

**Female Objectification, Body Dissatisfaction and Disordered
Eating Behaviour in a Non-clinical Sample**

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ABSTRACT

Attractiveness, and associated thinness, continues to be the determinant of social acceptance and desirability for most women in Westernised societies. The way in which females are objectified through social attitudes and gender ideals, highlights the importance of attractiveness in through which women gain social status, acceptance and power. Failure to achieve this ideal has been linked to increased body surveillance, body dissatisfaction, and disordered eating behaviour(s).

While many women express body dissatisfaction and negative self-talk, fewer women actually engage in disordered eating practices. This study aimed to explore women's views about their bodies and to identify predictors of body objectification, body dissatisfaction, and disordered eating behaviour in a non-clinical population. It was hypothesised that women, who have strongly based their identity according to societal values and gender role expectations, would be more likely to experience higher levels of body dissatisfaction and be at greater risk of manifesting disordered eating behaviour(s).

Two-hundred-and-nine women, aged between 18-65 years ($M = 29.53$ years) were recruited via convenience sampling and completed the following battery of questionnaires: Socio-cultural Attitude Towards Appearance Questionnaire (SATAQ), Body Image Ideals Questionnaire (BIQ), Objectified Body Consciousness Scale (OBC), Silencing the Self Scale (STSS), Sense of Belonging Instrument-Psychological (SOBI-P), Eating Attitudes Test (EAT-26), and Conformity to Feminine Norms Inventory (CFNI). Predictors of body objectification, body dissatisfaction, and disordered eating were determined using multiple linear regression and analyses of variance were used to make comparisons between groups based on developmental age, disturbed eating, disordered eating, and body mass index.

Consistent with previous research findings, the current study found that body dissatisfaction, objectified body consciousness, and disturbed eating behaviour were prevalent within women aged 18-65 years. While a desire for thinness and attractiveness were important for women throughout the lifespan and pertinent to one's identity, there was a shift in the value and commitment invested in its achievement. It was concluded that heightened feelings of body

shame, poor sense of self and internalised feelings of self-hatred maintained body dissatisfaction and influenced disturbed eating behaviour.

DECLARATION

I, Lyndsey Nolan, declare that the Doctor of Psychology (Clinical Psychology) thesis entitled "Female Objectification, Body Dissatisfaction and Disordered Eating Behaviour in a Non-clinical Sample" is no more than 40,000 words in length, exclusive of tables, figures, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:

Date:

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Chapter 1: Introduction

Socialisation and the construct of gender role identification are determined by a complex interplay of biological, sociological, and psychological factors. These roles of gender identification and sense of self are often reflected through the internalisation of feminine or masculine traits which are typically influenced by family, society, and culture. In essence, objectification theory as illustrated by Fredrickson and Roberts (1997) offers a complex account of the processes involved in women's emotional and behavioural responses in their desire to meet cultural demands and expectations.

1.1. The Context of Social Environment

'The major manifestation of patriarchy is the primary image of women as good wives and mothers and objects of decorative worth' (Hesse-Biber, 1997, p.5).

Historically women have, and continue to exist, in a society dominated by male influence and ownership. As early as the 18th Century, it was documented that a woman was to have no legal rights as a citizen, including the right to own or bestow property, legalities, hold custody of minor children, or keep wages she had earned, 'by marriage, the husband and wife are one person in the law, that is, the very being and legal existence of the woman is suspended during the marriage, or at least is incorporated into that of her husband under whose wing, protection and cover she performs everything' (Blackstone, 1904, p.432 cited in Weitz, 1998). As her "protector", a husband had a legal right to beat his wife if believed it necessary, as well as a right to her sexual services (Weitz, 1998).

African American women were used as slaves for White American men before and following the civil war; the rape of African American women was justified by the definition that African American women were 'animalistically hypersexual' and thus were responsible for their own rapes (Weitz, 1998). Babylonian law treated rape as a form of property damage with rapists required to pay a fine to the husband or father of the raped woman for availing of another man's property (Weitz, 1998). In traditional Western society, wedded women continue to be walked down the aisle by their fathers and "given away" to their prospective husbands. Arranged marriages still exist in some cultures whereby the potential bride is contracted between husband and prospective father-in-laws without the bride's consent; the female child in these cultures is often considered to be a financial burden on her family given that her

family would be expected to pay a prospective husband to marry and “look after” their daughter. Thus, male children, in these cultures, are highly desired and expected to bring wealth into their family (Weitz, 1998).

Western laws are now in place to protect women from being “sold” and treated as objects, yet ownership of women continues to exist in some non-Western and Middle-eastern countries. While Western women are “privileged enough” to have laws to protect, promote independence and encourage equal rights, it is argued that they continue to struggle to be treated with the respect that men unwittingly receive (Ridgeway, 2001). In our culture, man is judged primarily in terms of his power, job status, ambition and dominance in his thoughts and actions; these attributes are based according to his mind rather than his body. Woman, however, is judged almost entirely according to her appearance, her attractiveness to men, and her ability to produce offspring (Faludi, 1991; Hesse-Biber, 1997).

Women have stereotypically played the role of caretaker and provider to both her husband and children. According to feminist theory (Bartky, 1990; Bordo, 1993; Gilligan, 1982; Gilligan, 1991; Piran, 2001; Piran & Cormier, 2005; Stern, 1991; Tolman, 1991), this common role and expectation to adhere to traditional feminine gender ideals has reinforced her passivity and dependence on her husband to be ‘taken care of’ and provided for financially; thus fortifying the male role of dominance and protection.

Arguably, female intelligence is still not respected, or alternatively can be perceived as threatening to men’s power and dominance. Indeed many men can often be hostile or dismissive toward females expressing their opinions. In the corporate world, women have experienced the phenomenon of tokenism, whereby even though they have been able to acquire a position, they have had difficulty in advancing to higher levels of management or power (Ridgeway, 2001). Thus, both female intellect and ambition are discounted, or they are perceived as too aggressive and unfeminine; both of which are viewed as unattractive.

Several feminist theorists (Bordo, 1993; Hesse-Biber, 1997; Ridgeway, 2001) have described the term “glass ceiling” as a transparent and yet effective barrier from enabling women to rise above a certain level with regard to equal rights in the workforce as a result of male attitudes and social discrimination. A woman’s sense of worth, social status and success is still therefore generally achieved indirectly through marriage. The ability to secure a partner in marriage necessitates a level of

competitiveness between women and heightens the propensity for many women to pursue ideals of attractiveness in order to be successful. Thus attractiveness serves as an indirect form of power and control, by increasing women's odds of obtaining the protection of powerful men, more marital prospects, friendships, and higher salaries (Bordo, 1993; Hesse-Biber, 1997; Piran & Cormier, 2005; Weitz, 1998).

1.1.1. Women – The Desire to Be Desired. Essentially, women have become the object and prey of male desire. She is objectified as a mere body, that presents itself as the potential object of another's intentions and manipulation, rather than one of intelligence and worthiness (Young, 1990). The beautifying of the body becomes essential to achieving the normative ideal of feminine beauty and subsequent desirability to men (Malson, 1998; Synnott, 1993).

The culture of foot binding in Ancient China was seen as a symbol of feminine beauty and represented a woman's only prospects in life to achieve a husband, with associated wealth and a family of her own. Hesse-Biber (1997) noted that this restricted women's mobility and sexuality, and ensured her captivity and submission as it was unlikely that a wife could engage in an extramarital affair when she remained physically restricted and house-bound. Females were made dependent on their fathers, husbands, and finally their sons upon the death of the husband, for mobility and to be carried from place to place. This therefore reinforced the disempowerment and helplessness of women, yet served the patriarchal authority of the Chinese society.

Similarly, corsets were used to transform the European woman's waist for which she would be aesthetically pleasing for male desire. In a period where there were no alternatives to marriage, and good husbands scarce, the pressures to conform to the submissive ideal that men demanded was enormous (Bordo, 1993; Hesse-Biber, 1997; Piran & Cormier, 2005; Weitz, 1998).

Today, women continue to seek men's attention by adhering to practices of perceived beauty and cultural norms. The culture of beauty is reinforced from a young age through toys such as the Barbie doll, which is represented to little girls as the perfect "ideal" figure. Children's fairy tales portray beautiful characters such as Cinderella and Snow White as good and generous natured, yet her ugly-stepsisters and the countless wicked witches were always depicted as ugly and evil, thus making the association between beauty, good-nature and popularity. Frost (2001) argued that little girls are encouraged to engage in playing 'mummies' by wearing lipstick,

staggering around in women's clothes and high-heels, as well as nurturing plastic dolls in a maternal role. Similarly, the socialisation of adolescence and desire for peer acceptance encourages adolescents to typically spend their spare time shopping for clothes, experimenting with make-up, or at the hairdressers, enhancing their femininity and appeal (Frost, 2001).

As girls approach adulthood they become the object of sexual desire and insert themselves into the paradoxical and highly complicated set of social regulations and perceived notions of attractiveness, for which she learns that positive identity is achieved through beauty (Frost, 2001; Hesse-Biber, 1997, McCabe & Griffiths, 2000). A common assumption of the female gender is that it is the desire of every girl to be good-looking, attractive and popular (Frost, 2001; Hemming, 1960).

Hesse-Biber (1997) suggested that if women are so busy trying to control their bodies through dieting, excessive exercise, and self-improvement activities, they lose control over other important aspects of selfhood that might challenge the *status quo*. Therefore while men are conquering and controlling nature and women, through achievement, intelligence, and physical strength, women become obsessed with controlling, monitoring and improving their bodies.

It is common for many women to report body dissatisfaction and complain that their thighs are too big, breasts too small, hair too thin, and/or stomach not flat "enough" (Phillips & Heining, 2002). Extensive literature in body image found that a large proportion of women and adolescents had idealized the idea that to be much thinner than their actual body weight was desirable (Kostanski, Fisher, & Gullone, 2004; Ricciardelli & McCabe, 2001; Stevens & Tiggemann, 1998). Alarmingly, children as young as five years old have internalised and reported similar levels of body dissatisfaction and a desire to lose weight, with researchers illustrating that children are well-informed and aware of the methods needed to employ and sustain weight loss (Dohnt & Tiggemann, 2005; Tiggemann & Lowes, 2002; Williamson & Delin, 2001).

Body dissatisfaction is therefore deemed pertinent for women, and longitudinal studies (Stevens & Tiggemann, 1998; Tiggemann, 2004; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003) confirm that women across the lifespan irrespective of age typically hold a normative discontent with their bodies. Make-up is checked and reapplied, precautions are taken to ensure one's hair is not spoilt by the rain, 'fat' concerns are often repeated, and daily food intake monitored; essentially,

women have become their own inner critic and a self-policing subject bound by patriarchal obedience (Weitz, 1998).

Further literature (Lieberman, Gauvin, Bukowski, & White, 2001; McVey, Pepler, Davis, Flett, & Abdolell, 2002) has proposed that marketing, advertising and media, play a crucial role in maintaining women's *status quo* and encouraging women as primary consumers, to adopt a critical attitude toward body, self and life style. Research investigating the exposure of media on body image found that exposure of thin media images resulted in heightened levels of body dissatisfaction and distorted body image in school-age girls, adolescents and young adults (Gowers & Shore, 2001; Levine, Smolak, & Schermer, 1996; Lieberman et al., 2001; McVey et al., 2002; Rubin et al., 2004).

It has been proposed that the subsequent increase in body dissatisfaction enables advertisers to promote beauty and household products, symbolic of good wives and mothers, and reassure women of their ability to attain attractiveness, femininity, and keep hold of their partner. Hesse-Biber (1997) argued that as long as women viewed their bodies as objects, they were controllable and profitable. While women are essentially controlled by the expectations to conform to societal standards, women ironically report heightened feelings of control over their body upon achieving the thin-ideal, as well as a sense of control in their ability to 'lure' a man through attractiveness (Gilligan, 1982; Gilligan, 1991; Piran, 2001; Piran & Cormier, 2005; Stern, 1991; Tolman, 1991).

As depicted by Fredrickson and Roberts' (1997) objectification theory, the objectified body and continual attempts to improve one's body heightens female insecurity and body dissatisfaction, where comparisons, rivalry and competition are often made with other women. Essentially, women feel they need to compete in the "attractiveness-stakes" in order to 'snag' and 'keep' a successful man who will provide for her (Gilligan, 1982; Piran, 2001; Piran & Cormier, 2005, Tolman, 1991). Research investigating body surveillance and the bodily comparisons made with other women revealed significantly higher levels of body dissatisfaction and body image anxiety in those women who had compared and contrasted their bodies to other women (Fredrickson & Roberts, 1997; Heinberg & Thompson, 1992; Striegel-Moore, McAvay, Rodin, 1986).

Successful wealthy men, football players and celebrity personalities often parade the most beautiful of young women on their arms despite generally being

much older and less attractive than their counterparts. By which case, the typical “trophy wife” is often an indication of the man’s wealth and social status, which seems to have heightened his ability to attract a beautiful woman. Women innately have internalised patriarchal standards of bodily acceptability and thus strive to follow the standards of the ideal thin body in order to reap the rewards she is likely to receive through being in the ‘right’ body.

1.1.2. Femininity and Acceptance Through Conforming. Butler (1990) argued that femininity is an artifice and an achievement “we are born male or female, but not masculine or feminine”. This notion suggests that femininity is achieved through adhering to beauty practices based on societal trends that determine female attractiveness and male desirability. Thus, femininity itself is measured according to one’s “prettiness”, body shape and size, and the way in which she presents herself through bodily gestures, postures and movement (Hesse-Biber, 1997; Malson, 1998; Spence, 1993).

Female passivity and delicacy are often viewed as highly desirable feminine traits, whereas female assertiveness and self-sufficiency are thought to be unattractive and threatening to male dominance. Gilligan (1982) and others (Jack, 1991; Piran, 2001; Piran & Cormier, 2005; Spence, 1993) assert that the gender role expectation of females requires women to fulfil care giving roles and sacrifice their own needs and sense of self, for the needs of others. The internalisation of femininity norms and associated passivity results in women silencing their own thoughts, feelings and needs in order to achieve and maintain close relationships (Jack, 1991; Piran & Cormier, 2005). She is merely a silenced object to be viewed and provide pleasure and nurturance to others.

While femininity and taking pride in her appearance is assumed to be voluntary, it is a spectacle in which virtually every woman is expected to participate in if she is to be accepted as female, and desirable to men with the prospect of marriage. Thus to have a “feminine” body socially constructed through appropriate practices, is in most cases, crucial to a woman’s sense of herself as female and as an individual. As noted in literature attaining to physical attractiveness and romantic relationships (Buss, Shackelford, Kirkpatrick, & Larsen, 2001; Townsend & Levy, 1990), physical attraction was deemed the “igniter” of romantic relationships, with men reportedly placing greater value on having an attractive partner compared to women who reportedly seek less attractive men with greater career advances and

financial security. Thus the importance of achieving attractiveness and feminine ideals prove vital to most women.

Images of femininity and social body acceptability have varied over time and across cultures, as reported by Butler (1990) and others (Weitz, 1998; Frost, 2001; Hesse-Biber, 1997). This was reflected in the Victorian times and among some African cultures where resources and wealth were limited, fatness was valued over thinness, as this indicated the person had access to greater resources such as food. Thus the large body was admired and depicted as a source of wealth and plentiful food supplies.

By the end of the 19th Century, it seems that the symbolism of thinness had become strongly linked with the idea of class. The imagery of the flapper emerged in the 1920s. The flapper's flamboyant-style, mobility, shortened skirts, and liberated sexuality shocked those who held onto the delicacy and passivity of Victorian style. The flapper and the exuberant 1920s culture then disappeared into the void of the Depression and World War II, followed by the introduction of the large-breasted female and hourglass figure of Marilyn Monroe and Jayne Mansfield in the post-war period (Hesse-Biber, 1997; Weitz, 1998). The preoccupation with weight control, particularly among women, never really disappeared as 1940s brought about the "new-wave" thin model, followed by the extreme androgyny, almost boyish and prepubertal style, of Twiggy in the 1960s. While 'curves' with a slender body had re-emerged in the 1980s, the 'waif-like' image soon resurfaced in the 1990s and continues to exist today.

The current body of fashion is thought to be taut, small breasted, narrow-hipped and of a slimness bordering on emaciation (Hesse-Biber, 1997; Saunders & Kashubeck-West, 2006; Weitz, 1998). Since ordinary women rarely measure up to such dimensions, they must diet to fit in with the ideal and unrealistic images of "normative femininity"; these trends are thus believed to be destructive to women's health, self esteem, and economic and social advancement within society. In spite of the unrelenting pressure to be feminine, women are then ridiculed and dismissed for their interest in such "trivial" things such as clothes, makeup and general appearance. She has merely become an object and it is difficult for her to be viewed otherwise.

1.1.3. Sexualisation and the Objectified Body.

Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women, but also

the relation of women to themselves. The surveyor of women in herself is male, the surveyed female. Thus she turns herself into an object – and most particularly an object of vision: a sight (Berger, 1972, p.47).

Hesse-Biber (1997) used the analogy of a mirror that reflects the virtual image of an object placed in front of it, to describe the over-identification women have with their body parts; by which case women's perceptions of their image is deeply distorted by their feelings about their bodies. For so many women whose bodies are their primary identities, the cult of thinness promises the reward of cultural acceptance and desirability.

As evidenced through the impact of menstruation, the growth of breasts, pregnancy, childbirth, and menopause, women hold a unique connection between their body, identity, and sense of self (Macdonald, 1995). This is further illustrated in the instance of a hysterectomy or mastectomy, where women often report a sense of loss of femininity and identity. Since the body is viewed as integral in the formation of a woman's identity and self-concept, body dissatisfaction is viewed as particularly destructive to a woman's self-esteem and well-being (Macdonald, 1995; Ricciardelli & McCabe, 2001).

Young women are typically taught "how to be a body". One's measure of identity and self worth are largely determined by what she observes in the mirror, weighing scales, her waistband measurements, boyfriend's comments, and the comparison's she has made with her friends and other random females; a purpose which serves to increase a sense of competition and insecurity in women (Motz, 2001; Shildrick, 1997). The scrutiny and judging of other women seems almost automatic in females, and girls learn of their own place in this system. As noted by Tiggemann and Lynch (2001), girls and women come to know that they are appraised in the same way and must inevitably internalise this judgment. Focault (1997) argued that the female body becomes "unembodied". It is constantly monitored, scrutinized for physical flaws, and objectified. By and large, the body becomes an object and site over which one can assert control over (Fredrickson & Roberts, 1997; Gilligan, 1982; Gilligan, 1991; Piran, 2001; Piran & Cormier, 2005; Stern, 1991; Tolman, 1991).

The internalised view of what a body 'should' look like is determined by mass standards influenced by unachievable fantasy objects used within the media (Bissell & Peiqin, 2004; McVey et al., 2002; Rubin et al., 2004; Schooler et al., 2004). Within

this context, women are defined according to their relationship with their body, and often display shame and body dissatisfaction should they not meet cultural expectations of body acceptance and perceived ‘normality’. Thus it seems that this idealised view of femininity reinforces the relentless struggle for women to attain perfection.

Theorists (Hesse-Biber, 1997; Shilling, 1994; Yoder, 1999), however, argue that while women’s bodies attract much attention, they are merely viewed as a ‘body’ necessary for procreation, one that is ‘over-burdened’ in sexuality, male violence, pornography, prostitution, pregnancy, childbirth, physical and emotional stress and pressures, domination, subordination, inequality, and oppression. As such, adolescent girls often experience ambivalence and hatred toward their changing body, which transforms an innocent prepubescent child into a breasted menstruating woman whose body is often viewed as “burdensome” or as a sexualised object susceptible to male attention (Hesse-Biber, 1997; Shilling, 1994).

A study by Lee (1998) measuring the relationship between menarche and sexuality found that girls who were “well-developed” and who experienced puberty earlier were often perceived as promiscuous by others, even though they were just young girls with no active sexual relationships. Given that girls’ bodies and sexuality are constructed as the object of male sexual discourse rather than sites of their own pleasure and desire, it has been suggested that eating disordered behaviour, restriction, and regression to a child-like, unfeminine and unsexualised body, is a means for protest and resistance against development into womanhood. This seems especially true for individuals who are not developmentally ready to engage in dating and intimate activity (Gowers and Shore, 2001; Lee, 1998; Weitz, 1998; Williams & Currie, 2000).

1.1.4. The Pursuit for Thinness: Cultural Acceptance. In a world where beauty is valued, lacking beauty becomes stigmatizing. Telson (1995) argued that women are stigmatized by the very expectation to be beautiful. Essentially, every individual aspires to belong, to be accepted, desired, and to “fit in” to their social world (Joiner & Kashubeck, 1996). When physical appearance forms part, and sometimes all, of one’s identity, one’s sense of self is built according to how she is viewed by others, based on a continuum of ‘normality’ and social standards (Prichard & Tiggemann, 2005). Thus perceived attractiveness through social interactions and experiences with others becomes a critical factor in the development of self-concept

for women, especially during adolescence and young adulthood. As such, in an environment where female subjectivity is heavily identified with sexual desirability, weight and the pursuit for thinness becomes a primary definer of a woman's worth, self esteem and social acceptance (Macdonald, 1995; Moradi et al., 2005; Piran & Cormier, 2005; Prichard & Tiggemann, 2005; Sabik & Tylka, 2006).

The common message presented to women and young girls is that:

Thin is sacred. Thin is beautiful and healthy, thin will make you happy. If you are female, thin will get you a husband. Salvation awaits those who attain the ideal body. Fat is profane. To be fat is to be ugly, weak, and slovenly; to have lost control, be lazy, and have no ambition (Hesse-Biber, 1997, p.11).

Attitudes towards obesity have been likened to racism, in that a certain set of negative assumptions are made about personal character based on an attribute of physical appearance. The moral discrepancy between slenderness and obesity equates to "good" versus "bad"; thus the meanings ascribed to one's weight inevitably impinge on her confidence and sense of self. Women who fail to live up to the typical beauty standard of being slim, White, able-bodied, and pretty by whatever contemporary version is prevalent, are therefore likely to feel pathologised, inferiorised, and rejected (Moradi et al., 2005; Piran & Cormier, 2005; Prichard & Tiggemann, 2005).

The stigmatized individual internalises their whole self as "not good enough" which often leads to strong feelings of shame, self-hatred and self-derogation. The objectified body is likely to be viewed as "the enemy", which may be punished through self-harm or immersed into disciplinary actions of diet and exercise (Hoskins, 2002). Failure to meet weight-loss goals, despite dieting and exercise attempts, thus further increases one's sense of helplessness, dissatisfaction, and is likely to heighten emotional and psychological vulnerability to depression and psychopathology (Lee, 1998; Lowes & Tiggemann, 2003; McCabe, Ricciardelli, & Banfield, 2001).

Fatness is thought to play a critical role in female biological development. Consistent with literature findings (Attie & Brooks-Gunn, 1989; Gowers & Shore, 2001; Swarr & Richards, 1996), the percentage of body fat tissue prior to puberty is approximately the same in both sexes. During puberty, however, the development of fat tissue is accelerated in girls through menstruation, with obesity in young adult females tending to be naturally higher than that in adult males. Research (Faust,

1977; Gowers & Shore, 2001; Gruber, Brooks-Gunn, Paikoff, & Warren, 1994) has further indicated that early-maturing girls accumulate body fat earlier and tend to be heavier than their later-maturing counterparts; findings have further suggested that early-maturing girls have poor body image, greater body dissatisfaction, and are more likely to engage in more disordered eating patterns than their later-maturing counterparts (Gowers & Shore, 2001; Gruber et al., 1994; Swarr & Richards, 1996).

Interestingly, a study by Greenberg and LaPorte (1996), found that higher levels of obesity were attributed to women of lower social class and African American women. This study further revealed that obesity was significantly less stigmatized among African American women. Consistent with other studies measuring the discrepancy in disordered eating between African American women and White women (Mokdad, Serdula, & Dietz, 1999; Perkins, 1996), findings suggested that there was a greater degree of tolerance and acceptance for larger women of this culture than in White women, and furthermore, this may attribute to the lower prevalence of eating disorders among African American women. Race differences in self-satisfaction and in perceptions of ideal weight suggest that there are race-based cultural differences in the "standards" presented and, therefore, in the development of body image and body ideals.

Given that most women's bodies do not meet the thin ideal, much of the beauty related advertising focuses on exploiting women's insecurities about their looks (Lieberman et al., 2001; McVey et al., 2002). Surgical cosmetic procedures; and food, cosmetic and weight-loss companies, have thrived on the purchases made to obtain the unobtainable goal of physical perfection. According to Maine (2000), Americans spend over \$50 billion on dieting and diet-related products each year. Marketing and media images of perfect female beauty convince women they fail to "measure up", and that independence is achieved through self-improvement and self-control.

Women, and adolescents in particular, are often exposed to large amounts of media images of sexualised objects through magazines, television, and music videos. Given the underlying intention of the media to serve economic purposes through advertising and marketing, it is concerning that adolescents, who typically attempt to "fit in" and seek acceptance within society, are bombarded with images promoting somewhat unrealistic expectations of what they should look like. Research findings (Bissell & Peiqin, 2004; McVey et al., 2002; Rubin et al., 2004; Schooler et al., 2004)

continue to demonstrate the link between frequent media use and greater body dissatisfaction as carved in cultural ideals of femininity; so much so, that exposure to depictions of thinness within the media was found to lead to greater perceptions of distorted body image in female school aged children and adolescents.

Levine (1997) noted that the average adolescent watches 3-4 hours of television per day; and yet in a study of 4,294 network television commercials (Myers et al., 1992), it was found that 1 out of every 3.8 commercials sent viewers some sort of message relaying the importance of attractiveness. In accordance with Levine's findings, these researchers estimate that the average adolescent is exposed to over 5,260 "attractiveness messages" per year in television viewing alone. Furthermore, Dohnt and Tiggemann (2006) found that girls who read fashion magazines and viewed television music clips, which are becoming increasingly more sexualised, reported greater dissatisfaction with their appearance. According to Liberty Sanger (Chair of the Ministerial Media Code of Conduct on Body Image, Final Report July 2007) much of what is depicted in the media, is a fusion of reality and fantasy, with many of the images presented having been altered or enhanced in some form, not reflecting an accurate representation of the normative female.

