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PERFECTIONISM, THE THIN IDEAL, AND DISORDERED EATING: DOES INTERNALIZED MISOGYNY PLAY A ROLE?

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PERFECTIONISM, THE THIN IDEAL, AND DISORDERED EATING:
DOES INTERNALIZED MISOGYNY PLAY A ROLE?

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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ABSTRACT

Research has consistently shown a relationship between both perfectionism and the internalization of the thin ideal with disordered eating behavior. The relationship between internalized misogyny and disordered eating behavior has not been examined, though internalized misogyny has been shown to be associated with other correlates of disordered eating, including low self-esteem, negative body image, and self-objectification. The purpose of this research study is to determine whether internalized misogyny moderates the relationship between the internalization of the thin ideal and disordered eating behavior, when controlling for the influence of perfectionism. Participants were 318 females ranging in age from 18-64, and contacted via social media to complete an online survey. Hierarchical multiple regression analysis was utilized to examine internalized misogyny's role as a moderator in the relationship between the internalization of the thin ideal and disordered eating.

"Psychopathology is the final outcome of all that is wrong with a culture." Jules Henry

Introduction

Eating Disorders: Prevalence and Current Statistics

Current literature estimates that between 2 and 10 million people have clinically diagnosable eating disorders (Bordo, 2003; Miller-Day & Marks, 2006), a significant number by any standard of measurement. Experts conclude that between 1% and 3% of women suffer from eating disorders, and that prevalence rates for men are approximately one tenth of those for women (Evans et al., 2005). Given this large disparity, female gender has been cited as perhaps the most obvious and salient risk factor for developing an eating disorder (Evans et al., 2005). In agreement, Striegel-Moore and Bulik (2007) suggested, "the single best predictor of risk for developing an eating disorder is being female" (p. 182).

Eating disorders (ED) remain the most lethal of psychiatric disorders, with anorexia exhibiting the highest mortality rate of all mental disorders (Costin, 1997; Streigel-Moore & Bulik, 2007). Estimates are that somewhere between 5% and 10% of those affected by eating disorders eventually die of related causes (Steinhausen, 2002), and some research suggests this number may be closer to 20% if eventual suicide is a consideration (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). Additionally, these disorders are some of the most difficult to treat, as no form of psychotherapy or psychopharmacology has been proven efficacious in the treatment of Anorexia Nervosa (AN), and only minimal success has been established with treatments for Bulimia Nervosa (BN; Wilson, Grilo, & Vitousek, 2007). One of the most accepted risk factors for the treatment of AN is the duration of symptomatology, such that the

longer a patient has been restricting their food intake, the poorer their long-term prognosis for complete recovery (Eisler et al., 2000; Russell, Szmukler, Dare, & Eisler, 1987).

Longitudinal studies suggest that 14%-46% of those with partial syndrome eating disorders progress to full syndrome within 1-2 years (Shisslak, Crago, & Estes, 1995). Thus, early signs of disturbed eating attitudes may be potential predictors of more serious eating disturbances later in adolescence and young adulthood (Westerberg, Edlund, & Ghaderi, 2008). Furthermore, there is evidence that concerns about weight and shape regularly occur in girls as early as the third grade (Agras, Bryson, & Hammer, 2007), and that between 40% and 50% of girls age 7 to 11 years select a preferred or "ideal" body that is thinner than their own (Evans, Tovee, Boothroyd, & Drewett, 2012). Taken together, this data supports the importance of continued research on disordered eating, with an emphasis on early indicators and variables that may preclude, alter, or otherwise impact the development of a full-blown eating disorder. It follows that inquiry focused on disordered eating behaviors, not solely on clinically diagnosable eating disorders, is called for by an abundance of documented research evidence.

