



Not hating what you see: Self-compassion may protect against negative mental health variables connected to self-objectification in college women



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ARTICLE INFO

Article history:

Received 25 September 2014

Received in revised form 20 February 2015

Accepted 23 February 2015

Keywords:

Objectification theory

Self-objectification

Self-compassion

College women

Negative eating attitudes

Depression

ABSTRACT

Self-objectification is related to maladaptive mental health variables, but little is known about what could ameliorate these associations. Self-compassion, a construct associated with mindfulness, involves taking a non-judgmental attitude toward the self. In this study, 306 college-aged women were recruited; those who were highest ($n = 106$) and lowest ($n = 104$) in self-compassion were retained for analyses. Levels of body surveillance, body shame, depression, and negative eating attitudes were lower in the high self-compassion group. Furthermore, the fit of a path model wherein body surveillance related to body shame, which, in turn, related to negative eating attitudes and depressive symptomatology was compared for each group, controlling for body mass index. The model fit significantly differently such that the connections between self-objectification and negative body and eating attitudes were weaker in the high self-compassion group. Treatment implications of self-compassion as a potential means to interrupt the self-objectification process are discussed.

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Introduction

Young women in Western society live in a world where their bodies are consistently examined and evaluated by others, and women are given the message that their bodies are a primary source of their value and worth (Fredrickson & Roberts, 1997; Moradi & Huang, 2008). One proposed consequence of this culture of objectification is that women learn to think about their bodies as objects rather than as active agents and start to view their bodies from an observer's perspective (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Noll & Fredrickson, 1998). This process is known as self-objectification, and one of the most common manifestations of self-objectification is body surveillance wherein women view themselves from a third-person perspective and habitually monitor their bodies (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Moradi & Huang, 2008; Vandenbosch & Eggermont, 2012). When women survey their bodies from an outsider's perspective, they frequently discover that their bodies fail to meet social standards

of beauty and thinness and are likely to experience body shame (McKinley & Hyde, 1996; Moradi & Huang, 2008).

Theoretically, self-objectification has been linked to a number of negative clinical variables, most notably eating disorders and depression (Fredrickson & Roberts, 1997; Moradi & Huang, 2008). Habitual body monitoring, or body surveillance, has been linked to higher depression (Muehlenkamp & Saris-Baglama, 2002; Peat & Muehlenkamp, 2011; Szymanski & Henning, 2007) and negative attitudes about eating or symptoms of eating disorders (Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Peat & Muehlenkamp, 2011; Tylka & Hill, 2004). Most studies have found that the relationships between body surveillance and depressive and disordered eating symptomatology are mediated by the experience of body shame (Moradi, Dirks, & Matteson, 2005; Szymanski & Henning, 2007; Tiggemann & Kuring, 2004; Tiggemann & Williams, 2012; Tylka & Hill, 2004). However, research has also suggested that habitually monitoring the body is directly related to negative eating attitudes (Miles-McLean, Liss, & Erchull, 2014; Tolaymat & Moradi, 2011).

Women, especially those who live in Western cultures, live in an environment in which objectification is rampant, and consequently, the experience of body surveillance, or habitual body monitoring, is extremely common (Moradi & Huang, 2008; Szymanski, Moffitt, & Carr, 2011; Tiggemann & Lynch, 2001). Although there has been considerable research investigating

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variables related to self-objectification, particularly when operationalized as body surveillance, there is less understood about variables that may interrupt, or moderate, the self-objectification process. Given the clinical symptomatology associated with engaging in body surveillance, it is important to understand personality variables that may serve as protective factors that would mitigate the clinical symptomatology related to engaging in it.

To date, attempts to find variables that moderate the clinical symptomatology related to the objectification process have been largely unsuccessful. One study attempted to determine whether coping strategies such as appearance-fixing or rational acceptance coping would moderate any links in the chain from being appearance-focused to experiencing body shame to clinical symptomatology (Choma, Shove, Busseri, Sadava, & Hosker, 2009). However, this study failed to find evidence of moderation. Nevertheless, a characteristic that could attenuate maladaptive symptomatology linked to self-objectification would be useful in a clinical context, especially if it is a characteristic that could be shifted in response to an intervention. Since the clinical symptomatology associated with objectification and self-objectification are proposed to stem from a sense that one is not living up to an external standard, and thus, that one is not good enough, a promising variable that may ameliorate the clinical symptomatology associated with self-objectification is self-compassion. Indeed, patients with eating disorders who had greater increases in self-compassion early in treatment had faster decreases in eating disorder-related outcomes over the 12-week study period (Kelly, Carter, & Borairi, 2014). Furthermore, self-compassion is particularly promising as a moderator for investigation as increases in self-compassion and decreases in body shame and dissatisfaction have been found in response to compassion-based meditation interventions (e.g., Albertson, Neff, & Dill-Shackleford, 2014).

