhealthy or inadequate coping strategies to deal with an individual's high amount of perceived stress. Additionally, this theory could develop strategies to help individuals recognize the incongruence between their perceived level of stress and actual or more realistic level of stress.

### Conclusion

The importance of having an understanding of body image concern and its impact on women and the development of eating disorders is somewhat overlooked in the literature. Research has demonstrated over and over again that body image dissatisfaction is one of the strongest predictors of disordered eating, not only in clinical groups, but in nonclinical groups as well. Despite these results, current literature and research still focuses almost exclusively on the nonclinical population.

Furthermore, even with all the attention that is placed on individual factors of body image dissatisfaction, little remains known about the interaction of multiple factors and how these factors affect this widespread group of females who admit to dissatisfaction over their perceived bodies.

Therefore my hope in this study was to add new insight into this topic that will be useful for psychologists in helping accomplish their role when working with women suffering from body image dissatisfaction. Given the widespread nature of body image dissatisfaction among females, this is a critical topic to understand in hopes of beginning to understand who, among such a large group reporting body image concern, will go on



to develop an eating disorder. This understanding regarding the role of body image dissatisfaction in developing eating disorders may allow psychologists to use body image work for both the prevention and treatment of eating disorders.

APPENDICES



## I. Consent Form

You are being invited to participate in a research study that is trying to measure factors that may or may not influence body image satisfaction. The research is being conducted by Kiri Faul, a doctoral student in the UND Department of Counseling.

If you are willing to participate in this research, you will be asked to complete a survey packet containing eight brief questionnaires. The questionnaires include a demographics form, and instruments measuring body satisfaction (MBSRQ), parental characteristics (PBI), perfectionism (FMPS), gender-role identity (BSRI-SF), stress (PSS), sociocultural influence (SATAQ), and guilt (BIGSS). The total time to complete these inventories will be between 30 and 45 minutes. The forms are completely anonymous (no names will be requested), and participation in this research is completely voluntary. You may decline to participate or withdraw from participation at any time. You will not be penalized in any way for withdrawing from the research, and withdrawing will have no effect on your relationship with the University of North Dakota or the classes in which you are enrolled.

There are a few risks involved in participating in this study. Confidentiality will be protected and you will personally not be associated with the study in any way. Your confidentiality will be protected by collecting and storing your signed consent form separate from your responses. Furthermore, no identifying information will be attached to your responses. The other risk involved in this study is the possibility of experiencing psychological discomfort. However, this possibility is believed to be quite low. If you do begin to experience emotional discomfort in any way, please refer to the referral list of resources where you can contact a trained individual to talk with.

If you choose to participate in this research you will have the opportunity to take part in a research study that will help determine various influence in body image satisfaction and eating disorders. This may be useful to a wide range of individuals within the helping profession.

This consent form will be kept separate from the data collected in this study to ensure confidentiality. This information will be kept for three years in a locked cabinet in the Department of Counseling at UND. After a period of at least three years, this information will be destroyed by burning or shredding. Only the researcher named above, her advisor, Dr. Cindy Juntunen, and people who audit IRB procedures will have access to the data. All information will be kept confidential, unless information related to child abuse or harming one's self or others is revealed in the course of the study.

Please read the statement below, then write and sign your name on the appropriate blanks. A copy of this form will be given to you for your records.

If you have any concerns or questions in regards to this study, please call Kiri Faul at 701-795-5950, or her academic advisor, Dr. Cindy Juntunen at 701-777-3740. If you have any other questions or concerns, please call the Office of Research and Program Development at 701-777-4279.

I have read the above information, and my questions about this research have been answered to my satisfaction. I agree to participate in the study described above. I understand that I can withdraw from the study at any time without penalty.

