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Objectified body consciousness in relation to recovery from an eating disorder ☆

Ellen E. Fitzsimmons-Craft, Anna M. Bardone-Cone *, Kathleen A. Kelly

University of North Carolina at Chapel Hill, Department of Psychology, CB#3270-Davie Hall, Chapel Hill, NC 27599, United States

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ABSTRACT

In Western society, the feminine body has been positioned as an object to be looked at and sexually gazed upon; thus, females often learn to view themselves as objects to be observed (i.e., objectified body consciousness (OBC)). This study examined the relation between OBC and eating disorder recovery by comparing its components across non-eating disorder controls, fully recovered, partially recovered, and active eating disorder cases. Results revealed that non-eating disorder controls and fully recovered individuals had similarly low levels of two components of OBC, body surveillance and body shame. Partially recovered individuals looked more similar to those with an active eating disorder on these constructs. The third component of OBC, control beliefs, and a conceptually similar construct, weight/shape self-efficacy, did not differ across groups. Results provide support for the importance of measuring aspects of self-objectification, particularly body surveillance and body shame, across the course of an eating disorder.

1. Introduction

Objectification theory holds that in Western society, women internalize the societal message that their bodies are objects, valuable as something to be gazed upon or used by others, and learn to view themselves as objects to be looked at (Fredrickson & Roberts, 1997). A woman in American society may feel as if her "sexual parts or functions are separated out from her, reduced to the status of mere instruments, or else regarded as if they were capable of representing her" (Bartky, 1990, p. 35). Further, this message communicates that there is a certain form that a woman's body should take as object: thin (McKinley & Hyde, 1996). This adoption of the outsider's perspective of one's own body is known as objectified body consciousness (OBC), which consists of three components: body surveillance, body shame, and control beliefs (McKinley & Hyde, 1996), and has been associated with a number of negative consequences including depression, anxiety, decreased well-being, body dissatisfaction, and disordered eating (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Mercurio & Landry, 2008; Miner-Rubino, Twenge, & Fredrickson, 2002; Noll & Fredrickson, 1998; Tylka & Hill, 2004).

Because OBC can negatively impact body image (e.g., Harper & Tiggemann, 2008) and lead to eating disorder symptomatology (e.g., Noll & Fredrickson, 1998), elevated levels of self-objectification among those in the process of recovering from an eating disorder could worsen prognosis or increase risk for relapse. Relatedly, it may be that attaining levels of self-objectification similar to those of controls with no history of an eating disorder is essential to reaching *full* eating disorder recovery. The current study seeks to understand how the various components of OBC (body surveillance, body shame, and control beliefs) compare across different stages of an eating disorder.

The body surveillance component of OBC involves continual self-monitoring of body shape and weight in order to ensure conformity to culturally and socially imposed standards of beauty (McKinley & Hyde, 1996). This self-monitoring emerges from having internalized cultural standards of the ideal body and the observer's perspective of oneself as an object to be gazed upon (Fredrickson & Roberts, 1997). Indeed, research has indicated that body surveillance is the behavioral manifestation of self-objectification; that is, if a woman has internalized the observer's perspective of her own body, she will engage in persistent body surveillance or monitoring (e.g., Moradi, 2010, 2011). While it theoretically could be implemented in a neutral way as a means to check whether one is attaining an appearance standard, the reality is that most women will come to recognize that their bodies are far from the unattainable cultural body standard, and as a result, may experience body dissatisfaction and adopt unhealthy or disordered eating patterns (McKinley & Hyde, 1996). As previously suggested, body surveillance may also contribute to the

☆ The authors note that findings regarding the Body Shame subscale of the Objectified Body Consciousness Scale were previously published in Bardone-Cone et al. (2010) as a way to validate a new definition of eating disorder recovery; however, the authors believed it to be important to report the body shame findings again here in an effort to provide the reader with a more complete picture of what the components of objectified body consciousness look like in relation to recovery from an eating disorder. This is the first piece of work to focus on the full set of constructs related to objectified body consciousness in relation to eating disorder recovery.

* Corresponding author. Tel.: +1 919 962 5989; fax: +1 919 962 2537.
E-mail addresses: fitzsimmonscraft@unc.edu (E.E. Fitzsimmons-Craft), bardonecone@unc.edu (A.M. Bardone-Cone), kakelly@email.unc.edu (K.A. Kelly).

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maintenance of an eating disorder or increase risk for relapse among individuals recovered from an eating disorder.

The impossibly thin cultural ideal that many women in Western society strive for creates a discrepancy between the perception of the real self and the desired self, which can produce body shame, the affective component of OBC (Harrison, 2001; McKinley & Hyde, 1996). As conceptualized by objectification researchers, body shame stems from a sense of failure and wrongdoing, and it extends beyond just negative attitudes about one's body to negative attitudes about oneself (McKinley & Hyde, 1996; Noll & Fredrickson, 1998). Further, this shame stems from a sense of "exposure" (e.g., being exposed as one who does not live up to cultural standards) and is typically coupled with feelings of inferiority and defectiveness (McFarland & Baker-Baumann, 1990). The more women self-objectify and internalize the thin ideal, the more likely they are to experience body shame and negative affect (Myers & Crowther, 2007), which may in turn lead to unhealthy eating patterns (Fredrickson & Roberts, 1997).