Families, schools and peer groups additionally reflect and amplify these societal norms. For example, children learn from a very young age that "fat" is associated with negative stereotypes and playground bullying, so much so, that 81% of 10 year old children were "afraid" of being fat as noted in research measuring children's dietary practices within the school playground (Mellin et al., 1991). One research study asked a group of young children to pick whom they like best from a set of pictures of several physically handicapped children plus one obese child; in each scenario, the obese child was the last to be selected (Richardson et al., 1961).

Given the internalisation of these social norms and the social prejudices associated with weight, it is alarming, yet not surprising to find that children as young as five years old had reported high levels of body dissatisfaction and a desire to lose weight (Dohnt & Tiggemann, 2005; Tiggemann & Lowe, 2002; Williamson & Delin, 2001). Furthermore, Shapiro et al. (1997) found in a sample of 8-10 year old girls, 11% had occasionally engaged in vomiting practices, and an additional 11% reported occasional usage of diet medication as a means of weight loss.

1.1.5. Re-modelling the Body: One's Attempt to "Fit In". The irony within cultural norms of female attractiveness is that few women can satisfy these norms,

and no woman can do so across the entire lifespan (Gordon, 2000). Given the sanctions against those who do not meet these norms, it is not surprising that women have turned to artificial means of conforming, from makeup and corsets, to diets and plastic surgery. Weight concerns, or even obsessions, are so common among women and girls that they escape notice. The self-policing, comparisons, and criticisms of women's bodies are a pervasive part of the female culture and means of collective engagement that women share with one another (Grogan, 1999). Dieting is not considered abnormal behaviour, even among women who are not overweight, yet only a thin line separates "normal" dieting from an eating disorder.

Medical research has indicated that many people who complete a commercial diet will regain one-third of their lost weight after one year, with the likelihood of retrieving all lost weight within three to five years (Halcomb, Heim, & Loughin, 2004). It is theorised that one's body weight is regulated by a biologic set point system in the hypothalamus that maintains a particular weight through sustaining energy balance and food consumption at a specific level. Traditional restrictive diets often fail because the lowering of food intake sets off a "starvation reaction" which triggers a decrease in the basal metabolic rate and overall activity level. Thus research indicates that weight loss is best determined through aerobic exercise, whereby the basal metabolic rate is elevated, and changes within the composition of food intake rather than overall restriction through dieting (Halcomb et al., 2004; Gowers & Shore, 2001).

Cosmetic surgery and media-related "make-over" shows impress consumers as enhancing one's life through cosmetic appearance, and the assumption of "undoing" the poor self-concept, psychological and emotional abuse, one may have encountered through bullying and social exclusion. The literature has shown that many consumers of cosmetic surgery undertake the surgery as a means to combat body dissatisfaction and obtain social acceptance by meeting social expectations (Crerand, Infield, & Sarwer, 2007; Frost, 2001; Simis, Verhulst & Koot, 2001). For example, Frost (2001) reported that Jewish women requested nose reductions in order to "pass" as one of their Aryan sisters who form the dominant ethnic group.

Similarly, adolescent Asian girls demanded "westernizing" of their own eyes and the creation of higher noses in the hope of securing better job and marital prospects. Black women, by contrast, indulged in toxic bleaching agents with hopes of attaining lighter skin. As Frost (2001) noted, what appeared to be created in each

of these instances was not merely a beautiful construction of face and body, rather it reflected the extensive level women would reach in their attempt to achieve ‘White, Western, Anglo-Saxon bodies in a racist, anti-Semitic context’.

In a patriarchal society where inequality still exists between men and women, women obtain status and a sense of control through adhering to the internalised practices of femininity and attractiveness. The objectification of women’s bodies and the value placed on thinness, inevitably results in heightened levels of body dissatisfaction, dieting behaviour and maladaptive eating as a means to achieve social acceptance and desirability through one’s bodily appearance.

1.2. *Eating Disorders*

1.2.1. *Manipulating the Object.* In a society still largely controlled by men, where women must compete in the sexual, academic, and occupational realms, women’s bodies offer them an outlet in which they can attain some sense of culturally approved control over their environment (Brown & Jasper, 1993; Chernin, 1986; Piran, 2001; Weitz, 1998). As such, the body becomes an object. It becomes a disciplinary project of transformation in order to achieve a slender physique which is representative of achievement, success, happiness and power.

Gordon (2000) suggested that eating disorders were ultimately a sexual political protest, wherein the issue of controlling the female body and conformation to prevailing standards of beauty, were a magnified reflection of the much more pervasive conflicts surrounding the female role and position in Western culture. As argued by Gilligan (1982), in a society where assertiveness and aggression are deemed unattractive and unfeminine, the “loss of voice” becomes pertinent in the eating disordered individual (Gilligan, 1982; Jack, 1991). Control becomes internalised through self-surveillance and policing, and one’s rage and innermost feelings are expressed “socially appropriately” through appetite (or loss of appetite). Expressions of one’s feelings are suppressed and manipulated through deprivation, rejection and starvation of the body. The female takes on a passive-aggressive masochistic relationship with herself wherein she engages in a process of ongoing abuse, punishment and self-hatred of her body and self.

The use of self starvation as a tool of manipulation and control over self and others has often been used as a tactic of revolt by women, particularly in the political event of hunger strikes. Gordon (2002) reported anorexic-like behaviour to be first evident as early as the 10th Century when it was reported that *Wilgerfortis*, the

daughter of a Portuguese king, starved herself when confronted with the prospect of marriage to a brutal king of Sicily. As a consequence of her resulting emaciation, the marriage arrangement was broken off by the suitor; however her father subsequently had her crucified. Gordon (2002) contrasted the parallel underpinnings of eating disorders to hysteria. He noted that both illnesses were considered ‘expressions, appropriate to their own times, of the dilemmas of female identity, in a cultural climate in which the female role is ambiguously defined and still limited by institutionalized male control’ (p.97).

In a culture where thinness of women is depicted as being of most importance, women may experience additional stress in efforts at dieting, given their greater biological propensity towards adiposity. Consistent with research findings (Kenardy et al., 2001; O’Dea & Abraham, 2000; Patton et al., 1997; Stice, Mazotti, Krebs, & Martin, 1998) dieting was viewed as the second greatest risk factor of the development of an eating disorder; dissatisfaction with one’s body size and shape being the first.

The research has shown that adolescent girls who diet on a moderate basis were five times more likely to develop an eating disorder in contrast to their non-dieting counterparts (Patton, 1999). Those who dieted on a more severe basis were deemed 18 times more likely to develop an eating disorder (Patton, 1999). This information is of high concern given that dieting is such normative behaviour in our society. For example, one Australian study measuring weight loss behaviour in adolescents aged 11-15 years found that 16% of girls and 7% of boys had reported having already employed at least one potentially dangerous method of weight reduction, including starvation, vomiting and laxative abuse (Dohnt & Tiggemann, 2005; Tiggemann & Lowes, 2002). Furthermore, 25% of 7-10 year old children have reportedly engaged in dieting behaviour as a means of weight reduction (Schur, Sanders, & Steiner, 2000).

Research measuring college students’ body satisfaction found that young women were highly dissatisfied with their bodies in contrast to male students (Fallon & Rozin, 1985; Green & Pritchard, 2003). Females had overestimated their current weight, idealized a smaller figure than perceived as most attractive to men, and were most dissatisfied with their hips, thighs, and stomach regions (Fallon & Rozin, 1985; Grogan, 1999; Green & Pritchard, 2003).

College environments were suggested to be a “breeding ground” for weight obsessions and the development of disordered eating given the amplification of the socio-cultural pressures, competition, and solidarity among female college students within the “semi-closed” college environment; particularly since the transition period from adolescence to young adulthood can raise additional challenges in responsibility, independence, self-concept issues (Grogan, 1999).

Furthermore, college environments often serve the middle-high socio-economic population, a group that places a high premium on thinness in women (Fallon & Rozin, 1985; Grogan, 1999; Lindberg & Hjern, 2003). The importance of physical appearance in dating, and binge-eating patterns associated with stress and studying, were also considered to be contributing factors to weight preoccupation and eating disordered behaviour (Fallon & Rozin, 1985; Green & Pritchard, 2003; Hesse-Biber, 1997). Thus disciplinary projects such as dieting, exercising, and food restriction are means of internalised control adopted by women to combat body dissatisfaction.

1.2.2. Thinness, a Body Worth Dying for. Anorexia nervosa, the “nervous loss of appetite”, is better characterized by the German term *Pubertatsmagersucht*, which translates to “mania for leanness”, essentially a thinness addiction (Gordon, 2000). Anorexia nervosa, typically signified by the refusal to maintain minimum body weight expected for age and height, the intense fear of gaining weight or becoming fat, amenorrhea (the absence of menstrual cycle for at least 3 months in post-menarche), denial, and the distorted perception of one’s own body image; occurs predominantly in White Western females of middle-high social class with peak ages of onset at 14-18 years (APA, 2000).

Throughout a range of studies, anorexia nervosa has been estimated to have a fatal outcome in between 5 and 20% of treated cases; a considerably higher rate than those of other psychiatric disorders (Gowers, Weetman, Shore, Hossain, & Elvins 2000; Herzog, Fiehn, & Petzold, 1997). The variation in mortality rates is partly due to differences in study populations and dependent on the longitudinal nature of the study design. These studies indicated that at least 50% of the deaths had resulted from complications associated with extreme starvation, for example cardiovascular or circulatory failure due to nutritional deficiency, while a significant percentage was brought about by suicide.

The risk of successful suicide has been suggested to be 32 times more likely within an anorexia population than their counterparts (Steiner & Lock, 1998).

According to Lowe et al. (2001) approximately 50% of people who develop anorexia nervosa will return to a normal body weight within 6 months of treatment, 25% will have a low but stable weight, and the remaining 25% will be chronically ill with the condition or die. Given the increased risk of death associated with chronicity and duration, early intervention and awareness is considered to be a priority.

Anorexia nervosa often begins with an innocuous decision to diet, rarely with the intent and determination to starve oneself. As noted in the literature (Keel & Klump, 2003; Hermes & Keel, 2003; Stice, 2002; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999, Treasure, 1997) the typical patient with anorexia feels an overall sense of ineffectiveness; a feeling that one's actions, thoughts, and feelings do not actively originate within the self but rather are passive reflections of external expectations and demands.

As reported by Bruch (1974), these young women often speak of being a sense of "nothing", an inactive agent in control of one's destiny. Given her poor self-concept and developmental vulnerabilities, dieting begins to yield a particularly powerful sense of control; internally, it provides a sense of mastery and euphoria to a person who formerly felt weak, depressed and empty; externally, in a culture that values thinness, achievement of a thin body shape represents significant triumph. The manipulative power of her symptoms and thus the refusal of food evoke a powerful and helpless response in family and friends; she has made an assertion of her presence that no longer can be ignored (Gordon, 2000, Thompson et al., 1999). Despite the social and psychological reinforcements of the illness, the physiological effects resulting from starvation are further likely to lock the individual with anorexia into her emaciated and malnourished state (Gordon, 2000).

Ironically, in the majority of cases, it is not one's actual weight itself that is the central problem, but the fear of weight *per se* (Keel & Klump, 2003; Steiner & Lock, 1998). This is best understood in terms of the social and cultural expectations of women to achieve thinness, as well as the specific stigma, peculiar to Western societies, attached to fat women. Thus through the transformation of dieting and fasting to wilful starvation (in fear of fatness), she typically withdraws from activities and relationships, becoming obsessed with intensified thoughts of food, exercise

regimes, dieting, calorie counting, and with the sight of her own image in the mirror (Gordon, 2000; Steiner & Lock, 1998).

Despite initial ravenous hunger and intense suffering from starvation, her determination to resist food temptations reasserts her sense of power and self-control. Her body has become an externalised manipulated object, a site for which she unleashes her rage through deprivation and harm; she becomes “cut-off” from her emotions and is unable to identify internal feelings and needs, particularly hunger; she is incapable of nurturing or nourishing herself (Bruch, 1974; Frost, 2001; Gordon, 2000; Saunders & Kashubeck-West, 2006).

The fierce struggle for self control and a sense of power in anorexia nervosa is often rooted in one’s profound sense of powerlessness. This powerlessness is often an indication of the power imbalance within the family dynamics which results in the child being unable to independently assert herself, leading to such radical measures of self control in adolescence or later (Gordon, 2000; Palazzoli et al., 1989; Saunders & Kashubeck-West, 2006). Saunders and Kashubeck-West (2006) hypothesised that anorexia may be more common in females with regard to social ideology about sex roles. Several researchers (Bruch, 1981; Gilligan, 1991; Piran, 2001; Piran & Cormier, 2005; Snyder & Hasbrouck, 1996; Tolman, 1991) have argued that girls continue to be subjected to a much greater degree of parental control than boys, are more eager to please, and are encouraged less than boys to develop self-initiated and autonomous behaviours.

One popular conceptual perspective of anorexia has been that it reflects an excessive “enmeshed” relationship between the individual and her mother, whereby fear exists around individuality, and the family has an inability to express conflicts and differences (Frost, 2001; Jack, 1991). The mother is thought to “over-identify” with her daughter as a compensation for the unarticulated disappointment in her marital relationship (Byely, Archibald, Gruber, & Brooks-Gunn, 2000; Gordon, 2000; Grigg et al., 1996; Swarr & Richards, 1996). Gordon (2000) asserted that the child who develops anorexic symptoms becomes “triangulated” into the parents’ relationship; the unresolved conflict between the parents is typically denied and detoured through anorexia, thus disabling the daughter’s attempts to achieve individuation. As a result, the conflicted child typically attempts to individuate through rejecting the intrusive mother and the food that mother has to offer.

1.2.3. Beyond Anorexia. Unlike individuals with anorexia, a significant number of whom are sexually avoidant and inexperienced, most patients with bulimia have a history of active sexual involvement and are oriented to pleasing men (Frost, 2001). It has been argued that sufferers of bulimia tend to have intense ambivalent relationships with their fathers, whereby the father is admired and idealized, and has generally set high standards of intellectual or professional achievement for his daughter. In view of her desire to please, she is often highly sensitive to male criticism and rejection, and her relationships with men are commonly turbulent (Gordon, 2000; Wooley & Wooley, 1986). Wooley and Wooley (1986) proposed that bulimic sufferers reject what they see as their mother's traditionalism and lack of assertiveness, in hope to achieve their father's perceived power.

Similarly to patients with anorexia, sufferers of bulimia typically struggle to solve their concerns of a conflicting identity, and are consequently torn between integrating ambition and a need to be powerful with an identity based on pleasing, compliance, and unassertiveness. The fluctuation between being overweight and underweight in bulimia has been suggested to embody the ambivalence and instability that surrounds gender and identity issues (Wooley & Wooley, 1986). Thinness is therefore symbolic of male power, control and competence, yet nurturing, submissive and pleasing to men. Fatness, however, is viewed as repulsive and a means of feminine weakness (Gilligan, 1982; Gordon, 2000; Wooley & Wooley, 1986).

A struggle of obesity is often evident in the family histories of bulimic patients whereby the avoidance of fatness is often a means of achieving a unique identity away from that of another family member (Brown & Jasper, 1993). Overeating is particularly common in the families of patients with bulimia, in which food is used as a means of reducing emotional distress and solving problems. Psychodynamic theories propose that these families tend to "move toward" food, in contrast with the families of anorexia who adopt a more avoidant attitude. The patient with bulimia typically turns to food as a means of solace, of filling the void left by parental inattentiveness or implicit abandonment, sexual abuse or mistreatment from society (Gordon, 2000; Littleton & Ollendick, 2003). On the outside, she portrays a positive character, one who is seemingly "in control"; underneath however, she typically feels needy, childlike, and dependent; feelings that are perceived as shameful. Rather than to expose her vulnerability and risk interpretation of "weakness", these shameful feelings are discharged in episodes of bingeing and purging.

Bulimia is thought to be 4 or 5 times more common than anorexia, yet is much more difficult to detect, given the secretiveness of their gorge-and-purge episodes and the discrete fluctuation in weight (APA, 2000; Kenardy et al., 2001). Bulimia is reported to be prevalent within 5 in 100 cases, yet the actual incidence within a student population is estimated to be as high as 1 in 5 cases (Kenardy et al., 2001). Since there is generally no significant amount of weight loss at any one time, bulimia can often be hidden for 8-10 years; the chronicity often resulting in serious medical and psychological consequences (Kenardy et al., 2001; Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). According to a study of 3000 Australian women in South Australia, purging behaviours were found to be most common in the 35-44 age group of the sample, indicative that 77% of those with bulimia or binge eating disorder were aged 25 years and over (Clayer, McFarlabe, Bookless, Air, Wright, & Czechowicz, 1995).

1.3. Disordered Eating and Identity

Eating disorders are considered to be indicative symptoms of the social pressures that women have internalised as ‘normative’ within modern Western society (Gilligan, 1991; Piran & Cormier, 2005; Powell, 2004; Stern, 1991; Tolman, 1991). Acceptable practices, behaviours and knowledge of social awareness are learnt through direct interaction with one’s social environment and modified accordingly to acceptable and desirable practices. Identity construction is believed to develop according to the perception of how one “fits in” and is perceived by others in the interaction with her environment.

Individuals are thus often concerned by their sense of belongingness and how readily they are accepted by others and their environment (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). It has been argued that women, in particular, are overly concerned by how they present and how they are perceived by others (Beck, 1999; Piran & Cormier, 2005). In essence, the perception derived from others gives one a sense of where they “fit in” on the spectrum of acceptance and belongingness within society, which in turn, provides one with a sense of identity (Gilligan, 1982; Tolman, 1991).

1.3.1. Identity Formation. It is the consensus among most theorists (Ghaderi, 2001; Hattie, 1992; Polivy & Herman, 2002; Stein & Corte, 2003) that self concept and self-esteem are influenced directly by one’s experiences, social relationships and environments. Kohut (1977) defined identity, and thus one’s self concept, as the

platform of a person where all of one's experiences build upon this basic sense of self and contribute to a person's self-esteem and confidence.

Identity formation is believed to begin as early as 2 years of age. This is the stage at which the child makes his/her first attempts to individuate, to separate from their primary caretaker, as a means to form their own personalities. This step is typically determined by the degree of secure attachment between mother and child, and the process of forming a self or thinking of self as separate from the primary caretaker becomes imperative to the development of one's identity and self-esteem. The child's self esteem is thus believed to be built upon the individual's achievements and accomplishments, which enhances their sense of identity and place within society.

Adolescence is deemed a pivotal point for identity development. It is a time when the adolescent further individuates from their family, and moves from being a child secondary to young adult. The adolescent is confronted with greater social expectations, responsibilities and further gender-specific identities; this stage is deemed particularly stressful for the adolescent girl as she moves from the identity of an innocent child to a sexualised object, following the physical changes of puberty. In addition, adolescents are faced with further demands to discover "who they are", define their interests, personalities, and future ambitions in order to determine their place in life (Santrock, 2001). Consistent with Erikson theory (1959; 1963), the decisions, adjustments and conflicts experienced at this point are considered crucial to adult identity formation, whereby the major task of this period is to achieve autonomy and further separation and individuation from parental dependence.

The process of individuation and separation of adolescence is often met with conflict and power struggles between the adolescent's urge for independence and the parent's need to maintain authority. Girls are often met with ambivalence in their desire to individuate and separate from their mothers; in one instance she tries to remain close and connected with her mother, in another instance, she is conflicted by her desire to "break away" and form her own identity at the risk of losing her mother's support. While this process is similarly difficult for boys, Powell (2004) hypothesised that the separation process may be easier and less complex for boys since the gender of the primary caretaker is usually different.

The style of parenting and parental willingness to allow the child to individuate, however, is considered a vital factor in determining the adolescent's identity development. Powell (2004) argued that should adolescents not accept their

new roles and assume challenging responsibilities, they may never face their conflicts to develop individuation and heighten self esteem and identity formation. Peer relationships and a sense of belongingness within societal groups were further identified as crucial means which support adolescents with separation and individuation from their families to enhance identity and self-worth (Powell, 2004; Santrock, 2001).

Bruch (1985) argued that the origin of disordered eating in anorexic girls was resultant from a deficit in one's sense of self. Literature in eating disorders (Crago, Shisslak, & Ruble, 2001; Polivy & Herman, 1999) confirmed these suggestions, having revealed that individuals with a poor sense of self and low self esteem, have greater levels of body dissatisfaction, and are more vulnerable to the pressures of thinness and maladaptive eating behaviours in an attempt to gain social acceptance (Bardone, Perez, Abramson, & Joiner, 2003; Stice, Schupak-Neuberg, Shaw, & Stein, 1994). Further, a longitudinal study measuring the impact of self-esteem and disordered eating, found that girls aged between 11 and 12 years with low self-esteem were eight times more likely to develop maladaptive eating by mid adolescence (Button, Loan, Davies, & Sonuga-Barke, 1997; Button, Sonuga-Barke, Davies, & Thompson, 1996).

1.3.2. Adolescence: Child to Sexual Object. Adolescence is the most critical period of identity formation. It is a period reported to reflect much ambivalence within the individual as they strive to accommodate social roles and cultural expectations (Erikson, 1963). The female child ripens from an autonomous individual to a sexualised object following puberty. She is then subjected to all the demands of female attractiveness.

As such, others (Gilligan, 1991; Gordon, 2000; Powell, 2004; Piran & Cormier, 2005; Tolman, 1991) have proposed that the development of anorexia nervosa is a radical avoidance and withdrawal from the implications of sexuality, female identity and expectations. The resulting effect: a male-like prepubescent body with no visible breasts, curves, and the absence of one's menstrual cycle; through her shape, the individual with anorexia makes a 'powerful statement of rejection of gender expectations, in effect, "I have sharp contours, I am not soft, I do not merge with you. I have nothing to give you' (Gordon, 2000, p.119).

In addition to the physical changes and sexualisation of adolescence, it has been theorised that the accumulation of body fat during puberty results in heightened

levels of body dissatisfaction as a significant deviation emerges between the prepubescent and pubescent body. Studies have found that having a higher body mass index than one's perceived ideal is associated with greater levels of body image dissatisfaction, and thus dieting behaviour and maladaptive eating practices are likely to be initiated as a means of weight loss and an attempt to attain the thin-ideal (Attie & Brooks-Gunn, 1989; Gowers & Shore, 2001; Taylor & Altman, 1997; Vincent & McCabe, 2000).

1.3.3. Gender Identity Roles. Gender, a socially constructed concept, is governed by multiple sets of socially shared beliefs, meanings, and dominant norms, namely social discourses, which originate from powerful cultural and political associations (Fox, 1997). Social critical theorists (e.g., Brown et al., 2000; Hyde, 2000) have argued that the construction of women has typically served the social, political, and economic interests of a patriarchal culture. In this instance, social expectations have traditionally reinforced stereotypes and gender roles of masculinity and femininity. Brown et al. (2000) identified men as being perceived as typically more rational, competitive, and emotionally independent; whereas women were likely to be viewed as weaker, more emotional, nurturing, and destined for domestic and caretaking functions.

With regard to identity formation, the adolescent is thrust into a culture whereby new challenges, expectations and responsibilities are believed to form the basis of their new identity. The female adolescent is typically forced to forfeit her already well-established sense of self and identity for an ambiguous and hesitant identity of womanhood. Femininity and masculinity issues become pertinent to adolescent development as the adolescent seeks to identify with his or her stereotyped gender role; should the female adolescent conform to cultural and gender role ideals and expectations, she will achieve membership and be accepted by peers. In essence, group membership will grant her with an identity and a sense of belonging.

Further, as noted by Piran and Cormier (2005), the female adolescent has internalised the gender-related discourses attributed to women, and learnt that popularity, power and success can be achieved indirectly through femininity, beauty and passivity. The internalisation of such social discourses thus leads to monitoring and regulating of women's bodies, behaviours, and social roles through a process of self-surveillance.

Similarly, Hoskins (2002) argued that by the time a female child had reached adolescence, she had already internalised through her home life, school, and the media. Consequently she “knew” that worthiness was achieved through sensitivity, dependence, vulnerability, and compliance; all traits of which perpetuate the norms, rules, and expectations of Western patriarchal society.

Within the current climate of our society, as a consequence of changes to the rhetoric of social equality, females are continually confronted with contradictory messages of independence and strength *vis a vis* compliance and vulnerability. This duality of messages consequently poses challenges to identity formation as young females are required to decipher between conforming to cultural expectations and resisting such impossible standards. To resist, however, and speak against the norm, is considered unfeminine-like and would entail risking one’s status within group membership. Thus it is inevitable that passivity and silencing oneself reinforces the behaviour of this unjust social discourse. As such, Gilligan (1982) theorised that girls and women are pressurized into silencing their thoughts, feelings, and needs in order to achieve and maintain close relationships. Furthermore Jack (1991) argued that women are not only expected to play a caregiver role to others, but are expected to put the needs of others before their own.

The silencing of needs and feelings by adolescent and adult women have shown to be detrimental to girls’ and women’s well-being, whereby the internalisation and compliance of such socialised practices are often manifested through depressive symptoms and eating disordered behaviour (Jack & Dill, 1992; Piran & Cormier, 2005). Piran and Cormier (2005) argued that self-silencing forces women to cope with a host of negative feelings, which inevitably impinge upon their self esteem, body esteem and sense of self, as well as disempowering women and minimising their social support.

Piran and Cormier (2005) suggested that it is culturally appropriate for the angry or sad woman to suppress her feelings in a tub of ice-cream or forbidden food yet not permissible to verbally express such feelings, after all, “nice girls do not get angry” (Bordo, 1993). These embodied cultural norms and the portrayal of one’s feelings through restriction and purging practices are thus problematic for those with eating disorders.

1.3.4. The Internalised Body and Body Objectification. The body is often viewed by women as an object through which one has the potential to bring about

success, wealth and lure the attention of men through an objectified gaze dependent on its attractiveness. Since thinness is internalised as desirable and attractive, most women aspire to achieve “thinness” irrespective of its attainability. At any point in time, approximately 45-60% of girls and young women attempt to lose weight via exercise, restriction and diet regimes, as a means to fit in with the “norm” and combat body dissatisfaction (O’Dea & Abraham, 2000). These findings have been mirrored in children and illustrated by Shapiro et al. (1997) where it was found that 13% of girls between 8-9 years of age reported “always” being on a diet, while 29% reported occasionally skipping meals, as a means of weight loss.