Self-compassion is related to mindfulness, a construct that stems from a Buddhist philosophy that emphasizes a nonjudgmental attitude toward the self (Bishop et al., 2004; Coffey, Hartman, & Fredrickson, 2010; Neff, 2011). Compassion soothes the self in times of stress and shame (Gilbert, 2009). Self-compassion has been found to be distinguishable from self-esteem in that it does not involve a need to compare oneself to others in order to feel good about the self (Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007) and, unlike self-esteem, is not related to narcissism (Neff & Vonk, 2009). Thus, while self-esteem may be contingent on feeling as though one meets external standards, such as appearance standards (Crocker, Luhtanen, Cooper, & Bouvrette, 2003), self-compassion involves kindness and love for oneself in a non-contingent and unconditional way (Neff & Vonk, 2009). Thus, self-compassion may interrupt the process through which body surveillance translates into body shame, negative eating attitudes, and depression. Even if a woman monitors and notices how her body looks, if she has an attitude of self-compassion, she is probably less likely to negatively judge and evaluate what she sees and be more likely to respect and appreciate her body for what it is and what it does (Stewart, 2004).

Much research has linked self-compassion to positive mental health outcomes. Self-compassion has been linked to lower depression, stress, and anxiety (Hall, Row, Wuensch, & Godley, 2013; MacBeth & Gumley, 2012; Neff, 2003) as well variables associated with positive psychology such as optimism and well-being (Neff, Rude, et al., 2007). A central protective feature of self-compassion is that it equips one to treat oneself with kindness versus self-criticism in a situation that may induce shame. One study took people prone to experiencing shame, asked them to write about a shameful memory, and instructed them to either take a self-compassionate attitude or simply to write about their deepest feelings (Johnson & O'Brien, 2013). Those instructed to take a self-compassionate attitude toward the event reported less depression,

shame, and rumination on a follow-up assessment than did those in the control group who were writing about their deepest feelings.

Given that the body is a central part of the self that is often the subject of negative thoughts and evaluation, particularly for women (Fredrickson & Roberts, 1997), research has begun to focus on the role of self-compassion in ameliorating body image disturbance and eating pathology. In a study of undergraduates, self-compassion was related to greater body image acceptance as well as to lower levels of weight concern and fewer dysfunctional attitudes about eating (Prowse, Bore, & Dyer, 2013). Self-compassion has also been found to be related to lower binge eating severity (Webb & Forman, 2013) as well as to a greater likelihood of engaging in intuitive eating, which is the ability to give oneself permission to eat when hungry and to eat in response to physical, as opposed to emotional, cues (Schoenfeld & Webb, 2013). Self-compassion has been linked to lower levels of body surveillance and body shame (Daye, Webb, & Jafari, 2014; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011) indicating that it may interfere with the process of self-objectification.

Self-compassion may interrupt the process wherein negative thoughts about the body lead to negative consequences. In one study, self-compassion was found to mediate the relationship between a sense of shame and the drive for thinness in both a sample of women with eating disorders and a sample from the general population (Ferreira, Pinto-Gouveia, & Duarte, 2013). Self-compassion has also been found to partially mediate the relationship between body dissatisfaction and depression (Wasylikiw, MacKinnon, & MacLellan, 2012). However, self-compassion may be better understood as a moderator, lessening the relationship between mental health risks or unhealthy attitudes and clinical symptomatology. The moderating role of self-compassion has been investigated, and one study that found that self-compassion moderated the relationship between rumination and stress (Samaie & Farahani, 2011). Another study found that self-compassion moderated the relationship between personality variables known to be precursors of depression (e.g., self-criticism) and the experience of depression (Wong & Mak, 2013).

Self-compassion has, in fact, recently been identified a moderator in the context of body image disturbance and the experience of self-objectification. One study found that self-compassion moderated the relationship between body mass index (BMI) and eating disorder pathology such that women with both high BMI and high self-compassion had lower levels of eating disorder pathology as compared to women with high BMI and low self-compassion (Kelly, Vimalakanthan & Miller, 2014). Furthermore, another study found that self-compassion moderated the relationship between recalling critical or restrictive comments about eating from one's parents and the experience of body surveillance and body shame (Daye et al., 2014).

We aimed to expand on this research with the current study by identifying whether self-compassion would act as moderator working to attenuate the relationships between self-objectification and its theorized negative outcomes (i.e., body shame, disordered eating attitudes, and depressive symptoms). In order to investigate these potential relationships, we felt it was important to work with two distinct samples of young adult women: one who scored distinctly high in self-compassion and another who scored distinctly low in self-compassion. Given this, after data collection was completed, we performed a tertiary split on self-compassion scores so that we could isolate distinct samples of women high and low on this construct. Subsequently, all analyses were performed on these sub-samples of participants so that differences could clearly be seen.

We had a number of specific hypotheses. First, we anticipated that women with higher levels of self-compassion would have lower levels of body surveillance, body shame, negative

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