The growing number of eating disorders diagnosed and treated each year, and the poor prognosis for recovery (Miller, 2000), suggest that current research and training have not adequately prepared practitioners to understand, identify, and effectively treat such issues. The best current therapeutic practices display inadequate impact with regard to effective treatment of these problems. Much of the emphasis has been on the psychopathology of the individual, and considerable research has

focused on developmental factors that shape personality traits. Perfectionism is one personality trait that has been consistently linked to disordered eating in the research literature. *Perfectionism* is best understood as a series of distinguishing characteristics such as an overwhelming motivation to be perfect, a tendency to set and hold unrealistic standards, compulsive strivings, all-or-none thinking regarding success and failure, a neurotic obsession with flaws and past failures, and a desire for infallibility manifested in an intolerance for mistakes, as well as a perception of even minor mistakes as failures (Ferrari & Mautz, 1997; Hewitt & Genest, 1990; Sassaroli & Ruggiero, 2005). Multiple studies (e.g., Peck & Lightsey Jr., 2008; Boone, Soenens, & Braet, 2011) have identified this variable, considered a personality trait that can reach maladaptive proportions, as part of the psychological makeup of individuals who suffer from EDs.

The difficulty with treatment progress for EDs suggests that unidentified elements may be influential in the formation of eating disorders and the disordered eating patterns that lead to them, however. Thus, an important arena for current research involves a social psychological perspective that seeks to better understand the interplay between the psychology of the individual and their sociocultural context. In particular, psychologists and researchers could benefit from understanding how this context is interpreted and internalized for individuals who display eating disturbances, above and beyond the influence of personality-based psychopathology.

Further supporting the relevance of sociocultural context, it is well known and widely documented that most women in Westernized culture experience dissatisfaction with their bodies regardless of their actual weight, shape, or size

(Morrison & Sheahan, 2009). The link between the internalization of the Westernized thin ideal and disordered eating behavior has also been strongly supported in the literature (Bradford & Petrie, 2008; Stice, Spangler, & Agras, 2001; Stice, 2002). The internalization of the thin ideal is seen as the extent to which an individual "cognitively 'buys into' socially defined ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals" (Thompson & Stice, 2001, p. 55). However, not all women who internalize thin ideal messages and who are dissatisfied with their bodies develop disordered eating. Further research is still needed to examine the link between the thin ideal and disordered eating behavior and the factors that intensify, modify, or otherwise alter that relationship. In addition, it is important to continue to examine how Westernized cultural messages interact to impact women outside of the influence of individual personality traits, familial variables, and biological factors, which have received a lion's share of the attention in the literature to date.

Feminist theories provide an important avenue to deconstruct this relationship, since these inherently recognize the importance of the internalization of cultural messages and how they impact the experiences of individuals and their resulting behavior. Internalized misogyny is one such construct that may have an impact on how strongly the thin ideal becomes internalized and thus how intensely disordered eating manifests itself. *Misogyny* refers to the subordination or devaluation of women as a cultural practice that maintains the power of the dominant male group (Piggott, 2004). *Internalized misogyny* refers to the level of sexism and patriarchy that individuals take in and endorse. Internalized misogyny in women has been correlated

with lower self-esteem, negative body image, and depression, all of which have a strong relationship with disordered eating (Piggott, 2004; Szymanski and Kashubeck-West, 2008).

Internalized misogyny has not yet been examined in conjunction with the internalization of the thin ideal. Therefore, in the interest of expanding the current framework for understanding and treating eating disorders, this study seeks to examine whether internalized misogyny serves as a moderator in the relationship between the internalization of the thin ideal and disordered eating in a community sample of females when controlling for the influence of perfectionism.

Review of the Literature

Feminist Cultural Analyses and Disordered Eating

Hesse-Biber et al. (2006) suggested that we "neither negate nor dismiss the psychological aspects of Eating Disorders. Rather the focus is to *expand* the framework of causality to include 'culturally-induced' manifestations of these disorders" (p. 209). In the case of eating disorders, this focus has begun to involve an examination of the positive reinforcement of the thin body ideal in Westernized culture, and how this idealized body affects eating patterns (Bordo, 2003; Bradford & Petrie, 2008). Studies have shown that the internalization of the thin ideal is correlated with higher levels of disordered eating patterns in women and young girls (Bradford & Petrie, 2008; Stice, Spangler, & Agras, 2001; Stice, 2002).