The extensive literature available (Attie & Brooks-Gunn, 1989; Byely et al., 2000; Fairburn et al., 2003; Joiner & Kashubeck, 1996; Kelly, Ricciardelli, & Clarke, 1997; Lawrence & Thelen, 1995; McVey et al., 2002; Stice, 2002) indicates that female gender and weight concerns are important risk factors for the development of eating disorders in adolescence. Specifically, an internalised thin-ideal and associated body dissatisfaction in girls has been found to significantly increase the risk of dieting, depressive symptomatology and eating disordered behaviour (McCabe et al., 2001). Moreover, the over-evaluation of weight and shape, body dissatisfaction, history of childhood obesity and internalisation of the thin ideal have been reported as precipitating factors in the maintenance of bulimia nervosa (Fairburn et al., 2003; McVey et al., 2002; Stice, 2002).

While body dissatisfaction is not the sole precipitating factor for the onset of an eating disorder, Hoskins (2002) identified the “not good enough” syndrome perpetuated by the media and advertising, as detrimental to the way in which females identify and feel toward their physical appearance. While it can be argued that television has been around since the early fifties, the viewing content has undergone dramatic shifts whereby sexuality is portrayed and marketed explicitly. These graphic portrayals of sexuality arguably affect the self esteem and body identification of women, whereby comparisons are made with unrealistic and unachievable body ideals. This in turn fosters feelings of inadequacy and the body is thus objectified and reframed into a “personal improvement project” (Hoskins, 2002).

Becker (1999) studied the body dissatisfaction of adolescent girls in Fiji prior to and following exposure to television images of idealised Western beauty. Prior to exposure of these images, eating disorders were typically rare in Fiji, as was body dissatisfaction and weight loss practices. Following exposure to these television

images however, Becker found that these girls began to re-evaluate themselves, body dissatisfaction had increased, and body monitoring and dieting practices were adhered to (Becker, 1999). Consistent with these findings, experimental research (Gowers & Shore, 2001; Groesz, Levine, & Murnen, 2002; Levine et al., 1996) have confirmed that exposure to thin media images served to enhance body dissatisfaction and disordered eating behaviour, particularly among young adolescents.

Undeniably, the more a woman's sense of self is based upon her body and attractiveness, the greater she is likely to engage in persecutory self-criticism, have heightened levels of body dissatisfaction, and attempt weight loss means of "self-improvement". Improving oneself is within itself suggestive of being flawed, in need of "fixing" and is indicative of one's poor sense of self. In a study measuring gender role identification in terms of eating disordered behaviour, Snyder and Hasbrouck (1996) found that those women who identified greater with feminist values were less concerned about their thinness, less dissatisfied with their body weight, had fewer bulimic tendencies, and fewer feelings of ineffectiveness in contrast to those who conformed to societal pressures to achieve thinness.

Snyder and Hasbrouck's study, however, had given a limited representation of the objectified woman in terms of eating disordered behaviour as the sample was restricted to middle-class college-educated White women between the ages of 17-22 years of age. In a similar study measuring feminist identity in terms of body dissatisfaction, Saunders and Kashubeck-West (2006) found that those women who adhered to a feminist ideology were more likely to have a positive or healthy body image.

Research (Cash, Winstead, & Janda, 1986; Grogan, 1999; Hetherington & Burnett, 1994; Paxton & Phythian, 1998; Tiggemann, 2004) has shown that women's desire to be thinner does not differ across age, nor does evaluation of appearance and preoccupation with being overweight. In fact, these researchers found that women's dissatisfaction with their bodies appears remarkably stable across the life span (Grogan, 1999).

Attractiveness is central to normative beliefs about women's identity and it has been argued that there is a "double standard" of aging, whereby older women are judged much more harshly than older men, in which case, women make attempts to conceal the effects of aging on their appearance. Anti-wrinkle creams, botox

treatments, face lifts and plastic surgery are just some means employed by women to combat the physical signs of aging (Sarwer, Magee, & Clark, 2004).

As noted by Sarwer et al. (2004), a high correlation exists between youthful appearance and facial attractiveness. Unlike men's rating of masculinity which remain stable across the lifespan, findings suggest that women are rated less attractive and less feminine with age (Sarwer et al., 2004). Since attractiveness is integral to a woman's identity, it can be understood why women may engage in cosmetic surgery and anti-aging procedures/products as a means to sustain a youthful looking appearance, and prolong female identity and associated attractiveness.

Hoskins (2002) argued that the distinction between what is considered "natural" and authentic has been blurred. Embodiment has obtained a new literal meaning in which increasing numbers of women, young and old, are undergoing cosmetic surgery as a means to reshape one's identity through the reshaping of one's physical body. Breast implantation for cosmetic reasoning, is a prime example of how women have contributed to the sexual objectification of their bodies whereby they seek the attention of male gaze.

Research in cosmetic surgery and breast augmentation (Crerand, Infield, & Sarwer, 2007; Sarwer et al., 2004) revealed that approximately 330,000 breast augmentation procedures were completed in the United States in 2006, resulting in an increase of 55% in breast surgical procedures since 2000, and more than 900% since 1992. These findings confirmed that body image dissatisfaction was the primary reason for cosmetic surgery, with body image dissatisfaction being highest in those patients seeking breast augmentation (Pertschuk, Sarwer, Wadden, & Whitaker, 1998; Simis et al., 2001).

Research in breast augmentation suggests that women with breast implantations engage in more sexualised behaviour than women without breast implants, further, these women have been identified as having a lower than average body weight raising concern for potential eating pathology within this population group (Brinton et al., 2000; Cook et al., 1997; Didie & Sarwer, 2003; as cited in Crerand et al., 2007). Longitudinal research showed that women with breast implantations required greater outpatient psychotherapy services, psychopharmacology, and psychiatric hospitalizations than women from the general population and from other patients who have sought other cosmetic procedures (Jacobsen et al., 2004, Sarwer et al., 2004 as cited in Crerand et al., 2007).

Women further objectify themselves through gazing at other women, comparing body shapes and attractiveness, and essentially “sussing out” their competition. Consistent with previous research on social comparison and body image, Rubin et al. (2004) found that women generally felt worse about their bodies after comparing themselves with others. Similar studies (Heinberg and Thompson, 1992; Strelan & Hargreaves, 2005) found that women, who compared themselves to other women, were more likely to engage in higher levels of self-objectification, and have greater levels of body image anxiety and body dissatisfaction, irrespective of whether they were “thinner” than their counterparts.

It is argued that the internalisation of body size and shape are likely to determine one’s identity, worth, and sense of self. Accordingly, it is believed that women have internalised social discourses of what constitutes desirable traits, such as femininity, passivity and attractiveness. As such, most women conform to such ideals through beauty products, exercise, diet regimes and restrictive eating in order to achieve group membership by fitting in with the desired norm. Those women that are successful enough to attain satisfactory physical appearance according to the normative ideal may feel a sense of pleasure in achieving membership and a sense of belonging and acceptance. Other women, however, despite their efforts to conform, may never reach the point where they are satisfied with their physical appearance. Is there typically a point where one will ever be satisfied with their bodies, or are there continual improvements to be made?

Normatively, women view their bodies as objects which they can manipulate, remodel and reshape according to what’s deemed attractive. In essence, the body becomes the physical representation of one’s identity and measure of self worth. Thus if one is dissatisfied with her body, in turn, it is likely that she may become dissatisfied with herself. If body satisfaction is measured according to self worth, identity, and feelings of belongingness and acceptance, it can be argued that an absence of these factors could heighten body dissatisfaction and the likelihood of engaging in disordered eating behaviour. Given that women’s bodies often change throughout their lifespan it is not surprising that body dissatisfaction and associated psychopathology widely exists within women of all ages.

1.4. Rationale for the Current Study

While the media are often blamed for the influence of eating disordered behaviour (Gowers & Shore, 2001; Groesz et al., 2002; Levine et al., 1996; Posavac,

Posavac, & Weigel, 2001) it solely fails to explain why some individuals are vulnerable to social pressures yet others are not. Furthermore, while the majority of women report body dissatisfaction to some extent, not all women partake in disordered eating practices. Various researchers have explored feminist attitudes and body dissatisfaction in terms of eating disordered behaviour (Alyn & Becker, 1984; Ossana, Helms, & Leonard, 1992; Prochaska & Norcross, 1999; Sabik & Tylka, 2006), however to date these studies have failed to explore the impact of feminist identity on the self, sense of self and social identity.

Research (Cash, Winstead, & Janda, 1986; Grogan, 1999; Hetherington & Burnett, 1994; Paxton & Phythian, 1998; Tiggemann, 2004) validated that women of all ages experience internalisation of social discourses and related body dissatisfaction, yet few studies have included women greater than 25 years of age within their samples in measuring eating disordered behaviour (Allaz, Bernstein, Rouget, Archinard, & Morabia, 1998; Cash & Henry, 1995; Garner, 1997; Stevens & Tiggemann, 1998; Tiggemann & Lynch, 2001).

To date, a small number of studies have supported theoretical links between the internalisation of the objectified gaze and adverse well-being. McKinley and Hyde (1996) have argued that the internalisation of the objectified gaze leads women to view their body with an externalised lens, experience shame, and believe that their body appearance should be controlled. Thus greater exploration of women's sense of self, objectification and body consciousness in terms of body dissatisfaction and eating disordered behaviour are needed across a larger age group to ascertain what factors are likely to influence eating disordered behaviour in women.

1.4.1 Aims and Hypotheses. The current study aimed to contribute to previous research and explore an overview of the way in which women objectify their bodies with relation to their identity and sense of self, through body dissatisfaction, and dysfunctional eating attitudes and behaviour. This will be achieved through a quantitative study, using a self report survey to evaluate whether there is any significant predictive relationship between identity development, objectification, body dissatisfaction and dysfunctional/pathological eating behaviour. Any comments received from subjects will be analysed using thematic analysis with consideration of the discourse presenting.

BMI level and age will be used as additional factors to ascertain whether one's body weight in contrast to their height affects their perception of poor body image,

dissatisfaction and eating disordered behaviour. Given that the study attempts to explore women's body dissatisfaction across the lifespan, it is therefore important to ascertain whether aging women share concern in body dissatisfaction, and further, identify if a relationship exists between age, BMI level, body dissatisfaction, and disordered eating behaviour. The correlation between current weight and ideal weight will also be explored to ascertain whether discrepancies between these two factors would result in increased body dissatisfaction. A further variable to be considered will include sense of belongingness. This variable is aimed to measure one's perception of feeling accepted within friendships and society's framework.

Due to the correlation between disordered eating and silencing behaviour within clinical observation, silencing behaviour will be assessed using the silencing of self scale, and contrasted against other variables. The silencing behaviour variable is composed of 4 subscales which specifically measure different components of silencing behaviour. Given that silencing behaviour has not been commonly measured in previous studies, each of the 4 subscales were measured individually and collectively to ascertain specific attributes of silencing behaviour and maladaptive eating patterns. Additional protective factors which are associated with vulnerabilities to dysfunctional eating behaviour will also be examined.

The primary hypothesis suggests that women who have strongly based their identity according to societal values and expectations, and adopted a role of passivity and silence with regard to their perception of femininity and gender role ideals, are those who are more likely to experience high levels of body dissatisfaction and are at greater risk of manifesting disordered eating behaviour. Subsidiary questions relating to the hypothesis suggest:

- Those women who fail to have a sense of self tend to experience more body dissatisfaction, as compared to those who clearly identify sense of self. This as a variable is defined as a sense of belongingness.
- Women who present with passive behaviour are more likely to internalise negative self perceptions regarding their identity and at greater risk of eating disordered behaviour
- Women who engage in higher levels of sociocultural attitudes toward appearance are more likely to experience body objectification and hence greater levels of body dissatisfaction

- A correlation would exist between age in women and level of body dissatisfaction, sociocultural attitude toward appearance, sense of belongingness, and one's desire to conform to feminine norms
- Women who feel they should conform highly to feminine norms may experience higher levels of body objectification and possibly experience greater levels of body dissatisfaction.
- Higher levels of BMI in women would correlate with higher levels of body dissatisfaction.
- A correlation would exist between BMI level in women and sociocultural attitude toward appearance, sense of belongingness, and one's desire to conform to feminine norms
- A wider discrepancy between women's current weight and ideal weight would result in increased body dissatisfaction.
- Women who are highly dissatisfied with their bodies, would be at greater risk of engaging in disordered eating behaviours as a means of weight loss and possibly a means to achieve satisfaction and a sense of control.

Chapter 2: Method

The study design is of a quantitative nature, using a self report survey to evaluate whether there is any significant predictive relationship between identity development, objectification, body dissatisfaction and dysfunctional/pathological eating behaviour. Secondary analysis allowed for qualitative data analysis of comments made by participants. Some participants were thoughtful enough to comment on the helpfulness of the questionnaire in voicing their body concerns. These comments were subsequently included in the study to add further insight into women's body dissatisfaction, and encourage exploration of these issues in future research. Using a phenomenological approach, comments were then thematically analysed through discourse analysis.

2.1. Participants

A minimum of 120 participants were sought for research participation in order to establish statistical power requirements; Worthington and Whittaker (2006) recommend a minimum of 5-10 participants per item for recruitment purposes. Participants were recruited typically through a convenience sample whereby 209

women aged 18 years to 65 years ($M = 29.53$; $SD = 10.81$) were recruited through email, advertisement flyers, sporting and leisure centers, and word-of-mouth within universities.

Given the research project had targeted a non-clinical population to determine body dissatisfaction and dysfunctional eating behaviour within the general community, participants later identified as having experienced dysfunctional eating behaviour upon completion of the questionnaire booklet were not excluded from the study as they were obtained within a non-clinical setting and deemed representative of the norm population.

2.2. *Measures*

Each participant was provided with a self report questionnaire booklet relating to eating attitudes, behaviour and societal views of body image. The questionnaire booklet was expected to take approximately 30 minutes to complete, and incorporated the following measures:

Demographic information. Participants were asked their age, height and weight. BMI was subsequently calculated as the ratio of weight (kg) to height squared (m^2) (Garrow & Webster, 1985).

Socio-cultural Attitude Towards Appearance Questionnaire (SATAQ; Heinberg, Thompson, & Stormer, 1995). The degree to which a participant is aware of and internalises societal standards of thinness and appearance was measured via the Socio-cultural Attitude Towards Appearance Questionnaire (SATAQ). The two subscales incorporated in this measure are Awareness and Internalisation. The questionnaire consists of 14 items that assesses participants' recognition (Awareness) and acceptance (Internalisation) of societal standards of appearance (e.g. "Attractiveness is very important if you want to get ahead in our culture"; "I wish I looked like a swimsuit model"). Each item uses a 5-point rating system ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with a midpoint rating of 3 for responses of "not applicable". The items in the Internalisation and Awareness subscales demonstrated adequate internal consistency in previous research (alphas = 0.88 and 0.71, respectively; Heinberg et al., 1995).

Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996). The Objectified Body Consciousness Scale (OBC) was used to assess the degree to which a woman has adopted an externalised view when relating to her own body. McKinley and Hyde (1996) argued that women continually engage in self-monitoring behaviour,

as well as attempts of body control, and feelings of shame, particularly if women fail to achieve the cultural ideal. The OBC consists of 24 items pertaining to three subscales which reflect these dimensions; Body Surveillance (e.g., “I often worry about whether the clothes I am wearing make me look good”), Body Shame (e.g., “I feel like I must be a bad person when I do not look as good as I could”), and Control Beliefs (e.g., “I think a person can look pretty much how they want to if they are willing to work at it”).

Each subscale is measured using a 5-point rating system ranging from 1 (*strongly disagree*) to 5 (*strongly agree*); a midpoint rating of “not applicable” is also offered. High scores are reflective of higher levels of body objectification. Total scores and subscale score can be computed individually, and have been shown to have adequate psychometric properties and internal reliability coefficients with young and middle-aged women. Development and validation of the OBC scale primarily used a sample of heterosexual European American women. Internal consistencies for body surveillance have been reported as .89, .75; and .72 (McKinley & Hyde, 1996); body shame, .76, .70, and .68 (McKinley, 1998); and appearance control belief scales reported as .79, .84, and .76 (McKinley, 1999).

Body-Image Ideals Questionnaire (BIQ; Cash & Szymanski, 1995). The Body Image Ideals Questionnaire (BIQ) measures the discrepancy between self-perceived physical attributes and ideal attributes. Participants are asked to evaluate their body in terms of 11 physical attributes (height, skin complexion, hair texture/thickness, facial features, muscle tone/definition, body proportions, weight, chest size, physical strength, physical coordination, and overall appearance) and rate whether they satisfactorily meet their ideal for these attributes.

The degree of discrepancy between actual and ideal physical attributes is rated on a 4-point Likert scale ranging from -1 (*exactly as I am*) to +3 (*very unlike me*). Participants are subsequently required to rate the importance they place on each ideal, using a 4-point Likert scale ranging from 0 (*not important*) to 3 (*very important*). The two subscales, discrepancy index and importance scale, can be scored individually or together as a total score. The reliability and validity measures have been affirmed by several studies (Cash, 1994; Cash & Szymanski, 1995; Szymanski & Cash, 1995) with alpha coefficient values for discrepancy, importance, and weighted discrepancy reported as .75, .82, and .77, respectively.

Silencing the Self Scale (STSS; Jack, 1991; Jack & Dill, 1992). The Silencing the Self Scale (STSS) is a measure that consists of 31 items designed to measure beliefs and behaviours about oneself in relationships with others. Participants are asked to rate how much they agree or disagree with each item, using a 5-point scale that ranges from 1 (*strongly disagree*) to 5 (*strongly agree*). Four separate subscale scores and a total score can be computed. In each case, higher scores are indicative of greater self-silencing behaviour. The four subscales represent varied but interrelated aspects of self-silencing.

Externalised Self-Perception, measures the degree to which individuals evaluate themselves according to another's view (e.g., "I tend to judge myself by how I think other people see me"). Care as Self-Sacrifice examines the degree to which an individual feels that others' needs should be placed before her own in order to sustain security within the relationship (e.g., "Caring means putting the other person's needs in front of my own"). Silencing the Self assesses the degree to which a person silences her own thoughts and feelings as a means to avoid conflict and disharmony (e.g., "I do not speak my feelings in an intimate relationship when I know they will cause disagreement"). The Divided Self subscale examines the degree to which an individual appears to be seemingly compliant, yet conceals feelings of hostility and resentment within (e.g., "Often I look happy enough on the outside, but inwardly I feel angry and rebellious").

The STSS has been validated with a variety of population groups, internal consistency typically ranging from .86 to .94, and test-retest reliability coefficients ranging from .88 to .93 (Jack & Dill, 1992).

Sense of Belonging Instrument-Psychological (SOBI-P; Hagerty & Patusky, 1995). The Sense of Belonging Instrument-Psychological (SOBI-P; psychological experience of fit and valued involvement) consists of 18 items scored on a 4-point Likert scale from 1 (*strongly disagree*) to 4 (*strongly agree*). The SOBI-P items address one's sense of feeling valued (e.g., "If I died tomorrow, very few people would come to my funeral") along with their sense of belonging (e.g., "I often wonder if there is any place on earth where I really fit in"). A high score indicates that the individual feels valued, needed, and accepted, representative of a higher sense of belongingness.

Hagerty et al. (1996) reported that Cronbach's coefficients alphas range from .91 to .93 with test-retest reliability reported as .84. Content validity and construct

validity have also been reported and supported by factor analysis, contrasting groups, and correlations with other related measures (Hagerty & Patusky, 1995).

Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982).

The Eating Attitudes Test (EAT-26) is a widely used 26-item screening tool for measuring eating disordered behaviour. While the scale is not a diagnostic instrument for anorexia and bulimia nervosa, it does identify maladaptive eating attitudes and behaviour which are attributed to disordered eating. The EAT-26 uses a 6-point Likert scale ranging from *Always* to *Never*. Cut-off scores are believed to reflect symptom severity, and discriminate normal groups from anorexia and bulimia nervosa populations. Validation from several population groups identified significant cases of disordered eating through high scores (25 and above), in contrast to intermediate scores (15-24) with mild symptoms, and very low scores (under 15) indicative of women with nil symptoms. The EAT-26 has been found to have excellent psychometric properties with consistency reliability coefficients ranging between .70 and .88. There will be no individual clinical cut-off scores determined from the EAT-26 in this study. The overall aim of the EAT-26 was to determine likelihood of disordered eating behaviours as opposed to analysis of clinical cut-off scores and clinical diagnosis.

An overall view of section one, the Likert scale, and section two, question responses “yes/no” to engaging in specific disordered eating behaviours allows for an overview. This overview will be considered in terms of the possibility of categorisation and general discussion. This will be assessed according to section two, the overall patterns of behaviour as measured by one or more affirmative responses to uncontrolled binge eating, laxative/diuretic abuse, and/or intentional vomiting as a means to lose weight, over the past 6 months.

The Conformity to Feminine Norms Inventory (CFNI; Mahalik et al, 2005).

The Conformity to Feminine Norms Inventory (CFNI) is an 84-item questionnaire used to measure the degree to which women adhere to traditional gender roles and practices of feminine norms. The CFNI consists of 8 subgroups identified as normative means of femininity; Have Nice Relationships, Thinness, Modesty, Domestic, Involvement with Children, Involvement in Romantic Relationships, Sexual Fidelity, and Investment in Appearance. Example of items include, “I feel good when others know I care,” and “I would be happier if I were thinner.”

Items are scored on a 4-point Likert scale ranging from Strongly Agree to Strongly Disagree. Women adhering greater to feminine norms were found to have a higher total score, and likewise score significantly higher in subscales pertaining to Have Nice Relationships, Thinness, Domestic, Involvement with Children, Sexual Fidelity, and Investment in Appearance. The development of items adhering to feminine norms were devised through several intensive focus groups representative of White middle class heterosexual females with dominant cultural norms. As reported by Mahalik et al. (2005), the CFNI has been found to have reliable psychometric properties; coefficient alpha for the total CFNI score was reported to be .88, while individual subscales had consistent reliability coefficients ranging between .77 and .92.

A new category, “disturbed eating” was created in order to acknowledge participants who engage in binge eating, laxative/diuretic abuse, and vomiting behaviour, but who had no previous diagnosis and/or treatment for disordered eating. Eighty-four participants who had engaged in at least one episode of (uncontrolled) binge eating, laxative/diuretic abuse, and/or vomiting as a means to control weight over the past 6 months, were identified as engaging in “disturbed eating”, while 125 participants did not meet these criteria. Secondary analysis allowed for qualitative data analysis of comments made by participants. Using a phenomenological approach, comments were then thematically analysed through discourse analysis.

2.3. *Procedure*

The study was announced in email notices that were sent to university staff, student and faculty providers, as well as being advertised on notice boards within the university, various gyms, sporting and leisure centres. Undergraduate lectures at Victoria University were approached by the researcher, and upon granted verbal permission from the lecturers, the project was introduced to students and questionnaires distributed to interested female participants. Participants were informed of the voluntary and anonymous nature of the project, and were provided with a questionnaire booklet in a marked and pre-stamped envelope to return to the researcher following completion.

The researcher’s contact details were provided on advertisement flyers introducing the project, and interested participants were able to contact the researcher to receive further information of the project and/or a questionnaire booklet.

Questionnaire booklets and a marked and pre-stamped envelope were mailed out to interested participants for completion. Consent forms were not given to participants, as completion and return of the questionnaire was assumed to indicate consent. Of the 250 questionnaires distributed, 211 were returned, resulting in a response rate of 97.5%. Incomplete questionnaires, with missing responses ($n = 2$), were not included in the sample.

2.3.1. Data Handling. Raw data were entered into the Statistical Package for Social Sciences (SPSS-v.16.0). The responses for all of the items were entered into the SPSS program based on self-report responses as indicated by the participants. Upon completion of data input, each questionnaire was coded and scored according to the scoring procedure described in section 2.2. In order to examine the data, a total of 15 variables were created, and each variable was further divided into subscales.

These variables were as follows:

- (1) Age of participant (Years)
- (2) Height (Cm)
- (3) Weight (Kg):
 - a. Current weight
 - b. Highest weight
 - c. Lowest weight
 - d. Ideal weight
- (4) Socio-cultural attitudes towards appearance
Measured using the Socio-cultural Attitude Towards Appearance Questionnaire (SATAQ) and divided into 2 subscales:
 - a. Awareness
 - b. Internalisation
- (5) Objectified body consciousness
Measured using the Objectified Body Consciousness (OBC) scale and divided into 3 subscales:
 - a. Body Surveillance
 - b. Body Shame
 - c. Body Control
- (6) Body dissatisfaction
Measured using the Body Ideal Questionnaire (BIQ)

(7) Silencing behaviour/passivity

Measured using the Silencing the Self Scale (STSS) and divided into 3 subscales:

- a. Externalised self perception
- b. Silencing the self
- c. Divided self

(8) Sense of belongingness

Measured using the Sense of Belongingness Inventory-Psychological (SOBI-P)

(9) Eating attitudes and behaviours

Measured using the Eating Attitudes Test (EAT-26) and divided into 3 subscales:

- a. Dieting behaviour
- b. Bulimia and food preoccupation
- c. Oral control

(10) Conformity to feminine norms

Measured using the Conformity to Feminine Norms Inventory (CFNI) and divided into 8 subscales:

- a. Nice relationships
- b. Involvement with children
- c. Importance of thinness
- d. Sexual fidelity
- e. Modesty
- f. Romantic relationships
- g. Domestic chores
- h. Investment in appearance

(11) Body Mass Index (BMI)

(12) Previous diagnosis/treatment for an eating disorder

(13) Disturbed eating behaviour

To ascertain whether patterns of disordered eating, body dissatisfaction and objectified body consciousness existed in particular life stages and/or weight categories, additional variables, namely age groups and BMI groups, were created for subsequent analysis.

- (14) Age group
- (15) BMI group

Chapter 3: Results

3.1. *Tests of Assumptions*

Descriptive statistics for all data were examined using SPSS-v.16.0 to assess missing values and to determine whether all data were within the specified range. The data set was found to be complete with no missing values and within the specified ranges. In addition, Mahalanobis distance was used to test for multivariate outliers. Results indicated that there were no outliers among the 15 variables, and the respective subscales, examined. An analysis of the residuals and normality probability (P-P) was also performed in order to test the assumption of normality, linearity and homoscedasticity. These analyses revealed that these assumptions were adequately met and that all data were linear and within appropriate ranges.