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## 2. Demographics Form

Please respond to all questions or place an "X" by the appropriate choice:

What is your current age? \_\_\_\_\_ years

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Year in School:

\_\_\_\_\_ 1<sup>st</sup>  
\_\_\_\_\_ 2<sup>nd</sup>  
\_\_\_\_\_ 3<sup>rd</sup>  
\_\_\_\_\_ 4<sup>th</sup>  
\_\_\_\_\_ > 4

Ethnicity:

\_\_\_\_\_ Native American  
\_\_\_\_\_ African American  
\_\_\_\_\_ Asian/Pacific Islander  
\_\_\_\_\_ Caucasian  
\_\_\_\_\_ Hispanic American  
\_\_\_\_\_ Other

Have you previously or are you currently seeing a mental health practitioner for an eating disorder? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please state the combined duration of therapy rounded to the nearest month.  
\_\_\_\_\_ months



### 3. Multidimensional Body Self-Relations Questionnaire (MBSRQ)

The following pages contain a series of statements about how people might think, feel, or behave. You are asked to indicate the extent to which each statement pertains to you personally. Read each statement carefully and decide how much it pertains to you personally. Using a scale like the one below, indicate your answer.

1 = Definitely Disagree, 2 = Mostly Disagree, 3 = Neutral, 4 = Mostly Agree, 5 = Agree

1. Before going out in public, I always notice how I look. \_\_\_\_\_
2. I am careful to buy clothes that will make me look my best. \_\_\_\_\_
3. I would pass most physical fitness tests. \_\_\_\_\_
4. It is important that I have superior physical strength. \_\_\_\_\_
5. My body is sexually appealing. \_\_\_\_\_
6. I am not involved in a regular exercise program. \_\_\_\_\_
7. I am in control of my health. \_\_\_\_\_
8. I know a lot about things that affect my physical health. \_\_\_\_\_
9. I have deliberately developed a healthy life-style. \_\_\_\_\_
10. I constantly worry about being or becoming fat. \_\_\_\_\_
11. I like my looks just the way they are. \_\_\_\_\_
12. I check my appearance in a mirror whenever I can. \_\_\_\_\_
13. Before going out, I usually spend a lot of time getting ready. \_\_\_\_\_
14. My physical endurance is good. \_\_\_\_\_
15. Participating in sports is unimportant to me. \_\_\_\_\_
16. I do not actively do things to keep physically fit. \_\_\_\_\_
17. My health is a matter of unexpected ups and downs. \_\_\_\_\_
18. Good health is one of the most important things in my life. \_\_\_\_\_
19. I don't do anything that I know might threaten my health. \_\_\_\_\_
20. I am very conscious of even small changes in my weight. \_\_\_\_\_
21. Most people would consider me good-looking. \_\_\_\_\_
22. It is important that I always look good. \_\_\_\_\_
23. I use very few grooming products. \_\_\_\_\_
24. I easily learn physical skills. \_\_\_\_\_
25. Being physically fit is not a strong priority in my life. \_\_\_\_\_
26. I do things to increase my physical strength. \_\_\_\_\_
27. I am seldom physically ill. \_\_\_\_\_
28. I take my health for granted. \_\_\_\_\_
29. I often read books and magazines that pertain to health. \_\_\_\_\_
30. I like the way I look without my clothes on. \_\_\_\_\_
31. I am self-conscious if my grooming isn't right. \_\_\_\_\_
32. I usually wear whatever is handy without caring how it looks. \_\_\_\_\_
33. I do poorly in physical sports or games. \_\_\_\_\_
34. I seldom think about my athletic skills. \_\_\_\_\_
35. I work to improve my physical stamina. \_\_\_\_\_
36. From day to day, I never know how my body will feel. \_\_\_\_\_
37. If I am sick, I don't pay much attention to my symptoms. \_\_\_\_\_

- 38. I make no special effort to eat a balanced and nutritious diet. \_\_\_\_\_
- 39. I like the way my clothes fit me. \_\_\_\_\_
- 40. I don't care what people think about my appearance. \_\_\_\_\_
- 41. I take special care with my hair grooming. \_\_\_\_\_
- 42. I dislike my physique. \_\_\_\_\_
- 43. I don't care to improve my abilities in physical activities. \_\_\_\_\_
- 44. I try to be physically active. \_\_\_\_\_
- 45. I often feel vulnerable to sickness. \_\_\_\_\_
- 46. I pay close attention to my body for any signs of illness. \_\_\_\_\_
- 47. If I'm coming down with a cold or flu, I just ignore it and go on as usual. \_\_\_\_\_
- 48. I am physically unattractive. \_\_\_\_\_
- 49. I never think about my appearance. \_\_\_\_\_
- 50. I am always trying to improve my physical appearance. \_\_\_\_\_
- 51. I am very well coordinated. \_\_\_\_\_
- 52. I know a lot about physical fitness. \_\_\_\_\_
- 53. I play a sport regularly throughout the year. \_\_\_\_\_
- 54. I am a physically health person. \_\_\_\_\_
- 55. I am very aware of small changes in my physical health. \_\_\_\_\_
- 56. At the first sign of illness, I seek medical advice. \_\_\_\_\_
- 57. I am on a weight-loss diet. \_\_\_\_\_