Feminist theorists recognized the impact of culture on the individual when asserting that *The Personal is Political*. This is a central tenet that undergirds all feminist theoretical models, and as such is agreed upon as a fundamental guidepost for understanding that the experiences of individuals are fully embedded within – and thus reflective of – cultural context. Furthermore, feminist therapists recognize that intrapsychic symptoms and problems often arise as a response to surviving in and coping with oppressive circumstances (Enns, 2004).

Research has shown that a number of mental health disorders, including depression, anxiety, and eating disorders, are significantly more prevalent in women than men (Sabik & Tylka, 2006). While sociocultural context is acknowledged as a contributing factor in the development of disordered eating, treatment models generally do not fully address culture or feminist consciousness (Shisslak, Crago, &

Estes 1995; Sabik & Tylka, 2006). This is likely due, in part, to the complexity and invisibility of such variables, and the difficulty inherent in attempting to understand them.

A discussion regarding the cultural treatment of the body – and the female body in particular – seems essential when conceptualizing treatment approaches. Considering the examination of the influence of culture on women's experiences that feminist research and literature provides, and the reality that eating disorders are a primarily female phenomenon, feminist constructs and research may provide rich and important information in the continued discourse surrounding eating disorders.

Bordo (2003) has openly asserted the relationship between the power of patriarchy in our culture and the development of disordered eating in women. She calls the "relentless pursuit of excessive thinness…an attempt to embody certain values, to create a body that will speak for the self in a meaningful and powerful way" (p. 67). Bordo argued a type of internalized misogyny when she posited that:

> On the gender/power axis the female body appears, then, as the unknowing medium of the historical ebbs and flows of the fear of woman as 'too much.' That, as we have seen, is how the anorectic experiences her female, bodily self: as voracious, wanton, needful of forceful control by her male will. (p. 163)

In support of the importance of feminist consciousness, several research studies have identified that feminist identification may play a protective role against various types of disordered eating. Among adult women, Guille and Chrisler (1999)

found that higher levels of acceptance of traditional gender roles was positively correlated with compulsive eating, whereas higher levels of commitment to feminist activism was negatively correlated with compulsive eating. Identification with feminist values was negatively associated with bulimic symptomatology among college women in a study conducted by Snyder and Hasbrouk (1996). In a study looking at the moderator effects of feminist identity styles on disordered eating, Sabik and Tylka (2006) found that for women low in *Synthesis* (i.e., integration of a positive self-concept including positive attributes associated with women and transcendence of traditional gender roles) and *Active Commitment (*i.e., commitment to social change and the belief that men are equal to, but not the same as, women), perceived lifetime and recent sexist events were positively related to disordered eating, and for women high on both feminist identity styles, perceived lifetime and recent sexist events were not related to disordered eating. Synthesis and Acitve Commitment each also buffered the relationship between both perceived recent sexist events and perceived lifetime sexist events and disordered eating.

A recent study evaluated the roles of internalization of the thin ideal and feminist beliefs on (a) appearance-focused social comparisons and (b) body image disturbance, for undergraduate women (Myers, Ridolfi, Crowhter, & Ciesla, 2012). Myers et al. (2012) wanted to gather data on comparisons that occur in a naturalistic environment rather than a laboratory setting. They also sought to eliminate the bias that occurs with retrospective recall, and so utilized ecological momentary assessment (EMA) to gather samples with a PDA device at the moment they occurred in the environment. They found a strong association between what was termed *upward*

appearance focused comparisons (i.e., when women compare themselves to perceived superior targets) and body dissatisfaction for all women, but found that feminist beliefs offered some protection. Women high in feminist beliefs experienced significantly less state body dissatisfaction than women low in feminist beliefs, when making what was termed a *lateral comparison* (i.e. comparing themselves to a perceived similar target); and only women low in feminist beliefs engaged in greater body checking behavior in response to upward comparisons. Myers et al. stated that "[g]iven that body checking has been shown to be associated with eating disorder symptoms, these findings are cause for optimism, as upward comparisons are not associated with the behavioral component [body checking] for women with feminist beliefs" (p. 349). This evidence provides the groundwork for the argument that feminist beliefs may provide a protective barrier against disordered eating, and that feminist constructs are of value in the continued discourse around eating disorders.