3.2. *Hypothesised Findings*

It is hypothesised that women who have strongly based their identity according to societal values and expectations, and adopted a role of passivity and silence with regard to their perception of femininity and gender role ideals, would be more likely to experience high levels of body dissatisfaction and be at greater risk of manifesting disordered eating behaviour(s). A series of multiple linear regression analyses will be conducted to ascertain predictor variables of disordered eating, body dissatisfaction and body objectification, and a number of multivariable analyses of variances (MANOVA) will be performed to specifically examine significant main effects and relationships between these predictor variables. While it is likely that the results of the MANOVA analyses may overlap with the results obtained from multiple linear regression analyses, the MANOVA analyses are conducted to substantiate and strengthen the initial hypotheses presented.

Each of the variables, namely age, BMI level, current weight versus ideal weight, sociocultural attitude towards appearance, body objectification and consciousness, silencing of the self, sense of belongingness, eating disordered behaviour and conforming to female norms, will be compared and contrasted against one another to specifically explore and examine the variables which predict body

dissatisfaction, body objectification and disordered eating. MANOVA analyses will similarly be conducted to ascertain the strength of the relationship between the variables measured.

3.3. Data Analysis

Means and standard deviations for the SATAQ, OBC, BIQ, STSS, SOBI-P, EAT-26 and CFNI were computed using SPSS-v16.0 (see Table 3.01) and a number of descriptive tables were produced. A multivariate analysis of variance was conducted on each of the variables listed in Table 3.01 and these results indicated several significant differences between groups, with correlations ranging on average between 0.3-0.6. A series of correlational analyses and multiple linear regression analyses were performed to ascertain predictor variables of disordered eating, body dissatisfaction and body objectification.

The design of the study involved comparisons between groups based on age and BMI level, and also an examination of the relationships between various dependent variables. Given the exploratory nature of the study, correlations and linear regression analyses were used to examine the relationships between variables, and MANOVA's were used to examine group differences. All statistical analyses were two-tailed and alpha was set at 0.05, rather than 0.01, to avoid elimination of potential predictive relationships.

Multiple linear regression analyses were performed to test the hypotheses that; (1) social attitudes (awareness and internalised); (2) objectified body consciousness (body surveillance, body shame, body control); (3) body image dissatisfaction; (4) silencing the self (externalised self-perception, care as self-sacrifice, silencing the self, divided self); (5) one's sense of belonging; (6) eating attitude (dieting, food preoccupation, oral control); and (7) conformity to feminine norms (the importance of nice relationships, thinness, modesty, domestic chores, involvement with children, involvement in romantic relationships, sexual fidelity, investment in appearance) were likely to account for a significant proportion of the variance of female objectification, body dissatisfaction and disordered eating in a non-clinical female population.

Table 3.01

Means and Standard Deviations for Factors (BMI, SATAQ, OBC, BIQ, STSS, SOBI-P, EAT-26 & CFNI) for the Sample of 209 Women.

		<i>M</i>	<i>SD</i>	<i>N</i>
BMI		24.37	4.90	209
SATAQ				
	Internalisation	22.51	6.83	209
	Awareness	14.77	3.66	209
OBC				
	Body surveillance	21.16	3.42	209
	Body shame	22.59	5.16	209
	Body control	23.31	4.14	209
BIQ				
	Total	1.91	1.38	209
STSS				
	Externalised self perception	18.01	5.55	209
	Silencing the self	21.44	7.67	209
	Divided self	16.28	6.45	209
SOBI-P				
	Total	56.49	10.98	209
EAT-26				
	Dieting	8.01	9.42	209
	Bulimia & food preoccupation	2.61	3.19	209
	Oral control	1.70	2.64	209
CFNI				
	Nice relationships	37.50	5.90	209
	Involvement with children	22.56	7.71	209
	Importance of thinness	20.10	6.67	209
	Sexual fidelity	17.77	6.35	209
	Modesty	13.79	3.95	209
	Romantic relationships	13.91	3.72	209
	Domestic	15.79	3.99	209
	Investment in appearance	12.57	4.10	209

3.4. Demographic Characteristics of the Participants

Participants consisted of 209 females, between the age range of 18-65 years, with a mean age of 29.53 years ($SD = 10.81$; see Table 3.02). The age ranges were further compiled into three age groups according to theoretically-based developmental life stages, which could influence weight cycles, namely young adulthood, 18-35 years; middle adulthood, 36-55 years; and older adulthood, 55 years and above. The mean weight across the entire sample was 66.28 kg ($SD = 13.69$; see Table 3.02) and ranged from 42-115 kg.

Given that participants vary in height and weight, BMI levels were calculated by weight (kg)/height (m)² to ensure a universal and consistent measurement in body mass across the sample. Calculated BMI levels ranged from 16.51 to 46.07 with a mean of 24.38 ($SD = 4.89$; see Table 3.01). BMI levels were divided into four groups; underweight (BMI <19.99), normal weight (BMI = 20-25), overweight (BMI = 25.01-29.99), obese weight (BMI >30). This procedure was performed in order to determine differences between BMI groups with regard to body objectification, body dissatisfaction and disordered eating behaviour.

Table 3.02

Demographic Characteristics of Participants

	<i>M</i>	<i>SD</i>	<i>N</i>
Age	29.53	10.81	209
Height (cm)	164.93	7.36	209
Weight (kg)	66.28	13.69	209
BMI	24.38	4.89	209

Fourteen of the 209 participants reported previous treatment for an eating disorder, while the remaining 195 reported no previous treatment (see Table 3.03). Fifty-one participants reported binge eating within the past six months (frequency ranging from once to 15 times during the worst week); 49 reported using laxatives, diet pills or diuretics to control weight or shape (frequency of usage ranged from once

Table 3.03

Eating Disordered Demographics of Participants

	<i>N</i>	<i>Min</i>	<i>Max</i>	<i>M</i>	<i>SD</i>
Treatment for an ED	14	-	-	0.07	0.25
No treatment for an ED	195	-	-	-	-
Freq binge eating (6 mths)	51	1	15	0.99	2.64
Freq laxatives/diuretics	49	1	42	2.44	6.36
Freq vomiting	29	1	15	0.77	2.57

to 42 times during the worst week); and 29 reported using vomiting as a means of controlling weight or shape (frequency ranged from once to 15 times during the worst week) within the past 6 months.

3.5. Body Dissatisfaction

3.5.1. Predictors of Body Dissatisfaction. A correlational analysis (see Table 3.04) was performed in order to assess the relationships between age, BMI level, conformity to feminine norms (CFNI), sense of belongingness (SOBI-P), social attitudes (SATAQ), silencing the self (STSS), and objectified body consciousness (OBC) against body dissatisfaction (BIQ). The correlations indicated that the data were suitable for regression analysis.

Table 3.04

Correlations Between Body Dissatisfaction and Other Variables

Factor	BIQ (n=209)	
	r	p
Age	.11	.12
BMI	.21	.002
Nice Relationships	.05	.46
Involvement with Children	.02	.80
Thinness	.51	.0005
Sexual Fidelity	.16	.02
Modesty	.42	.0005
Involvement in Romantic Relationships	.14	.04
Domestic Duties	.15	.03
Investment in Appearance	.19	.007
Sense of Belongingness	-.46	.0005
Internalisation	-.48	.0005
Awareness	-.31	.0005
Care as Self Sacrifice	.34	.0005
Externalised Self Perception	.54	.0005
Silencing the Self	.40	.0005
Divided Self	.38	.0005
Body Surveillance	-.22	.0001
Body Shame	.52	.0005
Body Control	-.06	.37

A multiple linear regression was conducted to determine whether BMI, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS) and/or objectified body consciousness (OBC) predicted body dissatisfaction (BIQ scores). The results indicated that a significant amount of variation in BIQ scores was accounted for by

the predictor variables, $F(20,187) = 9.60, p = .0005$. Adjusted R-square value indicated that together 45% of the variance was accounted for by the regression equation, with 65% unaccounted for. The following factors were found to be significant predictors, BMI ($t = 2.61, p = .01$), modesty ($t = 2.21, p = .03$), internalisation ($t = -3.58, p = .0005$), externalised self perception ($t = 2.13, p = .04$) and body control ($t = -2.22, p = .03$).

3.5.2. Body Dissatisfaction and BMI Level. An ANOVA was conducted to determine whether BMI had an impact on body dissatisfaction. The ANOVA showed a significant difference in BMI groups and body dissatisfaction, $F(3, 205) = 5.95, p = .001$. *Post hoc* comparisons showed that there were significant differences for body dissatisfaction between underweight and obese groups ($p = .0005$), normal and obese groups ($p = .0005$), and overweight and obese groups ($p = .001$). Table 3.05 shows that obese participants reported the greatest body dissatisfaction ($M = 2.90, SD = 1.31$) followed by overweight ($M = 1.86, SD = 1.41$), normal ($M = 1.83, SD = 1.41$), and underweight groups ($M = 1.57, SD = 1.47$).

Table 3.05

Means and Standard Deviations and Univariate ANOVA Results for BMI Groups for Body Dissatisfaction

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
BIQ	1.57	1.47	1.83	1.23	1.86	1.41	2.90	1.31	5.95	.001

Model F (3,205) = 5.95, *p* = .001

3.5.3. Body Dissatisfaction and Age Groups. An ANOVA was conducted to ascertain whether age had an impact on body dissatisfaction. The ANOVA showed no significant difference in age groups and body dissatisfaction, $F(2, 206) = 1.28, p = .28$. The means and standard deviations for body dissatisfaction for each age group are shown in Table 3.06.

Table 3.06

Means and Standard Deviations and Univariate ANOVA Results for Age Groups for Body Dissatisfaction

		Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		F	p
		M	SD	M	SD	M	SD		
BIQ		1.84	1.33	2.17	1.50	2.31	1.72	1.28	.28

Model F (2, 206) = 1.28, p = .088

3.6. Silencing Behaviour

3.6.1. Predictors of Silencing Behaviour. A correlational analysis (Table 3.07) was performed in order to assess the relationships between body dissatisfaction (BIQ), age, BMI level, conformity to feminine norms (CFNI), sense of belongingness (SOBI-P), socio-cultural attitude towards appearance (SATAQ), objectified body consciousness (OBC), and eating attitudes (EAT-26) against silencing the self (STSS). The correlations indicated that the data were suitable for regression analysis.

Multiple linear regression was conducted to determine how much variance BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), body consciousness (OBC), body dissatisfaction (BIQ), eating attitudes (EAT-26), externalised self-perception (STSS), silencing the self (STSS), and/or divided self (STSS) accounted for in care as self sacrifice (STSS). The regression was significant, $F(24,183) = 8.54, p = .0005$. The R-square adjusted value indicated that 47% of the variance was accounted for by the regression equation. However, 53% of the variance of care as self sacrifice was not accounted for. The importance of adhering to domestic chores ($t = 2.02, p = .05$), one's sense of belongingness ($t = -2.11, p = .04$), silencing of oneself ($t = 5.22, p = .0005$), bulimic traits and food preoccupation [eating attitudes] ($t = -2.24, p = .03$), and oral control/restrictive eating [eating attitudes] ($t = 2.09, p = .04$) were significant predictors.

Multiple linear regression was conducted to determine how much variance in externalised self perception (STSS). was accounted for by BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), body consciousness (OBC), body dissatisfaction (BIQ), eating attitudes (EAT-26), care as self sacrifice (STSS), silencing the self (STSS), and divided self

(STSS). The regression was significant, $F(24,183) = 18.55, p = .0005$. The R-square adjusted value indicated that together 67% of the variance was accounted for by the regression equation, with 33% not accounted for. The following factors were found to be significant predictors: importance of having nice relationships ($t = 2.56, p = .01$), divided self ($t = 2.45, p = .02$), body image dissatisfaction ($t = 2.19, p = .03$), and body surveillance ($t = 2.02, p = .05$).

Table 3.07

Correlation Analysis for Silencing of the Self Scale (STSS)

Factor	Care as Self Sacrifice (n=209)		Externalised Self Perception (n=209)		Silencing of the Self (n=209)		Divided Self (n=209)	
	r	p	r	p	r	p	r	p
Body Dissatisfaction	.34	.0005	.54	.0005	.40	.0005	.38	.0005
Age	.03	.70	-.04	.57	.09	.18	.12	.09
BMI	.01	.94	.01	.84	-.01	.93	-.02	.74
Nice Relationships	.16	.02	.13	.05	.10	.16	-.03	.67
Involvement with Children	.08	.28	-.06	.41	.03	.73	-.06	.41
Thinness	.20	.003	.52	.0005	.30	.0005	.39	.0005
Sexual Fidelity	.39	.0005	.24	.0005	.33	.0005	.15	.03
Modesty	.37	.0005	.47	.0005	.43	.0005	.35	.0005
Involvement in Romantic Relationships	.17	.02	.23	.001	.22	.002	.14	.04
Domestic Duties	.18	.01	.09	.18	.09	.20	.13	.05
Investment in Appearance	-.01	.86	.11	.10	.05	.47	.07	.35
Sense of Belongingness	-.42	.0005	-.70	.0005	-.48	.0005	-.56	.0005
Internalisation	-.21	.003	-.46	.0005	-.24	.0005	-.38	.0005
Awareness	-.07	.30	-.29	.0005	-.18	.009	-.20	.004
Body Surveillance	-.04	.53	-.07	.30	-.04	.61	-.09	.20
Body Shame	.32	.0005	.52	.0005	.36	.0005	.39	.0005
Body Control	.18	.01	.04	.53	.12	.08	.12	.09
Dieting	.30	.0005	.56	.0005	.34	.0005	.42	.0005
Bulimia/Food Preoccupation	.25	.0005	.54	.0005	.37	.0005	.45	.0005
Oral Control	.34	.0005	.31	.0005	.24	.001	.16	.03
Care as Self Sacrifice	1.00	-	.49	.0005	.61	.0005	.43	.0005
Externalised Self Perception	.49	.0005	1.00	-	.62	.0005	.63	.0005
Silencing the Self	.61	.0005	.62	.0005	1.00	-	.71	.0005
Divided Self	.43	.0005	.63	.0005	.71	.0005	1.00	-

Multiple linear regression was conducted to determine how much variance silencing the self (STSS) was accounted by BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), body consciousness (OBC), body dissatisfaction (BIQ), eating attitudes (EAT-26), care as self sacrifice (STSS), externalised self perception (STSS), and/or divided self (STSS). The regression equation was significant, $F(24,183) = 16.04, p = .0005$. The R-square adjusted value showed that 64% of the variance was accounted for by the regression equation, but that 36% remained unaccounted for. The following factors were found to be significant predictors: importance of adhering to domestic chores ($t = -2.42, p = .02$), internalisation ($t = 2.05, p = .04$), divided self ($t = 8.43, p = .0005$), and care as self sacrifice ($t = 5.22, p = .0005$).

Multiple linear regression was conducted to determine how much variance of divided self (STSS) was accounted by BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), body consciousness (OBC), body dissatisfaction (BIQ), eating attitudes (EAT-26), care as self sacrifice (STSS), externalised self perception (STSS), and/or silencing the self (STSS). The regression equation was significant, $F(24,183) = 14.67, p = .0005$. The R-square adjusted value indicated that together 61% of the variance was accounted for, with 39% remaining unaccounted for. The following factors were found to be significant predictors: the importance of nice relationships ($t = -2.50, p = .01$), adhering to domestic chores ($t = 2.28, p = .03$), sense of belongingness ($t = -2.33, p = .02$), internalisation ($t = -2.50, p = .01$), EAT-26 oral control ($t = -2.27, p = .02$), externalised self perception ($t = 2.45, p = .02$) and silencing self ($t = 8.43, p = .0005$).

3.6.2. Silencing Behaviour and BMI Level. A MANOVA was conducted to ascertain whether BMI had an impact on silencing the self. The MANOVA showed no significant difference in BMI groups and silencing the self (*Wilks' Lambda* = .94, $F(12, 534) = .99, p = .45$, partial $\eta^2 = .02$).

Table 3.08 shows that obese BMI participants rated highest in care as self sacrifice ($M = 26.15, SD = 5.82$) and externalised self ($M = 18.78, SD = 4.74$), while normal BMI groups rated highest in silencing of the self ($M = 22.25, SD = 8.58$), and divided self ($M = 14.85, SD = 5.50$).

Table 3.08

Means and Standard Deviations and Univariate ANOVA Results for STSS for BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	p
	M	SD	M	SD	M	SD	M	SD		
Care As Self Sacrifice	24.68	6.16	24.85	7.00	23.81	6.35	26.15	5.82	.78	.51
Externalised Self	17.07	5.24	18.57	6.22	17.34	4.92	18.78	4.74	1.12	.34
Silencing the Self	20.66	7.25	22.25	8.58	20.51	6.76	21.52	6.85	.73	.54
Divided Self	14.85	5.50	17.31	6.94	16.06	6.25	15.19	6.40	1.70	.17

Model F (12, 534) = .99, p = .45

3.6.3. Silencing Behaviour and Age. A MANOVA was conducted to determine whether age had an impact on silencing the self. The MANOVA showed no significant difference in age groups and silencing the self (*Wilks' Lambda* = .94, $F(8, 406) = 1.48, p = .16, \text{partial } \eta^2 = .03$). The means and standard deviations between age groups and silencing behaviour are shown in Table 3.09.

Table 3.09

Means and Standard Deviations and Univariate ANOVA Results for Silencing the Self for Age Groups

	Young Adulthood		Middle Adulthood		Older Adulthood		F	p		
	18-35 years		36-55 years		55+ years					
	(n=161)	(n=38)	(n=10)							
	M	SD	M	SD	M	SD				
Care as Self	24.39	6.21	25.92	8.03	25.50	5.10	.92	.40		
Externalised Self Perception	17.94	5.67	18.03	5.45	18.60	4.33	.07	.94		
Silencing the Self	20.75	7.29	23.50	9.26	24.00	5.37	2.63	.08		
Divided Self	15.70	6.30	17.53	6.81	20.00	6.60	3.07	.05		

Model F (8, 406) = 1.48, p = .16

3.6.4. Silencing Behaviour and Eating Disorders. A MANOVA was conducted to determine whether those who reported previous treatment for an eating disorder were more likely to be silenced. The MANOVA showed a significant difference in silencing behaviour from those reporting previous treatment for disordered eating compared to those who reported no previous treatment (*Wilks' Lambda* = .90, $F(4,204) = 5.86, p = .0005, \text{partial } \eta^2 = .10$). Tests of between subjects

effects highlighted significant differences between each of the silencing subgroups and those reporting previous eating disorder treatment; care as self sacrifice, $F(1, 207) = 6.84, p = .01$, $\text{partial } \eta^2 = .03$; externalised self perception, $F(1, 207) = 19.12, p = .0005$, $\text{partial } \eta^2 = .09$; silencing the self, $F(1, 207) = 15.15, p = .0005$, $\text{partial } \eta^2 = .07$; and divided self $F(1, 207) = 18.14, p = .0005$, $\text{partial } \eta^2 = .08$.

Table 3.10

Means and Standard Deviations and Univariate ANOVA Results for Silencing for Groups Based on Report of Previous Treatment for an Eating Disorder

Factor	Previous treatment for ED (n=14)		No previous treatment for ED (n=195)		F	p
	M	SD	M	SD		
Care as self sacrifice	29.07	10.22	24.41	6.10	6.84	.01
Externalised self perception	24.00	5.45	17.56	5.32	19.12	.0005
Silencing the self	28.86	9.07	20.87	7.30	15.15	.0005
Divided self	23.07	6.47	15.74	6.20	18.14	.0005

Model F(4,204) = 5.86, p = .0005

Table 3.10 shows that those participants reporting previous eating disorder treatment engaged overall in more silencing behaviour than their counterparts. Specifically, participants identified as having been previously treated for disordered eating, engaged in more self sacrificing behaviour ($M = 29.07, SD = 10.22$), externalisation of self perception ($M = 24.00, SD = 5.45$), silencing ($M = 28.86, SD = 9.07$) and division of oneself ($M = 23.07, SD = 6.47$).

It should be noted that there was a significant difference in representation of participants across the two groups; 14 participants reported previous ED treatment, compared to 195 participants reporting no previous ED treatment. While only 14 participants reported having been previously treated for an eating disorder, 51 participants reported binge eating within the past 6 months; 49 reported using laxatives, diet pills or diuretics to control their weight or shape; and 29 reported vomiting as a means to control their weight or shape within the past 6 months.

A new category, “disturbed eating” was created in order to acknowledge participants who engage in binge eating, laxative/diuretic abuse, and vomiting behaviour, but who had no previous diagnosis and/or treatment for disordered eating.

Eighty-four participants who had engaged in at least one episode of (uncontrolled) binge eating, laxative/diuretic abuse, and/or vomiting as a means to control weight over the past 6 months, were identified as engaging in “disturbed eating”, while 125 participants did not meet these criteria.

3.6.5. Silencing Behaviour and Disturbed Eating. A MANOVA was conducted to ascertain whether participants with disturbed eating behaviours were more likely to feel silenced than those participants without disturbed eating behaviours. The MANOVA showed a significant difference in silencing behaviour in individuals identified as engaging in disturbed eating in contrast to those who had not engaged in disturbed eating (*Wilks' Lambda* = .85, $F(4, 204) = 9.33, p = .0005$, *partial η^2* = .16). Tests of between subjects effects further revealed that disturbed eating behaviours were prevalent among participants rating significant in care of self sacrifice, $F(1, 207) = 4.69, p = .03$, *partial η^2* = .02; externalised self, $F(1, 207) = 33.50, p = .0005$, *partial η^2* = .14; and silencing the self, $F(1, 207) = 9.87, p = .002$, *partial η^2* = .05.

Similarly to participants identified as having received previous treatment for disordered eating, participants identified with disturbed eating behaviour engaged more in overall silencing behaviour in contrast to their non-identified counterparts. Table 3.11 shows that those identified with disturbed eating behaviour engaged in more self sacrificing behaviour ($M = 25.90, SD = 7.37$), externalisation of self perception ($M = 20.51, SD = 5.82$), silencing ($M = 28.86, SD = 9.07$) and division of oneself ($M = 23.07, SD = 6.47$).

Table 3.11

Means, Standard Deviations and ANOVA Results for Silencing Behaviour Variables for Disturbed Eating and Non-Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Care as self sacrifice	25.90	7.37	23.93	5.79	4.69	.03
Externalised self perception	20.51	5.82	16.30	4.67	33.50	.0005
Silencing the self	23.39	8.19	20.07	7.02	9.87	.002
Divided self	18.64	7.27	14.62	5.31	21.38	.0005

Model $F(4, 204) = 9.33, p = .0005$

3.7. Eating Attitudes and Disturbed Eating

3.7.1. Predictors of Eating Attitudes. A correlational analysis (Table 3.12) was performed in order to assess the relationship between age, BMI level, conformity to feminine norms (CFNI), sense of belongingness (SOBI-P), socio-cultural attitude towards appearance (SATAQ), silencing the self (STSS), objectified body consciousness (OBC), and body dissatisfaction (BIQ), against eating attitudes (dieting, bulimia/food preoccupation, oral control). The correlations indicated suitability for exploratory regression analysis.

Table 3.12

Correlation Analysis for Eating Attitudes (EAT-26)

Factor	Dieting (n=209)		Food preoccupation (n=209)		Oral control (n=209)	
	r	p	r	p	r	p
Body Dissatisfaction	.51	.0005	.50	.0005	.25	.0005
Age	-.06	.40	.01	.93	-.12	.09
BMI	.06	.43	.01	.91	-.20	.004
Nice Relationships	.15	.03	.09	.18	.11	.10
Involvement with Children	-.01	.87	-.07	.29	.07	.35
Thinness	.71	.0005	.57	.0005	.31	.0005
Sexual Fidelity	.16	.03	.18	.01	.30	.0005
Modesty	.36	.0005	.34	.0005	.26	.0005
Involvement in Romantic Relationships	.13	.06	.18	.01	.01	.88
Domestic Duties	.29	.0005	.25	.0005	.17	.01
Investment in Appearance	.32	.0005	.29	.0005	.12	.10
Sense of Belongingness	-.53	.0005	-.60	.0005	.34	.0005
Internalisation	-.56	.0005	-.47	.0005	-.22	.001
Awareness	-.33	.0005	-.33	.0005	-.15	.03
Care as Self Sacrifice	.30	.0005	.25	.0005	.34	.0005
Externalised Self Perception	.56	.0005	.54	.0005	.31	.0005
Silencing the Self	.34	.0005	.37	.0005	.24	.001
Divided Self	.42	.0005	.45	.0005	.16	.03
Body Surveillance	-.33	.0005	-.26	.0005	-.11	.11
Body Shame	.59	.0005	.56	.0005	.23	.001
Body Control	.01	.91	.04	.58	.03	.67

Multiple linear regression was conducted to determine how much variance of dieting behaviour (eating attitude) was accounted for by the variables BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body consciousness (OBC), and/or body dissatisfaction (BIQ). The regression equation was significant, $F(22,185) = 17.12, p = .0005$. The R-square adjusted value showed that 63% of the variance was accounted for by the regression equation, but that 37% remained unaccounted for. The following factors were found to be significant predictors; importance of thinness ($t = 5.81, p = .0005$), involvement in romantic relationships ($t = -2.40, p = .02$), adherence to domestic chores ($t = 2.43, p = .02$), one's sense of belongingness ($t = -2.84, p = .01$), body surveillance ($t = -2.31, p = .02$), body shame ($t = 2.66, p = .01$), and body control ($t = 2.01, p = .05$).

Multiple linear regression was conducted to determine how much variance bulimic traits/food preoccupation (eating attitude) was accounted for by the variables BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body consciousness (OBC), and/or body dissatisfaction (BIQ). The regression equation was significant, $F(22,185) = 12.47, p = .0005$. The R-square adjusted value showed that 55% of the variance was accounted for by the regression equation (45% remained unaccounted for). The following factors were found to be significant predictors; BMI ($t = -2.04, p = .04$), importance of thinness ($t = 2.20, p = .03$), one's sense of belongingness ($t = -5.33, p = .0005$), care as self sacrifice ($t = -5.33, p = .03$), and body shame ($t = 3.11, p = .0005$).