The third component of OBC, control beliefs, refers to the belief that one has the ability to control one's body and appearance through one's actions and that effort can override genetic influences on weight/shape (McKinley & Hyde, 1996). In contrast to body surveillance and body shame, this aspect of OBC is not as clearly related to disordered eating. While some studies have found that women who believe they can and should control their weight are more likely to have higher rates of body dissatisfaction and eating disorder symptomatology (e.g., Furnham & Atkins, 1997; Laliberte, Newton, McCabe, & Mills, 2007; McKinley, 1998), other research has found no connection between control beliefs and eating disorder symptomatology (e.g., Basow, Foran, & Bookwala, 2007; McKinley, 1999; Tylka, 2004). Due to the inconsistent, but largely null, findings regarding the relation between control beliefs and eating disorder symptoms, we also examined another construct that is conceptually similar to control beliefs: weight/shape self-efficacy, which assesses confidence related to being able to attain one's desired weight/shape.

Research has shown that both body surveillance (the indicator of self-objectification) and body shame are strong correlates of eating disordered behavior (e.g., Calogero, Davis, & Thompson, 2005; Greenleaf, 2005; McKinley, 1999; Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Striegel-Moore & Bulik, 2007; Tiggemann & Slater, 2001). In the one known study that has investigated self-objectification among women with diagnosable eating disorders, results indicated that self-objectification partially mediated the relation between thin ideal internalization and drive for thinness and that body shame partially mediated the relation between self-objectification and drive for thinness (Calogero et al., 2005). However, what is not yet known is what these constructs related to OBC (as well as control beliefs and weight/shape self-efficacy) look like as an individual recovers from an eating disorder. Because OBC can negatively impact body image (e.g., Harper & Tiggemann, 2008) and because it is associated with eating disorder symptomatology (e.g., Noll & Fredrickson, 1998), it is important to understand exactly what these constructs look like as individuals recover from an eating disorder. Further, as noted by Calogero et al. (2005), "when women continue to view themselves from a third person, rather than a first person, perspective, factors that contribute significantly to eating disorders pathology remain untouched" (p. 48). That is, unless this socially constructed perception of the self is challenged, progress in other areas (e.g., eating patterns, family dynamics) may be difficult, as well. The present study answers the call of Calogero et al. (2005) for self-objectification to be examined in relation to recovery from an eating disorder.

As suggested by Calogero et al. (2005), it may be that high levels of self-objectification help maintain individuals in an incomplete state of recovery because they still perceive themselves in this socially constructed manner and that *full recovery* is more closely linked with obtaining levels of body surveillance and body shame (and potentially control beliefs and weight/shape self-efficacy) similar to those of non-eating disorder controls. Thus, in this study, we chose to examine the aspects of OBC across stages of eating disorder recovery, with particular interest in the self-reported levels of these constructs among those with evidence for being fully recovered according to physical, behavioral, and psychological indices (Bardone-Cone et al., 2010). Those fully recovered were compared to individuals currently diagnosed with an eating disorder, individuals partially recovered (physically and behaviorally recovered, but not psychologically recovered — e.g., still thinking a great deal about food), and a non-eating disorder control group. We hypothesized that individuals who were fully recovered would report less body surveillance and body shame than either those who were partially recovered or those who met criteria for an active eating disorder, and that their levels of these constructs would be comparable to non-eating disorder controls. Given the largely null findings regarding the relation between control beliefs and eating disorder symptomatology, we hypothesized that neither control beliefs nor weight/shape self-efficacy would differ across the groups. To our knowledge, this is the first study to comprehensively focus on examining OBC as it relates to recovery from an eating disorder.

2. Method

2.1. Participants and recruitment

Attempts were made to contact all female eating disorder patients (ages 16 and older) seen at the University of Missouri Pediatric and Adolescent Specialty Clinic ($n = 273$) between 1996 and 2007. This clinic is a primary care and referral clinic specializing in the care of children and adolescents (ages 10–25 years) that has physicians with expertise in eating disorders. Patients identified as having an eating disorder were sent a mailing to their address on file (or to updated addresses found on public registries or via paid tracking services) describing the study and inviting their participation by calling the second author. If no response was received, a second mailing went out, followed by several attempts by the second author to reach the patients by phone.

Of the 273 eating disorder patients identified, 96 (35.2%) were successfully contacted and recruited. Fifty-five (20.1%) of the 273 were contacted but did not participate due to other time commitments or lack of interest. Of the remaining patients, four (1.5%) were deceased and 118 patients (43.2%) could not be contacted due to absent or incorrect mailing addresses or inability to make phone contact. These rates are fairly comparable to those of other studies doing a first follow-up of eating disorder patients over a range of about 10 years (Reas, Williamson, Martin, & Zucker, 2000; Yackobovitch-Gavan et al., 2009), and results indicated that participants were not significantly different from non-participants on clinical variables such as eating disorder diagnoses, age, or BMI at first clinic visit. In sum, of the 151 eating disorder patients we were able to contact, 96 (64%) participated. Non-eating disorder controls were recruited from two sources: the clinic from which the eating disorder patients were recruited ($n = 17$) and introductory psychology courses on the university campus ($n = 50$) (i.e., total number of control participants = 67). Of note, the controls recruited from the clinic simply had a primary care physician at the clinic and would visit the clinic for minor medical problems (e.g., the flu). All eligible controls were females ages 16 and older with no current or past eating disorder symptoms.

Participants ranged in age from 16 to 40 years ($M = 21.78$ years, $SD = 4.28$), with most (91.6%) identifying as Caucasian, 1.3% as African American, 1.9% as Asian, and 5.0% as biracial/biethnic. In terms of socio-economic status, participants' highest level of parental education ranged from 11 to 21 years ($M = 16.60$ years, $SD = 2.73$, with 16 years of education corresponding to having graduated from a 4-year college). The groups were similar in terms of ethnicity and socio-economic status, but differed in age ($F(3, 151) = 15.44$, $p < .001$), with non-eating disorder controls significantly younger than the eating disorder groups (non-eating disorder controls: $M = 19.46$, $SD = 1.88$; fully recovered: