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Exploring the integration of thin-ideal internalization and self-objectification in the prevention of eating disorders

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ABSTRACT

Analyses of thin-ideal internalization and self-objectification were conducted within the context of a cognitive dissonance based eating disorder prevention program implemented in an undergraduate sorority. Participants completed self-report assessments at baseline ($n = 177$), post-intervention ($n = 169$), 5-month ($n = 159$), and 1-year follow-up ($n = 105$). Cross-sectional path analysis indicated that thin-ideal internalization and self-objectification predict each other and both predict body dissatisfaction, which in turn, predicts eating disorder symptoms. A longitudinal examination conducted using hierarchical linear modeling indicated that participants showed significant reductions in thin-ideal internalization, self-objectification, body dissatisfaction, and eating disorder symptoms after participating in the prevention program. Reductions of symptoms were maintained 1-year post-intervention, with the exception of self-objectification, which was significantly reduced up to 5-months post-intervention. Collectively, results suggest that targeting both thin-ideal internalization and self-objectification simultaneously within eating disorder prevention programs could increase the reduction of eating disorder symptoms.

Introduction

The majority of women in today's society are dissatisfied with their bodies, placing them at greater risk for developing eating disorders (Polivy & Herman, 2002). Body dissatisfaction has been associated with a number of negative psychological consequences, highlighting the importance of understanding the process by which women come to be dissatisfied with their bodies. Relevant to this study, there are two empirically supported sociocultural models that address this process. One of these models, outlined by self-objectification theory, indicates that self-objectification predicts body dissatisfaction and disordered eating (Noll & Fredrickson, 1998), while the other, the dual pathway model, indicates that thin-ideal internalization predicts body dissatisfaction and disordered eating (Stice, 1994). Since both models have extensive empirical support (Calogero, 2009; Greenleaf & McGreer, 2006; Prichard & Tiggemann, 2005; Stice, 2001; Stice & Agras, 1998; Stice, Nemeroff, & Shaw, 1996; Stice, Shaw, Margolis, & Flick, 1996; Tiggemann & Slater, 2001) and self-objectification and thin-ideal internalization have been found to predict body dissatisfaction and eating disorder symptoms separately (Noll & Fredrickson, 1998; Stice, 1994), it is important to explore how these theoretical models can potentially be integrated. Therefore, the current study examined the integration of self-objectification and thin-ideal internalization in predicting body dissatisfaction and eating disorder symptoms. Additionally, the current study examined the effects of a cognitive dissonance based eating disorder prevention program on thin-ideal internalization and self-objectification over time.

Objectification theory, proposed by Fredrickson and Roberts (1997), posits that women frequently experience sexual objectification, in which they are treated or regarded as an object by others. This regular exposure to objectifying experiences socializes girls and women to engage in self-objectification as a result of internalizing an outside viewer's perspective of their bodies. Self-objectification is characterized as regarding oneself as an object or collection of body parts (Fredrickson & Roberts, 1997), and is manifested by the habitual monitoring of one's physical appearance known as self-surveillance (McKinley & Hyde, 1996). This constant monitoring of appearance often leads to appearance anxiety, lower internal bodily awareness, body dissatisfaction, and body shame, which contribute to psychological disorders such as sexual dysfunction, depression, and eating disorders (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996).

Several studies have supported the relationship between self-objectification and body dissatisfaction and disordered eating (Greenleaf, 2005; Grippo & Hill, 2008; McKinley, 2004; Tiggemann & Lynch, 2001; Tylka & Hill, 2004). Noll and Fredrickson (1998) examined a sociocultural model of self-objectification and found that self-objectification predicts both body shame and eating disorder symptoms, and body shame also predicts eating disorder symptoms. These findings have been replicated by other

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researchers (Calogero, 2009; Greenleaf & McGreer, 2006; Hurt et al., 2007; Muehlenkamp & Saris-Baglama, 2002; Prichard & Tiggemann, 2005; Tiggemann & Slater, 2001) including experimental studies where self-objectification was induced (Morry & Staska, 2001), in populations of women 18–68 years old (Augustus-Horvath & Tylka, 2009), adolescent girls (Slater & Tiggemann, 2002), men (Calogero & Thompson, 2009), homosexual women (Haines et al., 2008), and a sample of women from Ireland (Morrison & Sheahan, 2009). Interestingly, a longitudinal investigation of this model of self-objectification in a population of undergraduate sorority women indicated that while this relationship was replicated cross-sectionally using the data from the initial assessment, longitudinally, body shame did not mediate the relationship between self-objectification and eating disorder symptoms (Rolnik, Engeln-Maddox, & Miller, 2010).

Thin-ideal internalization has also been found to be a significant risk factor for body dissatisfaction and disordered eating (Stice, 1994, 2001; Thompson & Stice, 2001). Thin-ideal internalization, or the extent to which an individual adopts socially defined ideals of attractiveness as part of their own beliefs (Thompson & Stice, 2001), occurs as a result of social pressures to attain a lean figure placed on individuals by the media, family, peers, and interpersonal encounters (Stice & Shaw, 1994). However, this ideal body type proposed by society is unattainable for most individuals (Cusumano & Thompson, 1997), commonly resulting in body dissatisfaction and body shame (Heinberg & Thompson, 1995), which then leads to unhealthy eating practices and disordered eating to attain this body type (Agliata & Tantleff-Dunn, 2004; Moradi & Subich, 2002; Stormer & Thompson, 1995).