Multiple linear regression was conducted to determine whether BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body consciousness (OBC), and/or body dissatisfaction (BIQ) predicted oral control (eating attitude). The results showed that the results were significant, $F(22,185) = 4.87, p = .0005$. The adjusted R-square value indicated that together 29% of the variance was accounted for by the regression equation, yet 71% remains unaccounted for. The following factors were found to be significant predictors: BMI ($t = -4.36, p = .0005$), importance of thinness ($t = 3.44, p = .0005$), sexual fidelity ($t = 2.18, p = .03$), importance of involvement in romantic relationships ($t = -2.89, p = .0005$), one's sense of belongingness ($t = -2.22, p = .03$), care as self sacrifice ($t = 2.07, p = .04$), and divided self ($t = -2.14, p = .03$).

3.7.2. Predictors of Disturbed Eating. A correlational analysis (Table 3.13) was performed in order to assess the relationships between age, BMI level, conformity to feminine norms (CFNI), sense of belongingness (SOBI-P), socio-cultural attitude towards appearance (SATAQ), silencing the self (STSS), objectified body consciousness (OBC), body dissatisfaction (BIQ), and eating attitudes (EAT-26), against disturbed eating. The correlations indicated that the data were suitable for regression analysis. Clinical cut-off scores on the EAT-26 were not specifically measured for each participant.

Table 3.13

Correlation Analysis for Disturbed Eating

Factor	Disturbed Eating (n=209)	
	r	p
Age	-.03	.65
BMI	.17	.02
Nice Relationships	-.01	.89
Involvement with Children	-.05	.45
Thinness	.43	.0005
Sexual Fidelity	-.06	.39
Modesty	.19	.01
Involvement in Romantic Relationships	.14	.05
Domestic Duties	.02	.78
Investment in Appearance	.08	.25
Sense of Belongingness	-.35	.0005
Internalisation	-.48	.0005
Awareness	-.23	.001
Care as Self Sacrifice	.15	.03
Externalised Self Perception	.37	.0005
Silencing the Self	.21	.002
Divided Self	.31	.0005
Body Surveillance	-.14	.05
Body Shame	.43	.0005
Body Control	.03	.67
Body Dissatisfaction	.38	.0005
Dieting Behaviour	.50	.0005
Bulimia/Food Preoccupation	.50	.0005
Oral Control	.12	.08

A multiple linear regression was conducted to determine whether BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body consciousness (OBC), body dissatisfaction (BIQ), and/or eating attitude (EAT-26) predicted disturbed eating. The results showed that the results were significant, $F(24,184) = 5.40, p = .0005$. The adjusted R-square value indicated that together 34% of the variance was accounted for by the regression equation, yet 66% remains unaccounted for. The following factors were found to be significant predictors: internalisation ($t = -3.17, p = .002$), dieting behaviour EAT-26 ($t = 2.05, p = .042$), and bulimia/food preoccupation EAT-26 ($t = 2.56, p = .011$).

3.7.3. Disturbed Eating and Objectified Body Consciousness. A MANOVA was conducted to determine whether participants who reported body consciousness and objectification were likely to engage in more disturbed eating patterns/behaviours than those identified as less body conscious. The MANOVA was used to substantiate and strengthen the results presented by the regression analysis. The MANOVA showed a significant difference in objectified body consciousness and disturbed eating behaviours (*Wilks' Lambda* = .82, $F(3, 205) = 15.50, p = .0005$, *partial η^2* = .19). Tests of between subjects effects highlighted significant differences specifically between body surveillance and disturbed eating, $F(1, 207) = 3.89, p = .05$, *partial η^2* = .02; and body shame and disturbed eating, $F(1, 207) = 45.76, p = .0005$, *partial η^2* = .18.

Table 3.14

Means and Standard Deviations and Univariate ANOVA Results for Objectified Body Consciousness for Groups Based on Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Body Surveillance	20.58	3.45	21.53	3.35	3.89	.05
Body Shame	25.31	4.97	20.82	4.52	45.76	.0005
Body Control	23.46	3.94	23.22	4.27	0.18	.67

Model $F(3, 205) = 15.945, p = .0005$

Table 3.14 shows that those identified with disturbed eating behaviour surveyed their body less ($M = 20.58$, $SD = 3.45$) than their non-identified counterparts ($M = 21.53$, $SD = 3.35$) yet disturbed-eating participants reported more body shame ($M = 25.31$, $SD = 4.97$: $M = 20.82$, $SD = 4.51$) and greater body control ($M = 23.46$, $SD = 3.94$: $M = 23.22$, $SD = 4.27$).

3.7.4. Disturbed Eating and Socio-cultural Attitude Towards Appearance. A MANOVA was conducted to determine whether participants who reported more awareness and internalisation of socio-cultural attitude towards appearance were more likely to engage in more disturbed eating patterns/behaviours than those identified as less aware and internalised. The MANOVA showed a significant difference in social awareness, internalisation and disturbed eating behaviours (*Wilks' Lambda* = .77, $F(1, 207) = 30.40$, $p = .0005$, *partial η²* = .23). Tests of between subjects effects highlighted significant differences specifically between awareness of social norms and disturbed eating, $F(1, 207) = 60.60$, $p = .0005$, *partial η²* = .23, and internalisation of social norms and disturbed eating $F(1, 207) = 11.87$, $p = .001$, *partial η²* = .05.

Table 3.15 showed that those identified with disturbed eating behaviour reported less awareness ($M = 13.73$, $SD = 3.73$) and less internalisation ($M = 18.54$, $SD = 5.45$) of social attitudes in contrast to their non-eating disturbed counterparts who reported greater social awareness ($M = 15.46$, $SD = 3.44$) and greater internalisation ($M = 25.14$, $SD = 6.37$) of social attitudes and norms.

Table 3.15

Means and Standard Deviations and Univariate ANOVA Results for Socio-cultural Attitude Towards Appearance and Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Internalisation	18.54	5.45	25.14	6.37	60.60	.0005
Awareness	13.73	3.73	15.46	3.44	11.87	.001

Model *F* (1, 207) = 30.40, $p = .0005$

3.7.5. Disturbed Eating and Sense of Belongingness. An ANOVA was conducted to ascertain whether participants who reported a sense of belongingness engaged in less disturbed eating patterns/behaviours. The ANOVA showed a

significant difference in sense of belongingness and disturbed eating behaviours $F(1, 207) = 29.54, p = .0005, \text{partial } \eta^2 = .13$.

Table 3.16 showed that those individuals identified as non-disturbed eating behaviour had a greater sense of belongingness ($M = 59.74, SD = 9.28$) in contrast to those identified as engaging in disturbed eating behaviour ($M = 51.83, SD = 11.69$).

Table 3.16

Means and Standard Deviations and Univariate ANOVA Results for Sense of Belongingness and Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
SOBI-P	51.83	11.69	59.74	9.28	29.54	.0005

Model F (1, 207) = 29.54, *p* = .0005

3.7.6. Disturbed Eating and Body Dissatisfaction. An ANOVA was conducted to determine whether participants who reported greater body dissatisfaction engaged in more disturbed eating patterns/behaviours than those identified as less body dissatisfied. The ANOVA showed a significant difference in body dissatisfaction and disturbed eating behaviours, $F(1, 207) = 35.59, p = .0005, \text{partial } \eta^2 = .15$). As indicated in Table 3.17, participants identified as engaging in disturbed-eating behaviour reported greater body dissatisfaction ($M = 2.57, SD = 1.40$) than their non-identified counterparts.

Table 3.17

Means and Standard Deviations and Univariate ANOVA Results for Body Dissatisfaction and Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
BIQ	2.57	1.40	1.49	1.19	35.59	.0005

Model F (1, 207) = 35.59, *p* = .0005

3.7.7. Disturbed Eating and Conformity to Feminine Norms. A MANOVA was conducted to ascertain whether participants who reported conformity to feminine norms engaged in more disturbed eating patterns/behaviours than those identified as less conforming to feminine norms). The MANOVA showed a significant difference in conformity to feminine norms and disturbed eating behaviours (*Wilks' Lambda* = .78, $F(8, 200) = 6.91$, $p = .0005$, *partial η²* = .22).

Tests of between subjects effects highlighted significant differences specifically between the importance of thinness and disturbed eating, $F(1, 207) = 46.50$, $p = .0005$, *partial η²* = .18; modesty and disturbed eating, $F(1, 207) = 7.47$, $p = .007$, *partial η²* = .04; and involvement in romantic relationships and disturbed eating, $F(1, 207) = 3.93$, $p = .05$, *partial η²* = .02.

Table 3.18 shows that participants identified as engaging in disturbed eating behaviour, valued thinness more than their non-identified counterparts ($M = 23.61$, $SD = 5.95$), were more involved in romantic relationships ($M = 14.54$, $SD = 4.12$), adhered greater to domestic duties ($M = 15.89$, $SD = 4.40$), and were more invested in appearance ($M = 12.98$, $SD = 4.19$) in contrast to their non-identified counterparts

Table 3.18

Means and Standard Deviations and Univariate ANOVA Results for Conformity to Feminine Norms and Disturbed Eating

Factor	Disturbed eating (n=84)		Non-disturbed eating (n=125)		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Nice Relationships	37.40	6.71	37.52	5.32	.02	.89
Involvement with Children	22.07	8.37	22.90	7.22	.59	.45
Importance of Thinness	23.61	5.95	17.79	6.11	46.50	.0005
Sexual Fidelity	17.33	5.98	18.10	6.57	.74	.39
Modesty	14.67	4.50	13.17	3.41	7.47	.007
Involvement in Romantic Relationships	14.54	4.12	13.50	3.37	3.93	.05
Domestic Duties	15.89	4.40	15.74	3.70	.08	.78
Investment in Appearance	12.98	4.19	12.31	4.01	1.33	.25

Model *F* (8, 200) = 6.91, *p* = .0005

3.7.8. Disturbed Eating, Eating Attitudes and BMI Level. A MANOVA was conducted to determine whether BMI had an impact on eating behaviour, namely eating attitudes (as measured by the EAT-26) and whether it subsequently influenced disturbed eating patterns. The MANOVA showed a significant difference in BMI groups and eating behaviours (*Wilks' Lambda* = .23, $F(12, 534) = 4.15, p = .0005$, *partial η^2* = .08). Tests of between subjects effects identified significant differences specifically between BMI and disturbed eating, $F(3, 205) = 3.92, p = .009$, *partial η^2* = .05; and BMI and oral control (EAT-26), $F(3, 205) = 4.36, p = .005$, *partial η^2* = .06.

Table 3.19

Means and Standard Deviations and Univariate ANOVA Results for Eating Behaviours and BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	<i>p</i>
	M	SD	M	SD	M	SD	M	SD		
Eating Disturbance	0.24	0.43	0.35	0.48	0.55	0.50	0.52	0.51	3.92	.009
Dieting (EAT-26)	6.02	9.20	9.01	10.27	6.40	7.23	10.78	9.81	2.28	.08
Bulimia & Food Preoccupation (EAT-26)	2.56	3.81	2.61	3.49	2.47	3.21	2.89	3.62	.09	.97
Oral Control (EAT-26)	2.54	3.03	1.98	3.01	0.74	1.18	1.45	2.24	4.36	.005

Model F (12, 534) = 4.15, *p* = .0005

A *post hoc* multiple comparisons test with regard to BMI and eating disturbances revealed significant differences between underweight and overweight groups (*p* = .003), underweight and obese BMI groups (*p* = .02), and normal and overweight groups (*p* = .021). With regard to BMI and oral control (EAT-26), the *post hoc* multiple comparisons test revealed significant differences between underweight and overweight groups (*p* = .001), and normal and overweight BMI (*p* = .006).

As indicated in Table 3.19, overweight participants engaged in more disturbed eating behaviour ($M = 0.55, SD = 0.50$) followed by obese ($M = 0.52, SD = 0.51$), normal ($M = 0.35, SD = 0.48$) and underweight ($M = 0.24, SD = 0.43$) groups. Obese participants reported greater dieting practices ($M = 10.78, SD = 9.81$), in contrast to

normal ($M = 9.01$, $SD = 10.27$), overweight ($M = 6.40$, $SD = 7.23$) and underweight ($M = 6.02$, $SD = 9.20$) groups.

Obese participants were also identified as engaging most in bulimia and food preoccupation ($M = 2.89$, $SD = 3.62$), followed by normal ($M = 2.61$, $SD = 3.49$), underweight ($M = 2.56$, $SD = 3.81$), and overweight ($M = 2.47$, $SD = 3.21$) groups. Underweight participants were identified as engaging highest in oral control and restrictive eating ($M = 2.54$, $SD = 3.03$), followed by normal ($M = 1.98$, $SD = 3.01$), obese ($M = 1.45$, $SD = 2.24$), and overweight ($M = 0.74$, $SD = 1.18$) groups.

3.7.9. Disturbed Eating, Eating Attitudes and Age. A MANOVA was conducted to ascertain whether age had an impact on eating behaviour, namely eating attitudes (as measured by the EAT-26) and whether it subsequently influenced disturbed eating patterns. The MANOVA showed no significant difference in age groups and eating behaviours (*Wilks' Lambda* = .97, $F(8, 406) = .89$, $p = .53$, *partial η^2* = .02). The means and standard deviations between age groups and eating behaviour are shown in Table 3.20.

Table 3.20

Means and Standard Deviations and Univariate ANOVA Results for Eating Behaviours and Age Groups

	Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Diet (EAT-26)	8.14	9.39	7.76	10.08	6.40	7.38	.17	.84
Bulimia/Food Preoccupation (EAT-26)	2.57	3.44	2.61	3.67	3.20	3.71	.16	.86
Oral Control (EAT-26)	1.81	2.76	1.50	2.29	.70	1.16	.98	.38
Eating Disturbance	.42	.50	.32	.47	.50	.53	.85	.43

Model *F* (8, 406) = .89, *p* = .53

3.8. Objectified Body Consciousness

3.8.1. Predictors of Objectified Body Consciousness. A correlational analysis (see Table 3.21) was performed in order to assess the relationships between age, BMI level, conformity to feminine norms (CFNI), sense of belongingness (SOBI-P), socio-cultural attitude towards appearance (SATAQ), silencing the self (STSS),

body surveillance (OBC), body shame (OBC), body control (OBC), and body dissatisfaction (BIQ), against objectified body consciousness (body surveillance, body shame, body control). The correlations indicated that the data were suitable for regression analysis.

Table 3.21

Correlation Analysis for Objectified Body Consciousness

Factor	Body Surveillance (n=209)		Body Shame (n=209)		Body Control (n=209)	
	r	p	r	p	r	p
Body Dissatisfaction	-.22	.001	.52	.0005	-.06	.37
Age	.02	.75	.02	.78	.15	.03
BMI	-.03	.65	.33	.0005	.03	.67
Nice Relationships	-.07	.33	.07	.34	-.16	.02
Involvement with Children	.07	.30	-.09	.20	-.08	.24
Thinness	-.39	.0005	.58	.0005	-.15	.03
Sexual Fidelity	.11	.11	.09	.20	.10	.16
Modesty	-.12	.08	.32	.0005	.07	.33
Involvement in Romantic Relationships	-.13	.07	.19	.005	.19	.01
Domestic Duties	-.10	.15	.14	.04	-.04	.58
Investment in Appearance	-.28	.0005	.21	.003	-.10	.15
Sense of Belongingness	.05	.51	-.47	.0005	-.09	.21
Internalisation	.27	.0005	-.52	.0005	.02	.83
Awareness	.19	.005	-.31	.0005	-.05	.46
Care as Self Sacrifice	-.04	.53	.32	.0005	.18	.01
Externalised Self Perception	-.07	.30	.52	.0005	.04	.53
Silencing the Self	-.04	.61	.36	.005	.12	.08
Divided Self	-.09	.20	.39	.0005	.12	.09
Body Surveillance	1.00	-	-.19	.01	.10	.14
Body Shame	-.19	.01	1.00	-	.14	.05
Body Control	.10	.14	.14	.05	1.00	-

A multiple linear regression was conducted to determine whether BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body shame (OBC), body control (OBC), and/or body dissatisfaction (BIQ) predicted body surveillance (objectified body consciousness). The results showed that the results were significant, $F(21,186) = 3.05, p = .0005$. The R-square adjusted value indicated that together 17% of the

variance was accounted for by the regression equation, with 83% not accounted for. The following factors were found to be significant predictors: the importance of thinness ($t = -3.88, p = .0005$), and involvement in romantic relationships ($t = -2.11, p = .04$).

A multiple linear regression was conducted to determine whether BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body shame (OBC), body surveillance (OBC), and/or body dissatisfaction (BIQ) predicted body control (objectified body consciousness). The results showed that the results were significant, $F(21,186) = 2.76, p = .0005$. The R-square adjusted value indicated that together 15% of the variance was accounted for by the regression equation, with 85% not accounted for. The following factors were found to be significant predictors: the importance of thinness ($t = -3.09, p = .0005$), involvement in romantic relationships ($t = 3.07, p = .0005$), body shame ($t = 2.43, p = .02$), and body dissatisfaction ($t = -2.18, p = .03$).

A multiple linear regression was conducted to determine whether BMI, age, conformity to feminine norms (CFNI), one's sense of belonging (SOBI-P), social attitudes (SATAQ), silencing of oneself (STSS), body control (OBC), body surveillance (OBC), and/or body dissatisfaction (BIQ) predicted body shame (objectified body consciousness). The results showed that the results were significant, $F(21,186) = 11.82, p = .0005$. The R-square adjusted value indicated that together 52% of the variance was accounted for by the regression equation, with 48% not accounted for. The following factors were found to be significant predictors: BMI ($t = 5.53, p = .0005$), the importance of thinness ($t = 2.00, p = .05$), investment in appearance ($t = 2.00, p = .05$), one's sense of belongingness ($t = -1.96, p = .05$), internalisation ($t = -2.84, p = .0005$), and body control ($t = 2.43, p = .03$).

3.8.2. Objectified Body Consciousness and BMI Level. A MANOVA was conducted to determine whether BMI had an impact on body consciousness and objectification. The MANOVA showed a significant difference in BMI groups and objectified body consciousness (*Wilks' Lambda* = .86, $F(9, 494) = 3.53, p = .0005$, *partial η²* = .05).

Tests of between subjects effects identified significant differences specifically between BMI and body shame, $F(3, 205) = 8.73, p = .0005$, *partial η²* = .11. A *post hoc* multiple comparisons test with regard to BMI and body shame revealed significant differences specifically between underweight and normal groups ($p = .02$),

underweight and overweight groups ($p = .003$), underweight and obese groups ($p = .0005$), normal and obese groups ($p = .0005$), and overweight and obese groups ($p = .01$).

As indicated in Table 3.22, underweight participants surveyed their body greatest ($M = 21.88$, $SD = 3.70$) in contrast to their counterparts, yet obese participants engaged in the highest level of body shame ($M = 26.63$, $SD = 5.18$) and attempts of body control ($M = 24.37$, $SD = 3.82$).

Table 3.22

Means and Standard Deviations and Univariate ANOVA Results for Objectified Body Consciousness and BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Body Surveillance	21.88	3.70	20.76	3.27	21.28	3.53	21.04	3.20	1.04	.38
Body Shame	20.15	4.34	22.30	4.90	23.26	5.57	26.63	5.18	8.73	.0005
Body Control	24.00	3.61	22.93	4.58	22.89	3.82	24.37	3.82	1.41	.24

Model F (9,494) = 3.53, $p = .0005$

3.8.3. Objectified Body Consciousness and Age. A MANOVA was conducted to determine whether age had an impact on body consciousness and objectification. The MANOVA showed no significant difference in age groups and objectified body consciousness (*Wilks' Lambda* = .96, $F(6, 408) = 1.30$, $p = .23$, *partial η^2* = .02. Table 3.23 shows the means and standard deviations between objectified body consciousness and age groups. While the table has indicated that body surveillance was highest in middle adulthood ($M = 21.42$, $SD = 3.76$), and body shame ($M = 24.10$, $SD = 7.14$) and body control ($M = 26.00$, $SD = 3.71$) both highest in older adult participants, the descriptive results must be treated with caution due to poor validity as a result of a discrepancy in sample size across age groups.

Table 3.23

Means and Standard Deviations and Univariate ANOVA Results for Objectified Body Consciousness and Age Groups

	Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		F	p
	M	SD	M	SD	M	SD		
Body Surveillance	21.09	3.38	21.42	3.76	21.10	2.81	.15	.86
Body Shame	22.52	5.24	22.68	4.39	24.10	7.14	.44	.65
Body Control	22.94	4.20	24.18	3.62	26.00	3.71	3.69	.03

Model F (6, 408) = 1.30, p = .23

3.9. Socio-cultural Attitude Towards Appearance

3.9.1. *Socio-cultural Attitude Towards Appearance and BMI Level.* A MANOVA was conducted to ascertain whether BMI had an impact on one's awareness and internalisation of socio-cultural attitude towards appearance. The MANOVA showed no significant difference in BMI groups and SATAQ (*Wilks' Lambda* = .97, $F(6, 408) = 1.08$, $p = .37$, *partial η^2* = .02).

Table 3.24

Means and Standard Deviations and Univariate ANOVA Results for SATAQ and BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	p
	M	SD	M	SD	M	SD	M	SD		
Internalisation	22.73	7.76	21.70	6.05	23.74	7.23	22.22	6.91	1.01	.39
Awareness	15.41	3.73	14.64	3.56	14.96	3.81	13.78	3.46	1.18	.32

Model F (6,969) = 1.08, p = .37

As shown in Table 3.24, overweight BMI participants engaged highest in internalisation of socio-cultural attitude towards appearance in contrast to underweight ($M = 22.73$, $SD = 7.76$), obese ($M = 22.22$, $SD = 6.91$) and normal ($M = 21.70$, $SD = 6.05$) groups. Further, underweight participants were identified as being most aware of the socio-cultural attitude towards appearance ($M = 15.41$, $SD = 3.73$) followed by overweight ($M = 14.96$, $SD = 3.81$), normal ($M = 14.64$, $SD = 3.56$), and obese ($M = 13.78$, $SD = 3.46$) groups.

3.9.2. Socio-cultural Attitude Towards Appearance and Age. A MANOVA was conducted to determine whether age had an impact on awareness and internalisation of socio-cultural attitudes toward appearance. The MANOVA showed no significant difference in age groups and SATAQ (*Wilks' Lambda* = .96, $F(4, 410) = 2.04, p = .09, \text{partial } \eta^2 = .02$). The means and standard deviations between age groups and socio-cultural attitude towards appearance are shown in Table 3.25.

Table 3.25

Means and Standard Deviations and Univariate ANOVA Results for SATAQ and Age Groups

	Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Internalisation	21.77	6.82	24.76	6.42	25.40	6.28	4.03	.02
Awareness	14.66	3.55	15.08	4.07	15.20	3.82	.28	.76

Model *F* (4, 410) = 2.04, *p* = .09

3.10. Sense of Belongingness

3.10.1. Sense of Belongingness and BMI Level. An ANOVA was conducted to determine whether BMI had an impact on one's sense of belongingness. The ANOVA showed no significant difference in BMI groups and sense of belongingness, $F(3, 205) = .85, p = .47$. Table 3.26 showed that underweight BMI participants rated highest in their sense of belongingness ($M = 57.37, SD = 11.89$) followed by overweight ($M = 57.36, SD = 9.56$), normal ($M = 56.65, SD = 11.17$), and obese ($M = 53.52, SD = 11.76$) groups.

Table 3.26

Means and Standard Deviations and Univariate ANOVA Results for Sense of Belongingness and BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
SOBI-P	57.37	11.89	56.65	11.17	57.36	9.56	53.52	11.76	.85	.47

Model *F* (3,205) = .85, *p* = .47

3.10.2. Sense of Belongingness and Age. An ANOVA was conducted to ascertain whether age had an impact on one's sense of belongingness. The ANOVA showed no significant difference in age groups and sense of belongingness, $F(2, 206) = .29, p = .75$. Table 3.27 lists the means and standard deviations between age groups and sense of belongingness.

Table 3.27

Means and Standard Deviations and Univariate ANOVA Results for Sense of Belongingness and Age Groups

	Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
SOBI-P	56.72	10.92	56.58	11.70	54.00	10.33	.29	.75

Model F (2, 206) = .29, *p* = .75

3.11. Conformity to Feminine Norms

3.11.1. Conformity to Feminine Norms and BMI Level. A MANOVA was conducted to determine whether BMI had an impact on conformity to feminine norms. The MANOVA showed a significant difference in BMI groups and femininity (*Wilks' Lambda* = .69, $F(24, 574) = 3.33, p = .0005$, *partial η^2* = .12).

Tests of between subjects effects identified significant differences specifically between BMI groups and the importance of nice relationships, $F(3, 205) = 4.23, p = .007$, *partial η^2* = .06, BMI groups and the importance of thinness, $F(3, 205) = 5.64, p = .001$, *partial η^2* = .08, and BMI groups and investment in appearance, $F(3, 205) = 4.02, p = .008$, *partial η^2* = .06.

A *post hoc* multiple comparisons test with regard to BMI and nice relationships revealed significant differences between underweight and overweight groups (*p* = .002), normal and overweight groups (*p* = .008), and obese and overweight groups (*p* = .01). With regard to BMI and thinness, significant differences were found between underweight and normal groups (*p* = .001), underweight and overweight groups (*p* = .006), and underweight and obese groups (*p* = .0005). With regard to BMI and investment in appearance, the *post hoc* multiple comparisons test revealed significant differences between underweight and obese groups (*p* = .002), and normal and obese groups (*p* = .003).

Table 3.28 shows that underweight participants viewed the importance of having nice relationships ($M = 38.90$, $SD = 5.75$) higher than their heavier BMI counterparts. Obese participants rated the importance of being involved with children ($M = 23.15$, $SD = 7.25$), and the importance of thinness ($M = 22.70$, $SD = 5.39$), higher than other BMI groups.