**For the remainder of the items, circle your response by using the response scale given with each item.**

58. I have tried to lose weight by fasting or going on crash diets.

- 1. Never
- 2. Rarely
- 3. Sometimes
- 4. Often
- 5. Very often

59. I think I am:

- 1. Very underweight
- 2. Somewhat underweight
- 3. Normal weight
- 4. Somewhat overweight
- 5. Very overweight

60. From looking at me, most people would think I am:

- 1. Very underweight
- 2. Somewhat underweight
- 3. Normal weight
- 4. Somewhat overweight
- 5. Very overweight.



61-69. Use the following scale to indicate how satisfied you are with each of the following areas or aspects of your body.

1 = Very Dissatisfied, 2 = Mostly Dissatisfied, 3 = Neutral, 4 = Mostly Satisfied, 5 = Very Satisfied

- |   |       |
|---|-------|
| 61. Face (facial features, complexion)              | _____ |
| 62. Hair (color, thickness, texture)                | _____ |
| 63. Lower torso (buttocks, hips, thighs, legs)      | _____ |
| 64. Mid torso (waist, stomach)                      | _____ |
| 65. Upper torso (chest or breasts, shoulders, arms) | _____ |
| 66. Muscle tone                                     | _____ |
| 67. Weight  | _____ |
| 68. Height  | _____ |
| 69. Overall appearance                              | _____ |

#### 4. Parental Bonding Inventory (PBI)

The following questions relate to your Mother/Father during your first 16 years of life, please rate the statements below on the following scale for both your mother and father:

3 = very like, 2 = moderately like, 1 = moderately unlike, 0 = very unlike

	<u><b>Mother</b></u>	<u><b>Father</b></u>
1. Spoke to me with a warm and friendly voice.	_____	_____
2. Did not help me as much as I needed.	_____	_____
3. Let me do those things I liked doing.	_____	_____
4. Seemed emotionally cold to me.	_____	_____
5. Appeared to understand my problems and worries	_____	_____
6. Was affectionate to me.	_____	_____
7. Liked me to make my own decisions.	_____	_____
8. Did not want me to grow up.	_____	_____
9. Tried to control everything I did.	_____	_____
10. Invaded my privacy.	_____	_____
11. Enjoyed talking things over with me.	_____	_____
12. Frequently smiled at me.	_____	_____
13. Tended to baby me.	_____	_____
14. Did not seem to understand what I needed or wanted.	_____	_____
15. Let me decide things for myself.	_____	_____
16. Made me feel I wasn't wanted.	_____	_____
17. Could make me feel better when I was upset.	_____	_____
18. Did not talk with me very much.	_____	_____
19. Tried to make me dependent on her/him.	_____	_____
20. Felt I could not look after myself unless she/he was around.	_____	_____
21. Gave me as much freedom as I wanted.	_____	_____
22. Let me go out as often as I wanted.	_____	_____
23. Was overprotective of me.	_____	_____
24. Did not praise me.	_____	_____
25. Let me dress in any way I pleased.	_____	_____



### 5. Frost Multidimensional Perfectionism Scale (FMPS)

Read each of the statements below and decide how much you agree with each of them according to the following scale: 5 = strong agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strong disagree.