The dual pathway model, developed by Stice (1994), hypothesizes that thin-ideal internalization predicts body dissatisfaction, and the relationship between body dissatisfaction and eating disorder symptoms is mediated by restrained eating and negative affect. Research has supported the dual pathway model cross-sectionally (Stice, Nemeroff, et al., 1996; Stice, Ziemba, et al., 1996) and longitudinally (Stice, 2001; Stice & Agras, 1998; Stice, Shaw, & Nemeroff, 1998); with one longitudinal study indicating that the model prospectively predicted the development of eating disorder symptoms in a sample of adolescent females (Stice et al., 1998). Cognitive dissonance based eating disorder prevention programs have been developed based on the dual pathway model (Stice, Mazotti, Weibel, & Agras, 2000), with research on these prevention programs providing further support for this sociocultural model (Stice, Chase, Stormer, & Appel, 2001; Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice, Ng, & Shaw, 2010; Stice & Shaw, 2004; Stice, Shaw, Burton, & Wade, 2006).

Although extensive empirical evidence supports both self-objectification and thin-ideal internalization as predictors of the development of body dissatisfaction and eating disorder symptoms, a limited number of studies have simultaneously investigated self-objectification and thin-ideal internalization. In one study, Morry and Staska (2001) found that for women, exposure to beauty magazines predicted self-objectification and eating disorder symptoms and that this relationship was mediated by thin-ideal internalization. For men, exposure to fitness magazines predicted thin-ideal internalization which then predicted self-objectification. Moradi, Dirks, and Matteson (2005), expanded upon Morry and Staska's study by examining links between sexual objectification experiences, thin-ideal internalization, body shame, eating disorder symptoms, and self-objectification. These authors found that sexual objectification experiences predicted thin-ideal internalization and self-objectification, thin-ideal internalization predicted self-objectification, body shame, and eating disorder symptoms, self-objectification predicted body shame and eating disorder symptoms, and body shame predicted eating disorder symptoms. These findings have been generalized to women suffering from eating disorders (Calogero, Davis, & Thompson, 2005), and a sample of undergraduate and community women in Ireland (Morrison & Sheahan, 2009). Cumulatively, the evidence from these studies suggests that thin-ideal internalization predicts self-objectification, which in turn predicts body dissatisfaction and eating disorder symptoms. However, the research to date has not examined other possible directionality between thin-ideal internalization and self-objectification.

Theoretically, thin-ideal internalization would commonly precede self-objectification, as societal pressures to attain the thin-ideal lead to thin-ideal internalization (Stice & Shaw, 1994), which could in turn lead to the habitual monitoring of appearance that is characteristic of self-objectification as a way of critically examining one's figure to determine if they are meeting societal standards of thinness. However, it is plausible that the habitual monitoring of one's body and appearance that is characteristic of self-objectification (Noll & Fredrickson, 1998) may lead individuals to internalize the thin-ideal and be more likely to attempt to attain this body type. This may occur because as individuals engage in self-objectification and self-surveillance, they may spend more time evaluating their own physical appearance and specific body parts and comparing themselves to others, which could then lead them to engage in thin-ideal internalization. Additionally, both thin-ideal internalization and self-objectification occur as a result of socialization experiences which encourage girls and women to value physical appearance over competence and attempt to attain the thin-ideal body type proposed by society, and both of these variables in turn predict a number of negative consequences including body dissatisfaction and eating disorder symptoms. The similarities between these constructs and their underlying theories suggest that the two variables could be related in ways that have not yet been explored, but could be valuable information for researchers in a number of contexts including eating disorder prevention.

To expand upon existing literature, the current study examined structural models of the relationship between thin-ideal internalization and self-objectification using cross-sectional data. First, a model consistent with previous research was explored, with thin-ideal internalization predicting self-objectification (Moradi et al., 2005; Morry & Staska, 2001). In order to determine if the reverse relationship between self-objectification and thin-ideal internalization was significant, exploration of a second model was then conducted with self-objectification preceding thin-ideal internalization. In addition to the paths explored between self-objectification and thin-ideal internalization, both models contained pathways consistently found in previous research hypothesizing that both self-objectification and thin-ideal internalization would predict both body dissatisfaction (Daubenmier, 2005; Strelan & Hargreaves, 2005) and eating disorder symptoms (Calogero, 2009; Tylka & Hill, 2004), and body dissatisfaction would predict eating disorder symptoms (Hrabosky & Grilo, 2007; Stice, 2002).

The current study also examined the influence of a cognitive dissonance eating disorder prevention program on self-objectification and thin ideal internalization longitudinally. Cognitive dissonance based prevention programs focus on creating cognitive dissonance (Festinger, 1957), a form of psychological discomfort that motivates individuals to change in order to restore internal consistency. Since most cognitive dissonance eating disorder prevention programs are based on the dual pathway model, the majority of these programs attempt to create cognitive dissonance about the thin-ideal, as it occurs early in the causal chain in the development of eating disorder symptoms (Stice et al., 2006). Once participants engage in a series of verbal, written, and behavioral activities in which they critique the thin-ideal proposed by society and voluntarily take a stance against it, they are more likely become faced with an internal conflict between their own acceptance of the thin-ideal and the arguments they generated to counter the pressures