Table 3.28

Means and Standard Deviations and Univariate ANOVA Results for Conformity to Feminine Norms and BMI Groups

Factor	Underweight (n=41)		Normal (n=88)		Overweight (n=53)		Obese (n=27)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Nice Relationships	38.90	5.75	37.85	5.88	35.17	5.42	38.59	6.11	4.12	.007
Involvement with Children	21.52	7.73	22.57	8.02	23.08	7.48	23.15	7.25	.37	.78
Thinness	16.68	8.68	20.76	6.01	20.43	5.63	22.70	5.39	5.64	.001
Sexual Fidelity	19.54	8.19	17.74	5.58	16.58	6.29	17.70	5.22	1.70	.17
Modesty	12.76	4.28	14.01	3.56	14.02	4.25	14.04	3.99	1.13	.34
Involvement in Romantic Relationships	14.24	2.89	14.10	3.24	13.38	4.45	13.89	4.68	.55	.65
Domestic Duties	15.46	3.85	16.57	3.97	15.04	3.52	15.30	4.80	2.01	.11
Investment in Appearance	13.59	4.17	13.01	3.83	12.19	4.23	10.41	3.83	4.02	.008

Model F (24, 574) = 3.33, *p* = .0005

The importance of sexual fidelity was rated highest by underweight groups ($M = 19.54$, $SD = 8.19$), and modesty rated highest by obese participants ($M = 14.04$, $SD = 3.99$). Underweight participants rated the involvement in romantic relationships ($M = 14.24$, $SD = 2.89$) as being most important in contrast to their counterparts; similarly, underweight participants also rated highest in the importance of investment in appearance ($M = 13.59$, $SD = 4.17$). Normal participants viewed the importance of adhering to domestic duties higher than their other BMI counterparts.

3.11.2. Conformity to Feminine Norms and Age. A MANOVA was conducted to determine whether age had an impact on conformity to feminine norms.

The MANOVA showed a significant difference in age groups and conformity to feminine norms (*Wilks' Lambda* = .85, $F(16, 398) = 2.09, p = .008$, *partial η^2* = .08).

Tests of between subjects effects identified significant differences specifically between age groups and adhering to domestic duties, $F(2, 206) = 3.97, p = .02$, *partial η^2* = .04, and age groups and modesty, $F(2, 206) = 4.54, p = .01$, *partial η^2* = .04.

Table 3.29

Means and Standard Deviations and Univariate ANOVA Results for Conformity to Feminine Norms and Age Groups

Factor	Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		F	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Nice Relationships	37.98	6.12	35.95	5.16	35.20	3.05	2.64	.07
Involvement with Children	22.36	7.91	23.76	6.69	21.40	8.11	.63	.53
Thinness	20.00	7.03	20.68	5.26	20.10	6.01	.16	.85
Sexual Fidelity	17.31	6.31	19.84	6.66	17.80	4.02	2.49	.09
Modesty	13.34	3.96	15.00	3.86	16.00	2.31	4.54	.01
Involvement in Romantic Relationships	14.09	3.80	13.47	3.48	12.80	3.16	.90	.41
Domestic Duties	15.48	3.97	17.39	3.94	14.80	3.08	3.97	.02
Investment in Appearance	12.89	4.31	11.39	3.05	12.10	3.25	2.15	.12

Model $F(16, 398) = 2.09, p = .008$

A *post hoc* multiple comparisons test with regard to age and adhering to domestic duties revealed significant differences between young adult and middle adult age groups ($p = .008$). With regard to age and modesty, significant differences were found between young adult and middle adult age groups ($p = .02$), and young adult and older adult age groups ($p = .04$).

Table 3.29 showed that younger aged adults viewed the importance of having nice relationships ($M = 37.98, SD = 6.12$), being involved in romantic relationships ($M = 14.09, SD = 3.80$), and investment in appearance ($M = 12.89, SD = 4.31$) higher than their aged counterparts. Middle aged adults rated highest in the importance of being involved with children ($M = 23.76, SD = 6.69$), the importance of thinness ($M = 20.68, SD = 5.26$), sexual fidelity ($M = 19.84, SD = 6.66$), and adhering to domestic duties ($M = 17.39, SD = 3.94$). Older adults viewed modesty of importance ($M = 16.00, SD = 2.31$) in contrast to younger and middle-aged counterparts.

3.12. BMI and Age Groups

An ANOVA was conducted to ascertain whether age had an impact on BMI levels. The ANOVA showed a significant difference in age groups and BMI levels, $F(2, 206) = 11.01, p = .0005$, partial $\eta^2 = .10$. A *post hoc* multiple comparisons test with regard to age and BMI levels revealed significant differences specifically between younger adult and older adult age groups ($p = .0005$), and middle adult and older adult age groups ($p = .001$).

The descriptive results should be treated with caution due to poor validity as a result of a discrepancy in sample size across age groups. Table 3.30 shows that older aged adults rated highest in BMI levels ($M = 30.73, SD = 6.43$) followed by middle-aged adults ($M = 25.16, SD = 4.62$), and younger adults ($M = 23.80, SD = 4.57$).

Table 3.30

Means and Standard Deviations and Univariate ANOVA Results for BMI Levels and Age Groups

Young Adulthood 18-35 years (n=161)		Middle Adulthood 36-55 years (n=38)		Older Adulthood 55+ years (n=10)		F	p		
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
BMI	23.80	4.57		25.16	4.62	30.73	6.43	11.01	.0005

Model F (2, 206) = 11.01, $p = .0005$

3.13. Current Weight V's Ideal Weight

A paired samples t-test was conducted to determine whether there was a significant difference between individual current weights in contrast to their ideal weight. Results indicated significant differences between current weight and ideal weight, based according to age groups and BMI groups.

As a group, young adults, aged 18-35 years ($n = 161$) weighed 65.11 kg on average ($SD = 13.14$), idealizing a weight loss average of 7.24 kg ($SD = 7.22, t = 12.73, p = .0005$). Middle-aged participants, aged 36-55 years ($n = 38$) weighed a group average of 66.91 kg ($SD = 13.17$), and idealized a weight loss average of 8.25 kg ($SD = 7.63, t = 6.67, p = .0005$), and older-aged adults, aged 55 years and above ($n = 10$) weighed a group average of 82.90 kg ($SD = 14.72$), yet had idealized the greatest weight loss average of 19.60 kg ($SD = 9.94, t = 6.24, p = .0005$).

Underweight BMI groups ($n = 41$) weighed a group average of 52.68 kg ($SD = 5.26$) and idealized a further group weight loss average of 1.41 kg each ($SD = 3.34$, $t = 6.67$, $p = .0005$). Normal-weighted groups ($n = 88$) weighed a group average of 61.27 kg ($SD = 6.63$) idealizing further weight loss of 5.06 kg each ($SD = 2.85$, $t = 16.68$, $p = .0005$).

Overweight groups ($n = 53$) weighed a group average of 72.66 kg ($SD = 7.18$), idealizing an average weight loss of 10.46 kg each ($SD = 5.15$, $t = 14.79$, $p = .0005$). In contrast, obese groups ($n = 27$) weighed a group average of 90.78 kg ($SD = 11.13$), idealizing the greatest weight loss average of 15.90 kg each ($SD = 7.48$, $t = 15.90$, $p = .0005$).

3.14. Qualitative Data

The current study was designed to employ mainly quantitative data analysis, but participants also contributed qualitative comments. Given that these data may be useful in providing further insight and understanding into the behaviour and attitudes relating to the research question they were analysed. Qualitative data were analysed by using thematic analysis, which adopted approaches from Interpretative Phenomenological Analysis (IPA) (Willig, 2001) and Miles and Huberman's data analysis model (1994). IPA principles enabled the transcribed data to be integrated and grouped according to relative content (Willig, 2001). In addition, data reduction, interpretation, and verification methods were also used in accordance with Miles and Huberman's data analysis model (1994).

3.14.1. Perception of One's Failure to Measure Up to Standards. With regard to the Silencing of The Self Scale (STSS), 87 participants reported that they "strongly agreed" or "somewhat agreed" that they had never seemed to measure up to the standards set for themselves. Participants who responded with "strongly agreed" or "somewhat agreed" for this particular question were provided with writing space on the questionnaire and asked to list up to three of the standards they felt they had failed to measure up to. One hundred and eighty-nine responses were obtained, and each was listed in a table with responses coded according to emerging themes and subject matter. Coding was denoted by the use of various colours; each theme was designated a particular colour to enable identification of emerging themes within the data sample.

Themes were repeatedly collated and contrasted against each other in order to achieve data reduction and delineate major emergent themes. Typically, the language

generated from the responses consisted of a negative, self-defeating, and derogative discourse; highlighting themes of passivity, helplessness, dependence on others, and failure. The words “should”, “could”, “need to”, and “not enough” were continually repeated throughout the data, with a strong narrative theme of “not thin enough, pretty enough, rich enough, and good enough”.

Thirty-six themes were initially generated from the data. These were further reduced to 13 existing themes. Fifty-three participants reported failing to measure up to physical attractiveness, sexual desirability and thinness: for example, “I’m not beautiful or pretty enough”; “I’m ugly”; “I’m not slim enough and have no sex appeal”. One participant further commented, “I’m not actually real. I try to look like a trophy when I’m out socially”. Twenty-eight participants reported failure to live up to self, achievement, and academic expectations; for instance, “I’m not good at anything”; “I have no solid future”; “I don’t achieve high enough”; “don’t work hard enough”; “need to achieve much more than what I do”. Two of the 28 participants specifically reported failure to meet “perfection”.

Twenty-two participants responded that they failed to make a good enough wife, mother, and daughter, thus failing to meet their expectations of what is required from a wife, mother and/or daughter. For example, “I should be a better housewife”; “my husband could do better. I need to make him happier”; “I fail to parent my children properly”. Eighteen respondents reported poor self discipline in adhering to their expectations in sport, exercise, and dietary habits, “I eat the wrong foods”; “I’m physically unfit and have no motivation. I should be able to lose more weight”.

Sixteen participants reported poor self-worth, confidence, assertion, and sense of self, for instance, “I’m not a morally good person”; “I can’t accept myself. I should be more outgoing”; “I feel weak. I am nothing”. Thirteen participants reported ‘need to please’ personality traits and felt they failed to make others happy, and for others to like them, for example, “I’m not popular enough”; “I struggle to make friends no matter how hard I try”; “I try to please everyone”. Eleven participants reported failure to meet career goals, while 6 participants felt they were too lazy and self-centered, for example, “I don’t care enough for others”; “I wish I wasn’t so self-centered”.

Five participants reported failure to meet time management and organizational skills; five participants felt they lacked independence and freedom; and another 5 participants reported an inability to have close and/or sexual relationships, “I can’t allow myself to get close to someone”; “I’ve been with my partner for 21 years. I’m

not good enough to marry". Four participants felt they failed to measure up to overall happiness, "life is a struggle"; "I can't feel good about myself"; "I'm not content with my life"; and three participants felt they should be more financially secure at this point in their lives.

3.14.2. Additional Commentary: Disordered Eating, Body Dissatisfaction, and General Survey Comments. Participants had the opportunity to make comments following questioning of the Eating Attitudes Test (EAT-26). While the comments section was listed under the questions enquiring about previous treatment for an eating disorder, comments were not limited to disordered eating commentary, and participants were encouraged to list feedback and/or implications of the survey. Forty-one participants (19.60% of the sample) had made comment to this section, nine of which were comments, reflections, and feedback from the survey. The remaining 32 participants (15.31% of the sample) had commented directly in relation to disordered eating and/or body dissatisfaction.

Seemingly, this section enabled women to have a voice in choosing to speak about persecutory thoughts, shameful behaviour, and disturbed eating. Four of the 32 women reported their continual struggle with disordered eating; others admitted to engaging in binge-eating behaviour at times of stress and as a means of "punishment" and threats to "self-sabotage". Seven women, who reported nil disordered eating, commented on engaging in restrictive eating patterns, dieting behaviour, and excessive exercise as a means to control their weight.

Eight women used this section to comment on their body dissatisfaction, "I feel dissatisfied with my post-baby body, it's difficult to compete physically with other females my age"; "I feel angry, sad and weak with myself when I overeat, I just wish I had a different body"; "I feel worse and lazy around thin people. I can't even make eye contact without having any makeup on"; "I'm more concerned with my shape than my weight. I wish I had thinner hips and thighs". Furthermore, two participants reported concern about socio-cultural attitudes within the workforce, "women's weight is important in the workforce. Fat women just aren't respected"; "I work as a swim teacher and am very self-conscious in bathers, I should look better for business".

Two of the 32 women reported losing a sense of "weight control" following menopause, both resorting to lapband surgery, and consequently feeling "happier". Another woman reported using lapband surgery as a means to contain her binging

behaviour, and others reported a desire to have lapband surgery as a means of weight loss, “I’m overweight and have struggled and been obsessed with weight my entire life. I have tried every diet yet continue to fail. My only hope is lapband surgery”.

While the majority of the comments themed weight loss due to body dissatisfaction and socio-cultural attitudes, three participants reported weight loss due to health and medical reasoning, for example, Celiac’s disease and cholesterol issues. In contrast, three participants identified as overweight and obese, reported less concern for their weight and felt esteemed and valued by other means, “while I am obese, I’ve begun to make life changes. I no longer deprive myself of sweets that I enjoy and deserve”; “I know my body isn’t perfect, but it suits me. I get compliments for ‘who I am’ which boosts my confidence. I’m happy in my skin”; “It’s important for girls to have a sense of being, identity and style. I focus less on my weight and take more pride in my style”.

Chapter 4: Discussion

Attractiveness, and associated thinness, continues to be a major determinant of social acceptance and desirability for most women in Western societies, with many women internalising the perceived cultural standard of beauty through social attitudes and gender ideals. Given that “fat” is associated with negativity and social discrimination, many women strive to attain the thin-ideal in order to achieve social acceptance through social expectations of femininity and attractiveness. While patriarchy has previously been held responsible for the objectification of women through male gaze, women have increasingly internalised and normalized this process, engaging in greater levels of self-objectification and body monitoring. Women’s body shape and weight largely determine her self-worth and sense of belongingness, while increased levels of body objectification serve to moderate body dissatisfaction, attempts of body control, and disordered eating behaviour (Fredrickson & Roberts, 1997; Lee, 1998; Motz, 2001; Sabik & Tylka, 2006; Thompson et al., 1999; Tiggemann & Slater, 2004).

As evidenced through the impact of menstruation, the growth of breasts, pregnancy, childbirth, and menopause, women hold a unique connection between their body, identity, and sense of self (Macdonald, 1995). This is further illustrated in the instance of a hysterectomy or mastectomy, where women often report a sense of loss of femininity and identity. Since the body is viewed as integral in the formation

of a woman's identity and self-concept, body dissatisfaction is viewed as particularly destructive to a woman's self-esteem and well-being (Fernandes et al., 2006; Macdonald, 1995; Ricciardelli & McCabe, 2001).

Body hatred is often internalised into self-hatred, and manifested as body dissatisfaction. The body typically becomes "unembodied" whereby it is merely an object, vacant of feelings and identity. Feminist theory (Fernandes et al., 2006; Shilling, 1994; Yoder, 1999) argues that women are over-burdened by this "body" which is exploited by sexuality challenges, male violence, pornography, prostitution, pregnancy, childbirth, domination, subordination, inequality and oppression. Eating disorder literature investigating the relationship between women's identity and their bodies maintains that the body merely becomes a vehicle whereby the individual can inflict punishment through starvation, purgatory means, and/or binge-eating behaviour, where one is able to unleash feelings of hatred and rage; feelings which were previously silenced as they were deemed unfeminine and unacceptable otherwise (Bruch, 1974; Gilligan, 1991; Gordon, 2000; Hoskins, 2002; Saunders & Kashubeck-West, 2006; Stern, 1991; Tolman, 1991).

While it has been proposed that the development and maintenance of disordered eating is attributed to the complex interplay of biological, socio-cultural, and individual psychological factors, significant gaps and limitations exist within the literature, offering little insight into how clinical and non-clinical samples differ. Despite studies (McCabe & Griffiths, 2000; Prichard & Tiggemann, 2005; Stice, 2002; Thompson et al., 1999; Webster & Tiggemann, 2003) suggesting that the majority of women engage in body dissatisfaction and negative self-talk, few women actually engage in disordered eating practices. Furthermore, research studies (Posavac et al., 2001; Schooler et al., 2004; Schur et al., 2000; Snyder & Hasbrouck, 1996) have typically investigated the relationship between body image and disordered eating in younger women and adolescents. Since attractiveness, femininity and self-objectification are deemed pertinent to a woman's identity, it is believed that body dissatisfaction and disordered eating would not be limited to younger women, but prevalent within women of all age groups.

The current study attempted to explore women's views towards their bodies, identifying predictors of body objectification, body dissatisfaction, and disordered eating behaviour within a non-clinical population aged 18-65 years. It was hypothesised that women who have strongly based their identity according to societal

values and expectations, and adopted a role of passivity and silence with regard to their perception of femininity and gender role ideals, would be more likely to experience high levels of body dissatisfaction and be at greater risk of manifesting disordered eating behaviour(s). The primary hypothesis was supported and the following discussion addresses the results of the current study with specific reference to previous research and the subsidiary hypotheses investigated. Qualitative data, obtained at two intervals within the questionnaire, were discussed and integrated in accordance with the findings from the quantitative data analyses.

4.1. *Body Dissatisfaction*

4.1.1. *Predictors of Body Dissatisfaction.* Body dissatisfaction appears to be the most likely factor in the development of disordered eating. A number of concurrent and longitudinal studies (Attie & Brooks-Gunn, 1989; Byely et al., 2000; Joiner & Kashubeck, 1996; Kelly et al., 1997; Lawrence & Thelen, 1995; McVey et al., 2002; Keel et al., 1997; Killen et al., 1996) support the idea that dieting and other means of weight regulation behaviours in response to negative body esteem and body dissatisfaction, could initiate disturbed eating behaviours increasing the progression of disordered eating. While disordered eating has typically existed within adolescents and young adults, body dissatisfaction appears to remain stable across the life span (Thompson et al., 1995; Stice et al., 1998; Webster & Tiggemann, 2003).

In the current study, it was hypothesised that body dissatisfaction would be determined by one's BMI level, their desire to adhere and conform to feminine norms, sense of belongingness, and passivity, in terms of silencing behaviour. It was also believed that one's socio-cultural attitude toward attractiveness, and body consciousness, would also be contributory factors to body dissatisfaction. Overall, results indicated that all the above variables were significant predictors of body dissatisfaction; in particular, one's BMI level, the importance of modesty through feminine norms, internalisation of socio-cultural attitudes, externalised self-perception through silencing behaviour, and body control as a result of body consciousness.

While BMI level was found to be a significant predictor of body dissatisfaction, results of the current study indicated that underweight, normal, overweight, and obese BMI groups all reported some form of body dissatisfaction, with each of the women having reported a desire to weigh less than their current weight. These findings concurred with previous research findings (Kostanski et al.,

2004; Stevens & Tiggemann, 1998) where it was found that women of all ages seem to hold a sense of normative discontent toward their bodies.

Research measuring body image dissatisfaction across the lifespan illustrates that the discrepancy between actual and ideal ratings remain relatively stable throughout the course of adulthood (Grogan, 1999; Tiggemann, 2004; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). While body dissatisfaction was not significantly greater within any particular age group, significant differences existed between BMI levels and age groups. Younger-aged women typically reported lower BMI levels followed by middle-aged and older-aged women. According to age groups, younger women weighed the least, and had idealised the lowest amount of weight loss (average of 7.24 kg). Middle-aged women idealised a slightly greater weight loss average of 8.25 kg, whereas older-aged women, who had reported the highest weight, idealised the greatest amount of weight loss averaging 19.60 kg.

Despite older-aged women weighing the greatest in body mass and idealizing the greatest amount of weight loss, body dissatisfaction was not identified in the current study as any greater in this particular age group. While it has been argued that over the lifespan, women's desire to be thinner does not differ, nor does preoccupation with being overweight, evaluation of appearance, or bodily satisfaction (Allaz et al., 1998; Cash & Henry, 1995; Cash et al., 1986; Garner, 1997; Wilcox, 1997; Paxton & Phythian, 1998), it could be hypothesised that older women may have lower levels of body dissatisfaction and subsequently place less expectations on achieving the idealised image.

Researchers have suggested that as women age, their experience of their bodies and weight also change, often resulting in greater acceptance of age-related changes in appearance (Pliner et al., 1990; Thompson et al., 1998; Tiggemann & Stevens, 1999). Grogan (1999) further proposed that older women may have fewer age-appropriate models displayed in the media, as well as having fewer thin age-appropriate peers to compare and contrast their bodies against. It could also be argued that with ailing health, older women become more preoccupied with their own health conditions and physical mobility rather than self-objectification. In spite of this, body image dissatisfaction continues to be reported among this older population group (Grogan, 1999; Tiggemann, 2004; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003).

Research suggests that having a higher body mass index than one's perceived ideal is associated with greater levels of body image dissatisfaction (Taylor & Altman, 1997; Vincent & McCabe, 2000). While results of the current study indicated that there were no significant differences between body dissatisfaction and age groups, findings suggested a marked difference in body dissatisfaction between BMI groups. Supporting previous findings (Cash et al., 1986; Sarwer et al., 1998), obese women were found to have the highest level of body dissatisfaction, followed by overweight, normal, and underweight women. These findings complimented womens' idealised weight loss according to BMI level; obese women were identified as idealizing the highest levels of weight loss (a mean desired weight loss of 15.90 kg), followed by overweight (mean 10.46 kg), normal (mean 5.06 kg), and underweight BMI groups (mean 1.41 kg).

The findings suggested that women who had internalised socio-cultural attitudes of attractiveness more than their counterparts, engaged in greater levels of body dissatisfaction. As expected, women with poor insight and awareness of the misrepresentation of "normality" as reflected through celebrity media images were more vulnerable to internalising these "social ideals" of attractiveness as realistic and achievable depictions of normality.

It has been argued by Spitzer, Henderson and Zivian (1999) and Rodin, Silberstein and Striegel-Moore (1985) that the ideal shape as portrayed by the media over the past few decades has become progressively thinner and unachievable, in contrast to actual women who have become heavier. Thus, it is inevitable that body dissatisfaction would be experienced by those women who fail to achieve the ideal body shape and size as measured through societal standards. Failure to achieve this ideal, despite dieting, restriction, and exercise regimes, has been shown to further heighten feelings of body shame and feelings of inadequacy (Motz, 2001; Rubin et al., 2004; Schooler et al., 2004; Shisslak et al., 1998).

These current findings mirror those of previous research, where social variables and attitudes, including exposure to thin media images and pressure from peers increased body dissatisfaction and the likelihood of disordered eating behaviour (Lieberman et al., 2001; McVey et al., 2002). Research has shown that women continue to underestimate the size and shape of their own bodies and hold misconceptions about the physical attributes that men find attractive (e.g., Cohn &

Adler, 1992; Fallon & Rozin, 1985; Huon, Morris, & Brown, 1990; Rozin & Fallon, 1988).

Qualitative analysis of the data obtained through the silencing of the self (STSS) questionnaire provided similar findings further suggesting that body dissatisfaction resultant from societal expectations was largely determined by one's sense of belongingness, and perhaps the internalisation of these social ideals. One hundred and eighty-nine women within the current study reported that they "strongly agreed" or "somewhat agreed" that they had never seemed to measure up to the standards set for themselves. Consistent with the "not good enough" syndrome described by Hoskins (2002) in relation to women failing to measure up to societal expectations, the language generated from the qualitative responses in the current study consisted of a negative, self-defeating, and derogative discourse; highlighting themes of passivity, helplessness, dependence on others, and abject failure.

The words "should", "could", "need to", and "not enough" were continually repeated throughout the dialogues, with a strong narrative theme of "not thin enough, pretty enough, rich enough, and good enough". Given that "enough" was used in the context of social comparison to another, it is believed that it is unachievable as it is not a form of measurement. If "enough" was measurable, it could be argued that one would become satisfied upon reaching it, yet if "enough" can never be reached, then it is doubtful that women will ever be happy and content with their sense of self and body image. This was further illustrated by fifty-three women in the current study reporting a failure to measure up to physical attractiveness, sexual desirability and thinness. For example, "I'm not beautiful or pretty enough"; "I'm ugly"; "I'm not slim enough and have no sex appeal".

4.2. *Silencing Behaviour*

4.2.1. *Predictors of Silencing Behaviour.* Research literature revealed a significant relationship between self-silencing behaviour, suppression of anger and disordered eating (Jack & Dill, 1992; Piran & Cormier, 2005; Ross & Wade, 2004; Smolak & Munstertieger, 2002). Jack (1991), and Gilligan (1982) have suggested the gender role expectation of females requires women to fulfil care giving roles and sacrifice their own needs and sense of self, for the needs of others. It has been argued that the internalisation of femininity norms and associated passivity, results in women silencing their own thoughts, feelings and needs in order to achieve and maintain close relationships (Piran & Cormier, 2005). Research indicates that self-silencing

behaviour is pertinent to disordered eating and depressive symptoms in women (Jack & Dill, 1992; Ross & Wade, 2004; Smolak & Münsterieger, 2002) and it was hypothesised that women who engaged in self-sacrificing and silencing behaviour would be more likely to engage in disordered eating.

The STSS, which included four subscales; self sacrifice, divided self, externalised self perception, and silencing the self, was used to ascertain whether relationships existed between silencing behaviour and BMI; age; conformity to feminine norms; sense of belongingness; social attitudes; body consciousness; body dissatisfaction, and eating attitudes.

The hypotheses were supported, and externalised self was identified as the strongest predictor of silencing behaviour. Externalised self was best predicted by the importance of having nice relationships (conformity to feminine norms), divided self, body image dissatisfaction, and body surveillance. As expected, one's externalised self was determined by dividing oneself, and engaging in body surveillance which would inevitably heighten body dissatisfaction as a result of social comparison.

Silencing the self was the second largest predictor of silencing behaviour, and predicted by each of the dependent variables; in particular, adhering to domestic chores (conformity to feminine norms), internalisation of social attitudes toward appearance, divided self, and care as self sacrifice. Consistent with Gilligan (1991) who suggested that women suppress thoughts, feelings and needs in order to achieve and maintain close relationships, it is not surprising that silencing the self was predicted by division of oneself and self-sacrificing behaviour. It could be argued that adhering to domestic chores is somewhat self-sacrificing itself, as well as associated with a desire to please.

The findings of the current study showed that the divided self was largely determined by the value placed on nice relationships and adhering to domestic chores with regard to femininity, internalisation of social attitudes toward appearance, oral control with regard to eating attitudes, externalised self perception and silencing the self.