Disordered Eating versus Eating Disordered

The classification system for eating disorders has placed the psychological community at odds with itself. Many support the usefulness of the diagnostic categories that are currently practiced, but others make a case for the establishment of new methods for categorizing these problems. *The Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (DSM-IV-TR; APA, 2000) formed the basis for the classification system that has been utilized in the treatment of mental health. However, in the case of eating disturbances, there is evidence that the *DSM-IV-TR* inadequately captured the reality with which we are faced. As a result, there has been recent intense debate within the discipline as to how best to classify individuals who

present for treatment with eating disordered behavior. In fact, the *DSM-V* (APA, 2013), published this year, contains massive restructuring of all the diagnostic categories related to eating disorders, reflecting the continued need for a better understanding of these issues in our field. Up until the recent DSM restructuring, the diagnostic categories were anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS). AN was marked by a refusal to maintain a body weight of at least 85% of what is expected for someone of the same height, while BN was characterized by recurrent episodes of binge eating followed by "compensatory" behavior such as vomiting, laxative or diuretic use, or compulsive exercise. Other diagnostic criteria within these two categories, such as the necessity for amenorrhea for a period of 3 months and body weight of less than 85% of a minimally normal weight for age and height to receive a diagnosis of AN, and the requirement that compensatory or purging behavior occur at least 2 times weekly for 3 months for a diagnosis of BN, caused the majority of individuals who presented with an eating disorder to be diagnosed EDNOS. This was due in part to the fact that the diagnostic criteria have been fairly narrow and specific in nature.

DSM-V (APA, 2013) has broadened and relaxed the criteria for both AN and BN in an attempt to remediate this issue. In addition, Binge Eating Disorder (BED) has been added as an official diagnostic category. These diagnostic categories now form a classification scheme that is mutually exclusive, and the stated rationale is that "despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs" (p. 329). According to the new criteria, intense fear of gaining weight and a disturbance in the

way body weight and shape are experienced are still markers of AN, but amenorrhea is no longer a requirement, and it is no longer a necessity that an individual's weight fall below 85% of what is minimally expected. Instead, an individual must be at what is termed *significantly low weight*, or a weight that is anything less than what is minimally normal or expected. For BN, compensatory behaviors now need only occur once per week for at least 3 months to receive a diagnosis. In addition, both AN and BN now include specifiers for partial and full remission.

In contrast, a growing body of research suggests that each classified disorder represents only one point on a continuum of disordered eating behaviors on which all women find themselves functioning (Bordo, 2003; Peck & Lightsey Jr., 2008; Tylka & Subich, 1999). Additionally, researchers who support this conceptualization purport that the continuum ranges from asymptomatic, through symptomatic, and finally to eating disordered at its most extreme, regardless of the specific ED behaviors exhibited (Tylka & Subich, 1999). They stress that only such a perspective adequately captures the full range of disturbed eating behaviors.

The continuum model of eating disordered behavior boasts convincing arguments in its favor. As previously mentioned, in the past the majority of patients diagnosed with an ED were given a diagnosis of Eating Disorder Not Otherwise Specified (EDNOS). This category, intended to be a residual diagnostic category, became the diagnosis for the majority of individuals seeking treatment (Peck & Lightsey Jr., 2008; Streigel-Moore & Bulik, 2007). This disconcerting reality caused psychologists and researchers to take notice of the problematic qualities of the current classification system. As Streigel-Moore and Bulik (2007) asserted, there are

"significant flaws in our nosology…[as] we have failed to characterize adequately the core pathology profiles that comprise the eating disorders" (p. 193).