1. My parents set very high standards for me. \_\_\_\_\_
2. Organization is very important to me. \_\_\_\_\_
3. As a child I was punished for doing things less than perfect. \_\_\_\_\_
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person. \_\_\_\_\_
5. My parents never tried to understand my mistakes. \_\_\_\_\_
6. It is important to me that I be thoroughly competent in everything I do. \_\_\_\_\_
7. I am a neat person. \_\_\_\_\_
8. I try to be an organized person. \_\_\_\_\_
9. If I fail at work/school, I am a failure as a person. \_\_\_\_\_
10. I should be upset if I make a mistake. \_\_\_\_\_
11. My parents wanted me to be the best at everything. \_\_\_\_\_
12. I set higher goals than most people. \_\_\_\_\_
13. If someone does a task at work/school better than I, then I feel like I failed the whole task. \_\_\_\_\_
14. If I fail partly, it's as bad as being a complete failure. \_\_\_\_\_
15. Only outstanding performance is good enough in my family. \_\_\_\_\_
16. I am very good at focusing my efforts on obtaining a goal. \_\_\_\_\_
17. Even when I do something very carefully, I often feel that it is not quite right. \_\_\_\_\_
18. I hate being less than the best at things. \_\_\_\_\_
19. I have extremely high goals. \_\_\_\_\_
20. My parents have expected excellence from me. \_\_\_\_\_
21. People will probably think less of me if I make a mistake. \_\_\_\_\_
22. I never felt like I could meet my parents' expectations. \_\_\_\_\_
23. If I do not do as well as other people, it means I am an inferior human being. \_\_\_\_\_
24. Other people seem to accept lower standards from themselves than I do. \_\_\_\_\_
25. If I do not do well all the time, people will not respect me. \_\_\_\_\_
26. My parents have always had higher expectations for my future than I have. \_\_\_\_\_
27. I try to be a neat person. \_\_\_\_\_
28. I usually have doubts about the simple everyday things I do. \_\_\_\_\_
29. Neatness is very important to me. \_\_\_\_\_
30. I expect higher performance in my daily tasks than most people. \_\_\_\_\_
31. I am an organized person. \_\_\_\_\_
32. I tend to get behind in my work because I repeat things over and over. \_\_\_\_\_
33. It takes me a long time to do something "right." \_\_\_\_\_
34. The fewer mistakes I make the more people will like me. \_\_\_\_\_
35. I never felt like I could meet my parents' standards. \_\_\_\_\_

6. Bem Sex-Role Inventory-Short Form (BSRI-SF)

For each word listed below, please rate yourself according to the following scale:

1 = never true, 2 = rarely true, 3 = occasionally true, 4 = mostly true, 5 = always true.

- |                                      |       |
|--------------------------------------|-------|
| 1. self-reliant                      | _____ |
| 2. yielding                          | _____ |
| 3. helpful                           | _____ |
| 4. defends own beliefs               | _____ |
| 5. cheerful                          | _____ |
| 6. moody                             | _____ |
| 7. independent                       | _____ |
| 8. shy                               | _____ |
| 9. conscientious                     | _____ |
| 10. athletic                         | _____ |
| 11. affectionate                     | _____ |
| 12. theatrical                       | _____ |
| 13. assertive                        | _____ |
| 14. flatterable                      | _____ |
| 15. happy                            | _____ |
| 16. strong personality               | _____ |
| 17. loyal                            | _____ |
| 18. unpredictable                    | _____ |
| 19. forceful                         | _____ |
| 20. feminine                         | _____ |
| 21. reliable                         | _____ |
| 22. analytical                       | _____ |
| 23. sympathetic                      | _____ |
| 24. jealous                          | _____ |
| 25. has leadership abilities         | _____ |
| 26. sensitive to the needs of others | _____ |
| 27. truthful                         | _____ |
| 28. willing to take risks            | _____ |
| 29. understanding                    | _____ |
| 30. secretive                        | _____ |



### 7. Perceived Stress Scale (PSS)

The questions in this scale ask you about your feelings and thoughts during the last year. In each case, please indicate how often you felt or thought a certain way according to the following scale:

0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often, 4 = very often.