Self-sacrifice was identified as the smallest predictor of silencing behaviour. As expected, the most influential factors of self-sacrificing behaviour were one's sense of belongingness, silencing of oneself, bulimic traits and food preoccupation, and oral control/restrictive eating. No relationship was found to exist between silencing behaviour and BMI level, nor silencing behaviour and age. It was not

possible to make any comparisons with previous research findings because research examining these two factors together is almost non-existent.

4.2.2. Silencing Behaviour and Eating Disorders. Since previous research (Jack & Dill, 1992; Piran & Cormier, 2005; Ross & Wade, 2004; Smolak & Munstertieger, 2002) has identified a significant relationship between self-silencing behaviour, the suppression of anger and disordered eating, the responses of those women identified as eating disordered were specifically explored to ascertain if they engaged in more silencing behaviour than their non-eating disordered counterparts. The findings were similar to previous findings (e.g., Ross & Wade, 2004; Smolak & Munstertieger, 2002) in that, women identified as having been previously treated for an eating disorder, continued to engage in greater silencing behaviour than women never treated for disordered eating. In particular, identified women engaged in more self-sacrificing behaviour, externalisation of self-perception, silencing, and division of oneself.

Identified women were specifically those who reported that they had been previously treated for an eating disorder. However, it became evident that despite only 14 women reporting previous treatment for disordered eating, a further 84 women reported having engaged in at least one episode of uncontrolled binge eating, laxative/diuretic abuse, and/or vomiting as a means to control weight over the past six months. It was also acknowledged that while some women had sought previous treatment for disordered eating, some sufferers may have been noncompliant with treatment, and/or have had poor insight and poor acceptance of a diagnosis despite engaging in disturbed eating behaviours. For this reason, women who had reported engaging in at least one episode of uncontrolled binge eating, laxative/diuretic abuse, and/or vomiting as a means to control weight (over the past six months) were identified as “disturbed eating” and this group of women were also examined with respect to silencing behaviour. Eighty-four women were identified as engaging in “disturbed eating”, while 125 women did not meet these criteria.

4.2.3. Silencing Behaviour and Disturbed Eating. Similarly to those women identified as having been previously treated for an eating disorder, women identified as engaging in disturbed eating behaviour, engaged in more silencing behaviour than their non-disturbed eating counterparts. These results were consistent with previous research findings (e.g., Ross & Wade, 2004; Smolak & Munstertieger, 2002) where it

was reported that higher levels of self-sacrificing and silencing behaviour were evident in women with disturbed eating.

Similar to eating disordered women, those women identified with disturbed eating patterns showed higher scores for self-sacrificing behaviour, externalisation of self-perception and silencing of oneself. As suggested by Jack (1991) and Gilligan (1991), women with disordered eating behaviour have a particularly low self-esteem, sense of belongingness and poor identity, thus often silencing their own needs in order to please and be accepted by others. Therefore, it is not surprisingly that women in the current study reporting disturbed eating displayed higher levels of self-sacrificing and silencing behaviour in contrast to women who did not engage in disturbed eating behaviour.

4.3. Eating Attitudes and Disturbed Eating

4.3.1. Predictors of Eating Attitudes. The EAT-26, which is composed of dieting, bulimia/food preoccupation, and oral control subgroups, was used to measure eating attitudes and possible predictors of disordered eating. It was hypothesised that women who held poor eating attitudes, would engage in greater disturbed eating behaviour and would be most vulnerable to disordered eating. The findings indicated that BMI, age, conformity to feminine norms, one's sense of belongingness, social attitudes toward appearance, silencing of oneself, body consciousness, and body dissatisfaction were all significant predictors of eating attitudes.

The strongest predictors of dieting were conforming to feminine norms, specifically, the value placed on the importance of thinness, and the importance of involvement in romantic relationships and adhering to domestic chores. One's sense of belongingness, body surveillance, body shame, and body control were also identified as strong predictors of dieting behaviour.

Since dieting behaviour is viewed as the second largest predictor of disordered eating (Kenardy et al., 2001; O'Dea & Abraham, 2000; Patton et al., 1997), it was expected that those who placed greater value on adhering to gender ideals would be most likely to engage in attempts of adjustment and reshaping, thus dieting behaviour, to achieve their ideal perception of femininity. In this instance, dieting behaviour was found to occur greatest in women who most valued the importance of thinness, the involvement in romantic relationships and those women who adhered greatest to domestic chores.

Bulimic traits/food preoccupations were significantly determined by BMI level, sense of belongingness, care as self-sacrifice, and body shame. Conforming to feminine norms, were found to be a strong predictor of bulimic behaviour, specifically, the value placed on the importance of thinness. As anticipated, those who placed high level of importance on adhering to gender ideals, specifically the value placed on the importance of thinness, were more likely to employ bulimic and dieting behaviours in an attempt to achieve their ideal body shape and weight. The current findings supported previous literature (Fairburn et al., 2003; Stice, 2002) which suggested that over-evaluation of weight and shape, body dissatisfaction, and internalisation of the thin ideal are the strongest precipitating factors in the maintenance of bulimia nervosa.

Oral control and restrictive eating behaviour were largely determined by BMI level, and conforming to feminine norms, in particular, the value placed on the importance of thinness, sexual fidelity, and involvement in romantic relationships. One's sense of belongingness, care as self-sacrifice, and divided self, were further identified as significant predictors of oral control and restricted eating patterns. Since previous research (Gilligan, 1982; Gilligan, 1991; Jack, 1991; Jack & Dill, 1992; Piran & Cormier, 2005) has highlighted the relationship between silencing oneself and disordered eating as a means of internalisation and self-deprivation, the current findings supported this framework suggesting that silencing behaviour, specifically care as self-sacrifice and divided self, predict oral control and restrictive eating.

A number of studies have similarly echoed the relationship found between disordered eating behaviour and a poor sense of belongingness (Joiner & Kashubeck, 1996; Lawrence & Thelen, 1995; Nassar et al., 1992; Thomas et al., 2000; Williams & Currie, 2000). However, it remains unclear whether a poor sense of self and resulting body dissatisfaction leads to disordered eating, or whether a poor sense of self leads to feelings of ineffectiveness, and restrictive dieting is subsequently employed as a means of enhancing feelings of control (Hart & Ollendick, 1985; Shisslak et al., 1998). Feelings of ineffectiveness in relation to eating attitudes were illustrated within the qualitative data obtained in the silencing of the self (STSS) questionnaire. Eighteen women reported shame about poor self-discipline to adhere to their expectations in sport, exercise, and dietary habits, "I eat the wrong foods"; "I'm physically unfit and have no motivation. I should be able to lose more weight".

4.4. Predictors of Disturbed Eating

Despite significant predictors of eating attitudes being identified, further analyses were performed in order to ascertain whether BMI, age, conformity to feminine norms, sense of belongingness, social attitudes toward attractiveness, silencing behaviour, body consciousness, body dissatisfaction, and eating attitudes were significant predictors of disturbed eating. The findings indicated a significant predictive relationship between these independent variables and disturbed eating. In particular, internalisation of social attitudes toward appearance, dieting behaviour, and bulimic traits/food preoccupation were identified as strong predictors of disturbed eating.

Previous research (Fredrickson & Roberts, 1997; Lee, 1998; Lieberman et al., 2001; McVey et al., 2002; Motz, 2001; Sabik & Tylka, 2006; Thompson et al., 1999; Tiggemann & Slater, 2004;) have shown that internalisation of social attitudes have heightened body dissatisfaction and feelings of inadequacy, in turn, lead to disturbed eating behaviour. Furthermore, dieting had been recognised as the second greatest risk factor of disordered eating, preceded by body dissatisfaction. Adolescent girls who dieted on a moderate basis were identified as five times more likely to develop an eating disorder compared to their non-dieting counterparts (Patton, 1999).

4.4.1. Disturbed Eating and Objectified Body Consciousness. It was proposed that self-objectification would lead to increased feelings of body shame and appearance anxiety, which would subsequently increase the likelihood of body dissatisfaction and disordered eating. Consistent with previous research by Fredrickson and Roberts (1997), Lee (1998), and Motz (2001), women from the current study who reported greater levels of body consciousness, placed further importance on appearance and exhibited higher levels of disturbed eating behaviour than those identified as less objectified and less body conscious. Moreover, body surveillance and body shame were identified as the strongest predictors of disturbed eating.

The findings indicated that women identified as engaging in disturbed eating behaviour surveyed their body less than their counterparts yet engaged in more body shame and body control practices. These findings support the hypotheses as it was expected that women who are more ashamed of their bodies would engage in greater means of body control practices, and therefore place oneself at greater risk of engaging in disturbed eating behaviour. With regard to women with disturbed eating

behaviour engaging in less body surveillance, it could be hypothesised that these women rarely engaged in social comparison and body surveillance due to high levels of shame and embarrassment associated with not having the ideal body.

Alternatively, it could be suggested that while social comparison occurs between most women, some women may deny body surveillance and social comparisons for whatever reasoning, and subsequently fail to report these behaviours.

4.4.2. Disturbed Eating and Socio-cultural Attitude Towards Appearance.

Socio-cultural factors, typically the media, cultural, peer, and parental influences, have been identified as some of the most potent factors that affect the development and maintenance of disordered eating (Ghaderi, 2001; Stice, 2002; Vincent & McCabe, 2000; White, 2000; Yates, 1989). Previous research has held socio-cultural factors responsible for the idealization of thinness, and its association with increasing levels of body dissatisfaction, disturbed eating behaviours and socio-cultural attitudes throughout Westernised societies (Ghaderi, 2001; Stice, 2002).

While it is understood that cultural factors, peers, and parental attitudes can influence body dissatisfaction (Hargreaves & Tiggemann, 2004; Pinhas, Toner, Ali, Garfinkel, & Stuckless, 1999; Stice, 2002; Thompson, Covert, & Stormer, 1999; Vincent & McCabe, 2000), the media continues to be one of the most powerful and damaging sources of the promotion of the thin-ideal (Polivy & Herman, 2004; Tiggemann & Slater, 2004). The frequency and repetition of these idealized images and social messages, in particular, are thought to have increased social acceptance of the thin ideal, and resulted in increasing levels of drive for thinness and body dissatisfaction among women (Hargreaves & Tiggemann, 2004; Pinhas et al., 1999; Stice, 2002; Thompson, et al., 1999).

It was hypothesised that women who reported less awareness and greater internalisation of socio-cultural attitudes about appearance would engage in more disturbed eating behaviour. The findings indicated a significant predictive relationship between awareness of social norms, internalisation of social norms and disturbed eating. As illustrated through the qualitative data in the current study, women reported greater levels of appearance anxiety in relation to the internalisation of socio-cultural attitudes towards attractiveness and body image in the workforce: “women’s weight is important in the workforce. Fat women just aren’t respected”; “I work as a swim teacher and am very self-conscious in bathers, I should look better for business”.

The findings of the current study showed that women identified as engaging in disturbed eating, reported less awareness and more internalisation of social norms. It could be hypothesised that these women had less insight into the impact of socio-cultural and external influences on body dissatisfaction, social acceptance and disturbed eating behaviour. Alternatively, it could be suggested that women reporting greater insight into the awareness and internalisation of socio-cultural attitudes towards attractiveness, would be less vulnerable to media imagery and gender ideals that have been associated highly with increasing levels of body dissatisfaction and disordered eating (Hargreaves & Tiggemann, 2004; Pinhas et al., 1999; Polivy & Herman, 2004; Stice, 2002; Thompson, et al., 1999). This latter theory would subsequently support Pinhas et al.'s (1999) findings that individuals identified as engaging in disturbed eating were more vulnerable to the effects of media exposure.

4.4.3. Disturbed Eating and Sense of Belongingness. An extensive range of literature has demonstrated associations between self-esteem, sense of belongingness and disordered eating (Bardone et al., 2003; Joiner & Kashubeck, 1996; Lawrence & Thelen, 1995; Ricciardelli & McCabe, 2001; Tiggemann, 2001). Previous findings have suggested that individuals with a poor sense of self are more vulnerable to the pressures of thinness and subsequent dieting practices (Bardone et al., 2003). A longitudinal study measuring the impact of self-esteem and disordered eating, found that girls aged between 11 and 12 years with low self-esteem were eight times more likely to develop maladaptive eating by mid adolescence (Button et al., 1997; Button et al., 1996).

In the study reported here, qualitative data analysis showed that many women reported significant confidence and self-esteem issues relating to a poor sense of belongingness. Sixteen women reported poor self-worth, low levels of confidence and assertiveness and poor sense of self. The following statements are illustrative of these issues; "I'm not a morally good person"; "I feel weak. I am nothing". Twenty-eight women reported a failure to measure up to their self expectations, "I'm not good at anything"; "I don't achieve high enough"; "I don't work hard enough". Thirteen women reported 'need to please' personality traits and felt they were somewhat disliked and failed to make others happy. The statements they made included the following; "I'm not popular enough" and "I try to please everyone". Eleven women reported failure to meet career goals, while six women felt they were too lazy and self

centered. For example, “I don’t care enough for others”; “I wish I wasn’t so self-centered”.

Five women reported an inability to have close and/or sexual relationships, “I can’t allow myself to get close to someone”; “I’ve been with my partner for 21 years. I’m not good enough to marry”, while four women reported failure to measure up to overall happiness, “life is a struggle”; “I can’t feel good about myself”; “I’m not content with my life”. It is thought that women, who hold such a poor sense of self and belongingness, as illustrated above, would be more likely to have higher levels of body dissatisfaction and disturbed eating behaviour.

The findings of current study were consistent with previous research findings (Silverstone, 1990) in that women identified as engaging in disturbed eating had a lower sense of belongingness in comparison to those women who did not engage in disturbed eating behaviour. As previously noted by Macdonald (1995), women hold a unique connection between their body, identity, and sense of self. Consistent with the current findings, one would assume that a poor identity and poor sense of self would result in disgruntled feelings toward the body, possibly ensuing bodily punishment and disturbed eating behaviour. Excessive exercise, diet regimes, deprivation of desirable foods, binge-eating, restriction, starvation, and purgatory behaviour could all act as means to punish the body, and in turn, oneself, for not having the ideal body.

Women often misconceive the idea that having the ideal body will result in contentment, satisfaction and an improved sense of self. Improvements are often attempted through reshaping of the body, rather than reframing core beliefs and challenging unhelpful thoughts. Thus, high self-esteem was identified as the most important predictor of body dissatisfaction, with positive self-esteem working as a protective factor against the likelihood of maladaptive eating behaviours, attitudes, and disordered eating (Crago et al., 2001; Mable et al., 1986; Ricciardelli & McCabe, 2001).

However, it must be noted that much of the research within eating disorder literature has used the terms self-concept, self-esteem, self-worth, and sense of self interchangeably. The current study typically measured one’s sense of belongingness in an attempt to encompass all of the above terms. It is argued that inconsistencies could exist within literature and the current study, given that significant differences exist between self-concept, self-esteem, self-worth, sense of self and belongingness.

Self-concept has typically been defined as one's identity and their perception of "who they are", whereas self-esteem and self-worth often pertain to one's perception of the value and worth that they place on themselves. One's perception of self-worth can often be influenced and shaped by perceptions of success and failure, achievements and accomplishments, family dynamics and school experiences, comments from others (e.g. parents, siblings, friends, teachers and mentors). Sense of self typically illustrates one's insight and awareness of their identity, and being confident in "who they are". This is inter-related with sense of belongingness, which often encompasses one's identity, confidence in their identity, and one's perception of how readily they belong and "fit in" with their environment. It is assumed that women who have a strong sense of belongingness would be confident in their sense of self and identity, subsequently placing high value in their self-worth and self-esteem.

Future studies may consider the development of a broader term which encompasses self-concept, self-esteem, self-worth, sense of self and belongingness, to ensure universality and reliability in reference to these meanings. Alternatively, studies should refrain from using these various terms interchangeably if they have not been accounted for through the appropriate measures to avoid misinterpretation of findings.

4.4.4. Disturbed Eating and Body Dissatisfaction. A number of concurrent and longitudinal studies (Attie & Brooks-Gunn, 1989; Byely et al., 2000; Joiner & Kashubeck, 1996; Kelly et al., 1997; Lawrence & Thelen, 1995; McVey et al., 2002) have demonstrated the role of body image dissatisfaction in the prediction of disordered eating behaviour. It was hypothesised that women identified as having disturbed eating would report greater body dissatisfaction than women not fitting criteria for disturbed eating.

In addition to measuring disturbed eating and body dissatisfaction, women in the current study were given the opportunity to make comments following the completion of the EAT-26 questionnaire. This seemingly enabled women to have a voice in choosing to speak about persecutory thoughts, shameful behaviour, and disturbed eating behaviour. Of the thirty-two women whose comments had reflected disordered eating and/or body dissatisfaction, four women reported their continual struggle with disordered eating; seven women commented on engaging in restrictive eating patterns, dieting behaviour, and excessive exercise as a means to control their weight despite reporting no previous treatment for disordered eating; while others

admitted to engaging in binge-eating behaviour at times of stress and as a means of “punishment” and threats of “self-sabotage”.

In contrast to reports of disturbed eating behaviour, eight women used this section to comment on their body dissatisfaction, “I feel dissatisfied with my post-baby body, it’s difficult to compete physically with other females my age”; “I feel angry, sad and weak with myself when I overeat, I just wish I had a different body”; “I feel worse and lazy around thin people. I can’t even make eye contact without having any makeup on”. As illustrated by the qualitative data, women often experience high levels of body shame and body dissatisfaction for failing to meet societal standards of beauty; and body shame and hatred are subsequently projected into feelings of self-hatred, resulting in consequential punishment for failing to control one’s shape and weight.

The hypothesis was supported and current findings supported those of previous researchers (e.g., Attie & Brooks-Gunn, 1989; Barker & Galambos, 2003; Cattarin & Thompson, 1994; McVey et al., 2002; Wilksch & Wade, 2004) where it was suggested that body dissatisfied individuals, from non-clinical sample groups, engaged in greater practices of maladaptive dieting, food restriction and weight loss practices, such as self-induced vomiting, the use of laxatives, and exercise, in contrast to women who were satisfied with their body. While body dissatisfaction seems likely to precede and predict disturbed eating behaviour, higher levels of body dissatisfaction appear considerable within women who report disturbed eating, thus suggesting that heightened feelings of body shame, poor sense of self and internalised feelings of self-hatred may maintain body dissatisfaction and disturbed eating behaviour.

4.4.5. Disturbed Eating and Conformity to Feminine Norms. In addition to stereotypical gender roles, gender identity is believed to include other factors such as; a series of self-images, self-perceptions, and perceived social comparisons made with others (Spence, 1993). Attractiveness is argued to be central to a women’s identity, and extensive research has suggested that women’s desire to be thinner does not differ across the lifespan, nor does body image and, evaluation and satisfaction with appearance (Allaz et al., 1998; Cash et al., 1986; Grogan, 1999; Hetherington & Burnett, 1994; Paxton & Phythian, 1998). It has been suggested that failure to meet societal expectations of attractiveness results in women feeling less feminine (Fernandes et al., 2006; Macdonald, 1995; Motz, 2001; Sabik & Tylka, 2006; Snyder

& Hasbrouck, 1996), thus it was hypothesised that women who report a greater desire to conform to feminine norms would engage in more disturbed eating behaviour than those identified as conforming less to feminine norms.

Qualitative analysis of the data obtained through the silencing of the self (STSS) questionnaire revealed that twenty-two women felt that they had failed to make a “good enough” wife, mother, and daughter, thus failing to meet their gender role expectations of what was required from a wife, mother and/or daughter. For example, “I should be a better housewife”; “my husband could do better. I need to make him happier”; “I fail to parent my children properly”.

The quantitative findings also supported the hypothesis, and the findings revealed that disturbed eating was strongly determined by the value placed on the importance of thinness, modesty, and involvement in romantic relationships. Women identified as engaging in disturbed eating behaviour typically valued thinness more than women with no disturbed eating behaviour, and were also more involved in romantic relationships, adhered more rigidly to domestic duties, and were more invested in their appearance.

The findings of the current study also supported those of Timko et al. (1987) who suggested that disordered eating in women was predicted by perceptions of the importance of physical appearance, femininity traits, and the number of roles which defined identity as a woman. Furthermore, a number of research studies (Duemm, Adams, & Keating, 2003; Friedman & Whisman, 1998; Oates-Johnson & DeCourville, 1999; Pliner and Haddock, 1995; Rosch, Crowther, & Graham, 1991) have illustrated similar patterns in women preoccupied with weight and disturbed eating behaviour. Typically, these women present with issues of dependency, a strong need for approval, avoidance of criticism and rejection, and heightened awareness of how one is perceived by others.

With respect to findings of the current study, it could be hypothesised that women identified as engaging in disturbed eating behaviour had desired involvement in romantic relationships as they required a need for love and acceptance. Similarly, a strong desire to please, and thus meet stereotypical gender ideals, could be responsible for strong adherence to domestic duties. Consistent with previous findings (Snyder & Hasbrouck, 1996), women identified as conforming less to feminine ideals reported less dissatisfaction with their body shape and weight, less concern for thinness, fewer feelings of ineffectiveness, and less disturbed eating behaviour.

4.4.6. Disturbed Eating, Eating Attitudes and BMI Level. Taylor and Altman (1997) and Vincent and McCabe (2000) have reported strong positive correlations between BMI and body dissatisfaction, and several studies have identified greater levels of body dissatisfaction and resultant disturbed eating behaviour in women with BMIs higher than their perceived ideal (Levine et al., 1994; Phelps et al., 1993; Timko et al., 1987). Therefore, BMI was explored against disturbed eating and eating attitudes to ascertain whether disturbed eating could be predicted by BMI level. The findings indicated significant differences between BMI groups for eating behaviours and disturbed eating patterns. The differences were between underweight and overweight groups, underweight and obese groups, and normal and overweight groups.

In accordance with previous research which suggests that women with higher BMI levels experience greater body dissatisfaction, overweight women in the current study reportedly engaged in more disturbed eating behaviour, followed by women in obese, normal and underweight BMI groups. Obese women reported engaging highest in binge-eating and food preoccupation practices, and had also reported attempting to diet more frequently. Consistent with Vincent and McCabe (2000), who identified BMI as a predictor of food restriction; underweight women were identified as engaging highest in oral control and restrictive eating, followed by women in normal, obese, and overweight BMI groups. These findings of oral control and restrictive eating are therefore reflective of the BMI levels exhibited within the study.

4.4.7. Disturbed Eating, Eating Attitudes and Age. Similarly to previous research investigating age and body dissatisfaction (Thompson et al., 1995; Stice et al., 1998; Stevens & Tiggemann, 1998; Tiggemann, 1992; Webster & Tiggemann, 2003), the current study did not find any significant differences in eating behaviours between groups based on developmental age. As previously noted, while body dissatisfaction remains relatively stable throughout one's lifespan, disordered eating and the investment in appearance tends to decline with older adulthood (Grogan, 1999).

While it was expected that there would be a greater prevalence of disturbed eating in younger age groups (Posavac et al., 2001; Schooler et al., 2004; Schur, Sanders, & Steiner, 2000; Snyder & Hasbrouck, 1996), disturbed eating traits and poor eating attitudes were not significantly different between age groups. This supports previous research that has shown that age is not a significant predictor of

disturbed eating behaviour (Paxton & Phythian, 1998; Pliner et al., 1990; Rozin & Fallon, 1988; Stevens & Tiggemann, 1998; Thompson et al., 1998; Tiggemann, 1992).

Consistent with quantitative findings, qualitative data revealed that middle-aged and older-aged women reported high levels of body dissatisfaction with some women reporting a loss of “weight control” following menopause. Lapband surgery was employed as a means of weight loss by two women following menopause, which reportedly resulted in an improvement in body image satisfaction. It is also noted that middle-aged and older-aged women had higher levels of BMI in contrast to younger women within the study. Furthermore, higher BMI groups idealised greater levels of weight loss.

In light of the findings, it is therefore expected that high levels of body dissatisfaction would exist within middle-aged and older-aged women. Given that body dissatisfaction was evidenced throughout women of all age groups, disturbed eating behaviour could not be identified to one particular age group, and thus disturbed eating was not predicted by age. Qualitative data confirmed these findings, suggesting that women in their 40s and 50s also engaged in binge-eating, dieting, and purgatory behaviour.

4.5. *Objectified Body Consciousness*

4.5.1. *Predictors of Objectified Body Consciousness.* Objectification theory (Fredrickson & Roberts, 1997) proposes that the female body in Western societies is socially constructed as an object to be viewed, evaluated, and in some instances, “improved” in order to meet cultural ideals and perceived expectations. The theory argues that through social development, girls and women internalise an observer’s perspective of their physical self, whereby they begin to treat themselves as an object, to be viewed and critiqued. This process of self-objectification and body monitoring often leads to feelings of body shame, appearance anxiety, and body dissatisfaction (Fredrickson & Roberts, 1997; Lee, 1998; Motz, 2001; Sabik & Tylka, 2006; Thompson et al., 1999; Tiggemann & Slater, 2004).

The Objectified Body Consciousness scale which includes the following three subscales; body surveillance, body shame and body control, was used to measure levels of objectified body consciousness. Multiple linear regression analyses found that BMI, age, conformity to feminine norms, sense of belongingness, socio-cultural

attitudes toward appearance, silencing behaviour, and body dissatisfaction were all significant predictors of objectification and body consciousness.

Body surveillance, in particular, was predicted by conformity to feminine norms, specifically, the importance of thinness and involvement in romantic relationships. This finding is consistent with research (e.g. Fredrickson & Roberts, 1997; Lee, 1998; Motz, 2001; Sabik & Tylka, 2006) which suggests that one's perceived ideal of femininity and thus the importance of thinness, results in an increase in body monitoring and surveillance. Similarly to the relationship found between disturbed eating and conformity to feminine norms, it could be postulated that engaging in body surveillance within romantic relationships is a means to monitor one's body to ensure it was aesthetically pleasing and attractive for one's romantic partner. Arguably, this surveillance aims to achieve acceptance and approval by one's partner, which could heighten a woman's sense of security, and possibly her sense of control by having kept her partner satisfied.

Similarly, body control was significantly predicted by the value placed on the importance of thinness, involvement in romantic relationships, and furthermore influenced by body shame and body dissatisfaction. As suggested with body surveillance, the involvement in romantic relationships would heighten one's desire to control her body to ensure it still meets approval for attractiveness and desirability from another. Consistent with findings from the current study, dieting behaviour, and thus body control, was predicted by the value placed on the importance of thinness and also the importance of involvement in romantic relationships. Body shame was also highly correlated with body dissatisfaction and disturbed eating behaviour.

The findings of the current study showed that body shame was the strongest predictor of objectified body consciousness. This supports previous research (e.g., Moradi et al., 2005; Thompson et al., 1999) which has suggested that body shame results from women's awareness of failure to meet unrealistic societal standards. Body shame was strongly predicted by BMI level, the importance of thinness and investment in appearance, sense of belongingness, internalisation of socio-cultural attitudes towards appearance, and body control.

Consistent with previous findings, BMI level, in particular high BMI levels were associated with body shame, body dissatisfaction, and body control. The importance of thinness, investment in appearance, and internalisation of socio-cultural attitudes towards appearance were identified with disturbed eating behaviour (Lee,

1998; Motz, 2001; Sabik & Tylka, 2006). Moreover, since a woman's self-worth is often measured by the internalised standards of attractiveness and femininity, it would therefore be expected that one's sense of belongingness would also play a detrimental role in self-objectification and objectifying behaviour (Moradi et al., 2005).

4.5.2. Objectified Body Consciousness and BMI Level. Given that BMI level has been identified as a predictor of body dissatisfaction, and this, in turn is typically preceded and maintained by objectified body consciousness, BMI was measured against objectified body consciousness to ascertain whether there was a relationship between the two variables. A significant difference was found between BMI groups and objectified body consciousness, specifically between BMI level and body shame. With regard to body shame, significant differences were found between underweight and normal BMI groups, underweight and overweight BMI groups, underweight and obese BMI groups, normal and obese BMI groups, and overweight and obese BMI groups. As suggested by previous findings, body dissatisfaction was often determined by BMI level, and therefore shame associated with body dissatisfaction would be expected to vary across BMI groups.

Consistent with previous research findings (Fredrickson & Roberts, 1997; Motz, 2001) which suggest that thin attractive women typically engage in greater levels of self-objectification, underweight women in the current study surveyed their bodies more than heavier women. Similarly to the findings for body dissatisfaction, obese women showed the highest levels of body shame and attempts of body control. Some authors (e.g., Matz et al., 2002; Sarwer et al., 1998) suggest that because body shame and body dissatisfaction are reported at higher levels by obese women in comparison to obese men, the relationship between weight and body dissatisfaction is therefore mostly moderated by self-esteem, teasing about weight and the internalisation of socio-cultural appearance standards.

4.5.3. Objectified Body Consciousness and Age. While it has been reported that body dissatisfaction remains stable throughout a woman's lifespan, previous research (Grogan, 1999; Tiggemann & Lynch, 2001) has indicated that self-objectification, habitual body surveillance, appearance anxiety, and disordered eating all significantly decrease with age. It was hypothesised that younger women in the current sample would engage in greater levels of body objectification and body surveillance than older women. Unlike findings by Tiggemann and Lynch (2001) which suggested that women in their 20s and 30s scored highest in self-

objectification, appearance anxiety, body surveillance, and disordered eating, the findings of the current study indicated no significant differences between age groups and objectified body consciousness. However, the means indicated that body surveillance reached its highest levels in middle adulthood.

Despite no significant differences between body objectification and age, the findings of the current study did show that body shame and body control both reached their highest in older women. Since BMI levels were highest within the older-aged population, and a significant predictive relationship exists between high BMI levels and body dissatisfaction, it would therefore be expected that high levels of body shame would be prevalent within this older age group. Similarly, women who were categorized according to obese and overweight BMI groups reported the greatest amount of dieting attempts as well as a desire to lose the greatest amount of weight. Thus, one could assume that high levels of body control would also be expected from these older age groups.

4.6. Socio-cultural Attitude Towards Appearance

4.6.1. Socio-cultural Attitude Towards Appearance and BMI Level. Many studies have measured socio-cultural attitudes towards appearance and body image and have suggested that an increase in internalisation of media ideals, and awareness of media ideals, are responsible for the increasing prevalence of body dissatisfaction and associated disordered eating (Lee, 1998; Levine et al., 1996; McVey et al., 2002; Patton et al., 1997; Pinhas et al., 1999; Polivy & Herman, 2004; Posavac et al., 2002; Thompson et al., 1999; Schooler et al., 2004; Shaw & Waller, 1995; Spitzer et al., 1999). While significant predictive relationships existed between body dissatisfaction and BMI, and objectified body consciousness and BMI, the findings reported here revealed no significant relationship between socio-cultural attitudes towards appearance and BMI.

The findings did indicate, however, that overweight women had internalised the highest levels of socio-cultural attitudes towards appearance, which could suggest that they had adopted societal attitudes in the importance of thinness and attractiveness as a means to feel accepted. Overweight women, who obviously failed to meet societal standards, may have inevitably experienced greater levels of body dissatisfaction, as revealed in the current study.

Findings suggested that underweight women were most aware of the socio-cultural attitudes towards appearance and the importance of thinness and

attractiveness, yet had not internalised these views as necessary. It is likely however, that underweight women were aware of the societal view on thinness and had probably experienced the reward of acceptance and envy for having the “ideal” body, yet had not internalised it as “needed” in order to gain cultural acceptance and a sense of belongingness. It could be hypothesised that underweight women did not appreciate the benefits of being thin and having the socially desired body shape. Arguably, if underweight women had experienced bodily shame from being overweight, they too may internalise greater levels of socio-cultural attitudes towards appearance and seek thinness as a means of cultural acceptance and desirability.

4.6.2. Socio-cultural Attitude Towards Appearance and Age. Some research suggests that older-aged women have less investment in appearance, supposedly due to the effort involved in adhering to appearance, increasing health issues, as well as the identification as an “older” woman beyond sexual objectification. Despite older-age women investing less effort in appearance, extensive research has shown that a woman’s desire to be thinner does not differ across age, nor does her preoccupation with weight gain, body image and, evaluation of and satisfaction with appearance (Grogan, 1999; Kostanski et al., 2004; Tiggemann, 2004; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). The findings reported here support previous research suggesting that there were no differences between age groups for internalisation of and awareness of socio-cultural attitudes about appearance. Therefore, age was not a factor determining socio-cultural attitudes about appearance as it existed across all age groups.

4.7. Sense of Belongingness

4.7.1. Sense of Belongingness and BMI Level. Previous research findings (e.g., Bardone et al., 2003; Joiner & Kashubeck, 1996; Lawrence & Thelen, 1995; Ricciardelli & McCabe, 2001; Tiggemann, 2001) have confirmed strong negative relationships between self-esteem, sense of belongingness and disordered eating. The findings of the current study showed that BMI level was not a significant predictor of one’s sense of belongingness.

It is noteworthy, however, that women in the underweight BMI group reported the highest levels of sense of belongingness followed by overweight, normal, and obese BMI groups. It could be proposed that underweight BMI groups who typically reported less body dissatisfaction had a stronger sense of belongingness, which protected them from engaging in higher levels of disturbed eating behaviour.

Alternatively, it could be suggested that women within the underweight BMI group were more satisfied with their weight as they had achieved the highly desired thin-ideal, which may have further promoted a positive self-esteem, sense of belongingness, and ultimately acceptance among societal trends and expectations.

While body mass index could not predict one's sense of belongingness, it was evidenced nevertheless that obese group members reported the lowest levels of sense of belongingness. Research investigating body image dissatisfaction in obese women seeking weight loss, found that self esteem and interpersonal factors predicted body dissatisfaction in adulthood rather than childhood experiences of being bullied (Matz et al., 2001). Low self-esteem and a poor sense of belongingness were identified by Matz et al. (2001) as prevalent within this population group.

Similarly Hagerty et al. (1992), Beck (1999), and Piran and Cormier (2005) argued that women are overly concerned about their appearance and how they are perceived by others, highlighting the relationship between appearance, identity, and "fitting in". Since the obese body differs significantly from the socially-accepted ideal, it is inevitable that obese women would experience feelings of body shame, isolation, failure to feel accepted, and a poor sense of belonging in a culture that is bound by thinness and attractiveness. While research cannot identify poor sense of belongingness as a predictor of obesity, findings indicate that a low self-esteem and poor sense of belongingness can precipitate binge-eating behaviour and maintain obesity (Matz et al., 2001).

4.7.2. Sense of Belongingness and Age. No relationship was found to exist between age and sense of belongingness. Further, it was not possible to make any comparisons with previous research findings because research examining these two factors together is almost non-existent. It is noteworthy that there was a significant discrepancy in sample size across the varying age groups which could attribute to the poor relationship between sense of belongingness and age.

It could be assumed, however, that older-aged women would have a stronger sense of belongingness given that they have lived and learnt through greater life experiences. If this was so, it could be suggested that the internalisation of attractiveness would have little bearing on older-aged women's sense of belongingness given that they have had less exposure to media images and subsequently experience less internalisation of cultural standards. In contrast, it could be argued that the identity of younger-aged women is greatly influenced by the

internalisation of sexually objectified images portrayed in the media, and young women's desire to meet cultural standards of beauty and acceptance (Bissell & Peiqin, 2004; McVey et al., 2002; Rubin et al., 2004; Schooler et al., 2004).

Alternatively, it could be hypothesised that sense of belongingness of women within the current sample was not identified as stronger or weaker within any particular age group. While one may predict that older-aged women would have a stronger sense of belongingness, Sarwer et al. (2004) reported that women were rated as less attractive and less feminine with age. Given the correlation between femininity, attractiveness and identity, it could be postulated that older-aged women experience feelings of no longer "fitting in". Further research studies investigating women's sense of belongingness and age are needed to confirm whether these findings are an accurate reflection of women's sense of belongingness across the lifespan.

4.8. *Conformity to Feminine Norms*

4.8.1. *Conformity to Feminine Norms and BMI Level.* Given that femininity is associated with thinness and attractiveness, and thinness associated with body objectification, body control and weight monitoring, it was hypothesised that women with a low BMI level would adhere more to conformity to feminine norms. The hypothesis was supported and results indicated that a significant relationship existed between BMI level and one's conformity to feminine norms, especially with regard to the importance of having nice relationships, the importance of thinness, and investment in appearance.

Underweight groups differed significantly from other BMI groups in their value for thinness. Underweight women reported the least value in thinness, whereas obese women reported the highest value in thinness. Since research (Grogan, 1999; Kostanski et al., 2004; Tiggemann, 2004; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003) has indicated that all women have a desire to be thin, or thinner, it could be proposed that underweight women had achieved their thin-ideal and were somewhat satisfied. Consistent with the current findings, it is likely that obese women would report higher value in thinness given that they are likely to have experienced greater levels of body shame, body dissatisfaction, disturbed eating behaviour, and possibly a poor sense of belongingness through failure to attain socially-approved standards of beauty.

Underweight women reported the highest scores for investment in appearance in contrast to any of the other BMI groups. Obese women rated thinness of high importance, but attractiveness was rated the least important by these women. These findings were partly consistent with previous research (Fredrickson & Roberts, 1997; Motz, 2001) which suggests that thin women typically engage in greater levels of self-objectification in contrast to their heavier counterparts. It could be hypothesised that thin women have achieved the “thin-ideal” and therefore place more emphasis on achieving attractiveness.

As suggested by various authors (Allaz et al., 1998; Cash & Henry, 1995; Cash et al., 1986; Garner, 1997; Grogan, 1999; Kostanski et al., 2004; Paxton & Phythian, 1998; Tiggemann & Lynch, 2001) who found that women are continually discontent with their bodies, it appears that once an aspect of content is achieved, in this instance thinness, another challenge is sought. In contrast, obese women may be disillusioned about the definition of attractiveness, and may feel that attractiveness could only be achieved first through achieving thinness.

Descriptive results suggested that underweight women also rated involvement in romantic relationships and the importance of sexual fidelity higher than any other BMI group. There appears to be an emergent theme that underweight women/women engaging in disturbed eating, value the importance of romantic relationships and sexual fidelity to a greater extent than women in the normal and heavier weight groups. Therefore, it could be hypothesised that these women felt that they had acquired a romantic partner through attaining a thin body, and that the body is essentially a vehicle to achieving and maintaining a sense of love, nurturance and security.

4.8.2. Conformity to Feminine Norms and Age. The findings showed that there was a significant relationship between age and conformity to feminine norms. This was shown specifically in terms of adherence to domestic duties and modesty. Young women and middle-aged women differed significantly with regard to adhering to domestic duties. Given that younger women within the current study ranged from 18-35 years of age, with a large proportion possibly still living at home, it would be expected that this younger-aged group may have less responsibility and value for the importance of adhering to domestic chores in contrast to their older counterparts. Similarly, younger women differed with middle-aged women and older-aged women with regard to modesty; older-aged women having valued modesty greatest. These

findings may therefore be reflective of increased maturity throughout the developmental life cycle, along with greater acceptance, and a lesser need for approval from others.

Having nice relationships, being involved in romantic relationships, and investment in appearance, were rated highest by younger-aged women, whereas middle-aged women valued the importance of being involved with children, thinness, sexual fidelity, and adhering to domestic duties. As highlighted by Tiggemann and Lynch (2001), young women in their 20s and 30s scored highest on self-objectification, habitual body monitoring, and appearance anxiety; whereas middle-aged women scored lower on self-objectification, and older-aged women scored lowest. It could be proposed that younger-aged women were more self-objectified, and concerned with their appearance in order to attract a romantic partner, whereas it could be assumed that middle-aged women were already involved in a romantic relationship, and while it was important for them to maintain attractiveness (and thinness), it was not necessary or relied upon in order to attract a new partner.

Further, while a desire for thinness and attractiveness appears to be important for women throughout the lifespan, there seems to be a shift in the value and commitment invested in its achievement. Although the current study indicates that body dissatisfaction, disturbed eating behaviour, and the importance of attractiveness is constant throughout a woman's lifecycle, it appears that the value that women place on particular aspects of daily living vary according to life stage. For instance, the identity of motherhood and maintaining a household introduces additional challenges to the woman, which requires reprioritization of tasks, and values attributed to those tasks. As noted in the current findings, middle-aged women placed greater value in their involvement with children and adhering to domestic chores, while older-aged women placed greater value in modesty.

4.9. Strengths and Limitations of the Current Study

To date, a small number of studies (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Sabik & Tylka, 2006; Thompson et al., 1999; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2004) have supported theoretical links between the internalisation of the objectified gaze and adverse well-being. Aside from extensive exploration of female objectification, body dissatisfaction and disordered eating behaviour within several contexts, a strength of the current study was the substantial variation in results across the different predictor variables. Each of the variables were

compared and contrasted, with some combinations indicating relatively stronger relationships than others. Some combinations revealed large differences between samples, particularly in relation to BMI level, age groups, and women identified as engaging in disturbed eating; whereas others showed much smaller differences and far weaker support for the hypotheses.

Given the complex interplay of biological, socio-cultural, and individual psychological factors in the aetiology and maintenance of disordered eating, comparative differences between results highlighted the importance of using a wide range of predictor and dependent variables. Had the study been limited to fewer predictor variables, a true representation of the factors modulating body objectification, body dissatisfaction and disturbed eating behaviour would not have been obtained, resulting in somewhat misleading and over-represented results.

Unlike the majority of studies who have typically measured eating disordered attitudes and behaviour within women aged 25 years and younger, the current study contributed to eating disorder literature by extending these findings to women aged 65 years, in an attempt to explore, compare and contrast levels of female objectification, body dissatisfaction, and disordered eating across 3 generations. While it was intended to observe women's relationships with their bodies over 3 different age groups, the study was limited with regard to a discrepancy in sample size across each of the age groups, in particular, low representation of older-aged women. For this reason, results contrasted with age should be treated with caution.

The study was further limited with regard to recruitment of the sample. Recruitment was typically a means of convenience sampling, whereby advertisements were placed within the university (Victoria University) via flyers and the university website, as well as distribution among local gyms, leisure centres, friends, and word-of-mouth. While the study had a very strong response rate of 97.5% (250 distributed; 211 returned; 209 completed with no missing data), it is expected that a large proportion of the responses were received from undergraduate university students. Despite the university being located within the Western suburbs of Melbourne, typically a low-medium socioeconomic area, it cannot be assumed that all of the students attending the university live within the Western suburbs.

There are likely to be other factors that moderate the effects of age and BMI on body dissatisfaction which were not accounted for by the study. Unlike previous studies which have commonly measured socioeconomic status against the prevalence

of disordered eating, socioeconomic status was not considered within the current sample. Since higher socioeconomic areas have typically identified a higher incidence of women with body objectification and disordered eating behaviour, it could be argued that the current sample may have identified a greater number of women who engage in disturbed eating behaviour if the study was conducted at a university within a higher socioeconomic area. Similarly, race and cultural differences, as well as level of education, were not accounted for. Given the venues and locality of questionnaire distribution, it could be expected that the recruitment of older-aged women would be low. In order to gain higher participation of older-aged women, future studies should re-evaluate advertisement localities to incorporate a more consistent age range in responses. Factors such as socioeconomic status, level of education, and cultural aspects should be considered in future research along with the effects of age and BMI on body dissatisfaction.

While each of the measures used within the questionnaire had good reliability and validity, it became apparent that the EAT-26, used to measure eating attitudes and behaviour, did not include an item to measure excessive exercise as a means of weight loss. Many women had reported binging behaviour yet did not respond to compensating binge-behaviour with laxative and/or vomiting; it is queried whether women used excessive exercise as a compensatory means yet were not given the opportunity to report this.

In addition, the EAT-26 failed to define the definition of a “binge”; it is assumed that one’s perception of binging may differ from another. It is suggested that further research clarify the definition of such behaviour to assist in the reliability of findings, and clarification for women. Finally, with regard to the final section of the EAT-26 which specifically measures eating disordered behaviour, the EAT-26 queried vomiting, laxative abuse and binge-eating behaviour, yet failed to consider restrictive eating patterns, and as previously mentioned, excessive exercise behaviour. This was specifically brought to the researcher’s attention when numerous women reporting poor body image had commented that they frequently engage in restrictive eating and/or excessive exercise patterns as a means of weight loss.

4.10. Conclusion and Future Directions

The results of the study support the primary hypothesis that women who had strongly based their identity according to societal values and expectations, and adopted a role of passivity and silence with regard to their perception of femininity

and gender role ideals, were more likely to experience higher levels of body dissatisfaction and were at greater risk of manifesting disordered eating behaviour.

The results of the current study suggest that body dissatisfaction was significantly predicted by a higher body mass index, conforming to feminine norms (importance of modesty), internalisation of socio-cultural attitudes towards appearance, silencing behaviour based on externalised perceptions from others, and body control as a result of body consciousness. The study introduced the concept of body dissatisfaction according to discrepancy between current weight and ideal weight. Consistent with previous findings, women within this sample, aged 18-65 years, reported a desire to weigh less than their current weight.

Future research may consider exploring realistic expectations in contrast to idealistic expectations around women's desired weight. Furthermore, consideration of the importance of adhering to feminine norms, fear of being judged by other women, and the internalising of socio-cultural attitudes towards appearance in relation to heightened feelings of body dissatisfaction may be explored.

As found in the results section measuring BMI and age, women typically increase in weight with age, and subsequently, this may result in increased feelings of body dissatisfaction. Future studies need to consider women of various ages, particularly women experiencing changes to their bodies, such as pregnancy, menopause, and the aging process. Future directions may also consider exploring body dissatisfaction across a cross-cultural domain which may provide further insight into body dissatisfaction and appearance concerns within non-Western populations and ethnic minority groups, within Western societies.

Given that it would be virtually impossible to change the sociocultural attitude toward appearance on a macro-level, future directions may consider promoting "plus-size" models and realistic figures representative of the average-size population within the media. Children's fairytales, story books, and cartoons may consider revising the focus from "beautiful" characters, to characters being adored for other qualities, such as kind-heartedness, intelligence, personality, sense of humour, athleticism etc. Additionally, children's toys such as Barbie dolls, may consider realistic body proportions and less "perfect" features which are internalised by children as "normal" and desirable features. Schools may be encouraged to undertake an education program which critically analyses the media, such as learning about airbrushing, the

effectiveness of marketing and sales with body dissatisfaction, and learning to identify and accept realistic body images.

While only 14 women within the sample reported previous treatment for disordered eating, a further 84 women reported having engaged in at least one episode of uncontrolled binge eating, laxative/diuretic abuse, and/or vomiting as a means to control weight over the past six months. These findings were particularly alarming as it seems that disturbed eating behaviour has become somewhat normalised within a “non-clinical” population, and thus women have begun to resort to destructive means in order to achieve weight loss.

Disturbed eating behaviour was strongly predicted by internalisation of social attitudes toward appearance, body dissatisfaction, dieting behaviour, and bulimic traits/food preoccupation. Women, who engaged in greater body objectification (body surveillance and body shame), subsequently placed further importance on appearance and thinness, and had higher levels of disturbed eating behaviour in contrast to their counterparts; self-sacrificing (silencing) behaviour and poor sense of belongingness were also identified within this population group and raised concern for passivity and self-esteem as risk factors in the development of disordered eating. Future directions may consider targeting industries likely to encourage or promote body improvement, such as gyms and weight loss centres, to provide education around positive body image and safe weight loss as a means to discourage disordered eating behaviour.

Findings measuring silencing behaviour were similar to results of previous research (e.g., Ross & Wade, 2004; Smolak & Munstertieger, 2002) in that, women identified as having been previously treated for an eating disorder, continued to engage in greater silencing behaviour than women never treated for disordered eating. As a result of analysing silencing behaviour according to subgroups, it was determined that self-sacrificing behaviour held the strongest relationship with disturbed eating behaviour. Future research may consider exploring the relationship between self-sacrificing and sense of belongingness, given that self-sacrificing behaviour often suggests a low sense of self, worthlessness, and an undeserving position; all of which are often clinically observed in individuals with disordered eating.

As reported on the silencing of self scale, one hundred and eighty-nine women within the current study reported that they “strongly agreed” or “somewhat agreed” that they had never seemed to measure up to the standards set for themselves. This was further validated in the qualitative responses of the study which consisted of a negative, self-defeating, and derogative discourse; highlighting themes of passivity, helplessness, dependence on others, and abject failure. Future directions may consider exploring sense of self, body dissatisfaction, and the likelihood of disordered eating behaviour in greater detail, ascertaining whether there are any specific interaction effects between these variables. Realistic expectations could be explored from a qualitative perspective to ascertain whether these women are particularly critical of themselves in setting unrealistic and unachievable expectations which would inevitably set one up for failure and promote dissatisfaction.

Future studies may consider longitudinal research in preventative school programs such as self-esteem enhancement, identity development, coping strategies, assertiveness training, and positive body image programs. While preventative psychoeducation programs in disordered eating have proved relatively unsuccessful, more comprehensive programs are needed to educate children and adolescents on the risks of disturbed eating. Given the emergence and prevalence of disordered eating behaviour in adolescence, these preventative programs should target children and pre-pubescent adolescents to assist with physical body changes, individuation and identity issues, as well as peer-pressure concerns.

Anti-bullying and teasing policies should be reinforced throughout schools to foster an environment free from prejudice according to body shape, weight and physical appearance. Education in the identification of body image issues should be provided to teachers to assist in the identification of those children at risk of disturbed eating behaviour. Preventative programs should specifically target aesthetic (e.g., gymnastics, dance) and weight-dependent (e.g., ballet dance, jockey) sports where the prevalence of disturbed eating behaviour is greatest. Success should be promoted through achievement rather than through attractiveness, and education programs relating to the pressure for thinness in society should be provided to children and adolescents, as well as encouraging a critical analysis through analyzing television and magazines.

Sense of belongingness was introduced into this study in order to explore one’s perception of feeling accepted within friendships and society’s framework, and

whether this would contribute to a greater desire to “fit in” and possibly “remould” one’s appearance and/or body shape for social acceptance. The results of the study supported this subsidiary hypothesis as findings suggested that a poor sense of belongingness attributed to disturbed eating behaviour. Belonging to a cultural group that is accepting of a variety of body types would therefore serve as a protective factor for women particularly with a high BMI or those at risk of body dissatisfaction, in reducing the likelihood of disordered eating behaviour. Participation in a non-aesthetic or weight dependent sport was identified by Tiggemann (2001) as positive in identity development and body image. Tiggemann (2001) reported that girls who had participated in such sporting activities were less body dissatisfied, had greater self-esteem, and were more invested in sporting performance rather than attractiveness.

Positive parental relationships have been recognized by researchers as pertinent in the prevention of disordered eating given that poor maternal body image, conflicted family relationships, difficulty with individuation, and poor child assertiveness and coping strategies have been identified as familial risk factors. It is postulated that if body image, social pressures for thinness, coping resources, self esteem and identity concerns are targeted earlier within childhood and adolescence, body dissatisfaction would be reduced and less women would engage in disturbed eating behaviour throughout adulthood. This in turn, could reduce body image dissatisfaction being passed onto children of body image dissatisfied mothers, which have been identified as a risk factor in children with disordered eating.

All women within the current study engaged in body objectification and were aware of the socio-cultural attitudes towards appearance; women with a higher body mass index were identified as engaging in higher levels of body shame and attempts of body control. Similarly, obese women were identified as feeling most excluded and less belonging, highlighting fat oppression and the importance of thinness in cultural acceptance within Western society.

Given that the study predominantly measured predictive variables of body objectification, body dissatisfaction, disordered eating behaviour, and the relationships between these variables, it was unable to examine the interaction effects. It is advised that future research explore the interaction effects between these variables to ascertain the strength and impact of these variables on one another.

Overall, body dissatisfaction, objectified body consciousness, and disturbed eating behaviour were prevalent within women aged 18-65 years. While a desire for

thinness and attractiveness appears to be important for women throughout the lifespan and pertinent to one's identity, there was a shift in the value and commitment invested in its achievement across developmental life stages. Given that the qualitative data obtained within the current study provided further insight into women's thoughts and feelings toward their bodies, future studies may consider using qualitative research as a means to explore body dissatisfaction, body objectification and disordered eating behaviour from a higher level of understanding which cannot be captured through quantitative data alone.

Qualitative data in future research would allow for greater understanding of how and why there appears to be a shift in women's attitudes toward their bodies throughout their lifespan, as well as gain further insight into those women who infrequently engage in disordered eating traits (namely the "disturbed" eating group). In addition, qualitative data could assist in identifying specific protective factors which serve to protect those individuals who report body dissatisfaction yet fail to engage in disordered eating behaviour.

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