1. In the last year, how often have you been upset because of something that happened unexpectedly? \_\_\_\_\_
2. In the last year, how often have you felt that you were unable to control the important things in your life? \_\_\_\_\_
3. In the last year, how often have you felt nervous and "stressed?" \_\_\_\_\_
4. In the last year, how often have you felt confident about your ability to handle your personal problems? \_\_\_\_\_
5. In the last year, how often have you felt that things were going your way? \_\_\_\_\_
6. In the last year, how often have you found that you could not cope with all the things that you had to do? \_\_\_\_\_
7. In the last year, how often have you been able to control irritations in your life? \_\_\_\_\_
8. In the last year, how often have you felt that you were on top of things? \_\_\_\_\_
9. In the last year, how often have you been angered because of things that were outside of your control? \_\_\_\_\_
10. In the last year, how often have you felt difficulties were piling up so high that you could not overcome them? \_\_\_\_\_

8. Sociocultural Attitudes Towards Appearance Scale – 3<sup>rd</sup> Edition (SATAS-3)

Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

1 = Definitely disagree, 2 = mostly disagree, 3 = neither agree nor disagree,  
4 = mostly agree, 5 = definitely agree.

1. TV programs are an important source of information about fashion and “being attractive.” \_\_\_\_\_
2. I’ve felt pressure from TV or magazines to lose weight. \_\_\_\_\_
3. I *do not* care if my body looks like the body of people who are on TV. \_\_\_\_\_
4. I compare my body to the bodies of TV and movie stars. \_\_\_\_\_
5. TV commercials are an important source of information about fashion and “being attractive.” \_\_\_\_\_
6. I *do not* feel pressure from TV or magazines to look pretty. \_\_\_\_\_
7. I would like my body to look like the models who appear in magazines. \_\_\_\_\_
8. I compare my appearance to the appearance of TV and movie stars. \_\_\_\_\_
9. Music videos on TV are *not* an important source of information about fashion and “being attractive.” \_\_\_\_\_
10. I’ve felt pressure from TV and magazines to be thin. \_\_\_\_\_
11. I would like my body to look like the people who are in the movies. \_\_\_\_\_
12. I *do not* compare my body to the bodies of people who appear in magazines. \_\_\_\_\_
13. Magazine articles are *not* an important source of information about fashion and “being attractive.” \_\_\_\_\_
14. I’ve felt pressure from TV or magazines to have a perfect body. \_\_\_\_\_
15. I wish I looked like the models in music videos. \_\_\_\_\_
16. I compare my appearance to the appearance of people in magazines. \_\_\_\_\_
17. Magazine advertisements are an important source of information about fashion and “being attractive.” \_\_\_\_\_
18. I’ve felt pressure from TV or magazines to diet. \_\_\_\_\_
19. I *do not* wish to look as athletic as the people in magazines. \_\_\_\_\_
20. I compare my body to that of people in “good shape.” \_\_\_\_\_
21. Pictures in magazines are an important source of information about fashion and “being attractive.” \_\_\_\_\_
22. I’ve felt pressure from TV or magazines to exercise. \_\_\_\_\_
23. I wish I looked as athletic as sports stars. \_\_\_\_\_
24. I compare my body to that of people who are athletic. \_\_\_\_\_
25. Movies are an important source of information about fashion and “being attractive.” \_\_\_\_\_
26. I’ve felt pressure from TV or magazines to change my appearance. \_\_\_\_\_
27. I *do not* try to look like the people on TV. \_\_\_\_\_
28. Movie stars are *not* an important source of information about fashion and “being attractive.” \_\_\_\_\_
29. Famous people are an important source of information about fashion and “being attractive.” \_\_\_\_\_
30. I try to look like sports athletes. \_\_\_\_\_



### 9. Body Image Guilt and Shame Scale (BIGSS)

Below are several situations that people are likely to encounter in day-to-day life, followed by several common reactions to these situations. As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. Please rate all responses because you may feel or react in more than one way to the same situation, or you may react in different ways at different times.

The following rating scale should follow each response for every item.

1-----2-----3-----4-----5  
Not likely Very likely

1. You and a friend decide to do some form of physical activity together each weekday, but after the first few days you make excuses not to go.
  - a) You would think: I'm totally undisciplined.
  - b) You would think: There were too many other things that distracted my attention.
  - c) You would think: I'll make up for it next week.
  - d) You wouldn't think about it as terribly important.
  
2. Your partner expresses disappointment over your body.
  - a) You would attribute your partner's disapproval to wrong priorities.
  - b) You would wonder "Why?" since you are happy with your physique.
  - c) You would attribute your partner's disapproval to your failure to keep trim.
  - d) You would feel diminished in your image of yourself.
  
3. Some makes a negative comment about some aspect of your physique.
  - a) You would feel so badly that you wouldn't be able to focus on anything else that day.
  - b) You would think: I must commit myself to regular exercise and watch what I eat.
  - c) You would think the person was insensitive and didn't realize what she or he was saying.
  - d) You wouldn't be troubled since people say negative things for all kinds of reasons.
  
4. You go to the gym and everybody seems to have a better-looking body than you.
  - a) You wouldn't care because your body is not an important aspect of your self-worth.
  - b) You would think: I should have stuck to my exercise program.
  - c) You would feel so awful that you want to hide.
  - d) You would think: They don't lead busy lives, so they are able to exercise regularly.

5. Your partner asks you to lose weight.
  - a) You would feel worthless and undervalued.
  - b) You would decide to do something about your weight.
  - c) You would tell your partner that she or he should accept you for who you are.
  - d) You would tell your partner that she or he is not perfect either.
  
6. You sit down in a self-serve restaurant and notice that you have much more food on your plate than everyone else at your table.
  - a) You would say to yourself that you are hungrier than they are.
  - b) You would decide not to eat all the food on your plate.
  - c) You would feel bad and think that everybody is looking at you and your food.
  - d) You wouldn't be worried and wouldn't give it a second thought.
  
7. You are at the beach and everyone else looks so slim and toned compared to you.
  - a) You would think: I need to get back to my healthy lifestyle plan.
  - b) You would think: There will always be people who look better than I.
  - c) You would feel totally inadequate and stay covered up.
  - d) You wouldn't care. How your body looks is not the most important thing in your life.
  
8. You have just eaten a big lunch, but as you pass the corner store, you buy a chocolate bar and eat it.
  - a) You would say to yourself: Tonight I will go for a long walk or run to make up for it.
  - b) You would say to yourself: I just felt like having something sweet.
  - c) You would feel disgusted by your lack of self-control.
  - d) You would say to yourself: Who cares?
  
9. At a family reunion, a relative says to you "You look like you've put on some weight."
  - a) You would feel embarrassed and belittled.
  - b) You would think: She or he didn't intend to be insensitive.
  - c) You would think: That person never liked me.
  - d) You would think that you deserved the comment and decide to lose some weight.
  
10. While you are with a group of friends you all make fun of an absent friend's body.
  - a) You would think: It was a joke; it's harmless.
  - b) You would feel immature and insensitive.
  - c) You would decide that you had to go along with it at the time.
  - d) You would promise yourself not to do it again.



11. While looking at some models on a swimsuit calendar, your partner makes negative comparisons in relation to your body.
- You would regret that you put off exercising this week.
  - You would think your partner is too concerned about external beauty.
  - You wouldn't be bothered by the calendar images; they are just pictures.
  - You would feel inadequate because you know you don't compare favorably.
12. You are trying on clothes in a store and the assistant says loudly, "You may need a larger size."
- You would feel as though you want the ground to open up and swallow you.
  - You would think: I won't buy these clothes until I can fit into them.
  - You would regard the comment as unimportant.
  - You would think: The assistant is probably having a bad day.
13. You are watching a television show with a friend and notice that all the actors have perfect bodies.
- You would say to your friend: They have money for a personal trainer.
  - You would tell your friend that you've decided to stop eating junk food from now on.
  - You would tell your friend how very depressed you feel after seeing all of those perfect bodies.
  - You would laugh with your friend about how unrealistic the show is.
14. Halfway through a celebration dinner, you realize you feel very full and that you have eaten far too much.
- You would feel very bad that you have no self-control.
  - You would decide not to eat any of the desserts that are in front of you.
  - You would be philosophical and say to yourself that it is a celebration.
  - You would think: What's done is done.
15. You find that your clothes from last summer are very tight around your waist.
- You would think: Well, it's time to buy some new clothes anyway.
  - You would feel undisciplined and overweight.
  - You would go out and buy a 6-month membership to a gym.
  - You would think: I've been very busy over the last year, with no time to exercise.

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