Feminist theorists (e.g. Brown & Jasper, 1993; Bordo, 2003) have posited that only a matter of degree divides those women who diet, exercise, count calories, and focus on their weight and shape from those who exhibit full-fledged AN or BN. They argue that the diagnostic system pathologizes and our culture stigmatizes these disorders even while praising and approving of those women who display similar behaviors in an attempt to attain the culturally prescribed ideal body (Brown & Jasper, 1993). Data has also suggested that, for many women who struggle with a clinically diagnosable eating disorder at one discrete point, the diagnosis or the behavior profile is likely to change over a lifetime (Brown & Jasper, 1993). Brown & Jasper (1993) reminded us that "these shifts are not uncommon and suggest that the psychological underpinnings remain quite similar, regardless of what form the weight preoccupation takes" (p. 58).

Thus far, a great deal of research has focused on the diagnostic categories of Anorexia Nervosa and Bulimia Nervosa, within a medical model perspective that sees these disorders as categorically and fundamentally different. This has made these problems easier to study with randomized control clinical trials; however, the reality is that treatment methods are currently disappointing in their effectiveness, and this evidence suggests that researchers may be on the wrong track overall (Miller, 2000; Wilson, Grilo, & Vitousek, 2007). With this in mind, this study views disordered eating as a continuous variable, representing all types of pathological eating behavior, and not understood by binge/purge or restricting behavior specifically or categorically,

in an effort to explore variables that could impact treatment for those struggling with disordered eating.

Perfectionism and Disordered Eating

As previously discussed, *Perfectionism* is best understood as a series of distinguishing characteristics such as an overwhelming motivation to be perfect, a tendency to set and hold unrealistic standards, compulsive strivings, all-or-none thinking regarding success and failure, a neurotic obsession with flaws and past failures, and a desire for infallibility manifested in an intolerance for mistakes, as well as a perception of even minor mistakes as failures (Ferrari & Mautz, 1997; Hewitt & Genest, 1990; Sassaroli & Ruggiero, 2005). It is most often considered a personality style that can reach maladaptive proportions. Perfectionism has been linked with higher suicide rates, irrational black and white thinking, and rigid adherence to impossible standards for self and others (Ferrari & Mautz, 1997). Due to its strong association with disordered eating and eating disorders, perfectionism has been a focus of research attention for some time (e.g. Bardone-Cone et al., 2007; Davis, 1997; Davis, Claridge, & Fox, 2000; Hopkinson & Lock, 2004).

The research consensus is that perfectionism is considered one of the most predictable predisposing risk factors in the development of an eating disorder (McLaren, Gauvin & White, 2001; Ruggiero, Levi, Ciuna, & Sassaroli, 2003; Sassaroli & Ruggiero, 2005), and that perfectionism is a central feature of eating disorders (Davis, 1997; Davis, Claridge, & Fox, 2000). However, data assessing whether premorbid perfectionism predicts eating disorders is limited and exhibits significant limitations. A recent meta-analytic review of the literature regarding

perfectionism and eating disorders showed that most of the data used to assess this relationship has relied on retrospective recall rather than utilizing prospective longitudinal designs (Bardone-Cone et al. 2007), which begs the question as to whether perfectionism is a premorbid, predisposing risk factor for eating disorders or is a feature that develops alongside eating pathology.

Although perfectionism is one form of individual psychopathology that has been widely researched in conjunction with disordered eating, "[i]t is not clear….whether the general psychopathology associated with EDs is a cause, an effect, or a correlate of the ED itself" (Shisslak, Crago, & Estes, 1995). Only two known studies have assessed premorbid perfectionism with a longitudinal design prior to onset of an ED. In a study by Tyrka, Waldron, Graber, and Brooks-Gunn (2002), premorbid perfectionism was a significant prospective predictor of AN, but not BN. However, in a study by Santonastaso, Friederici, and Favaro (1999), premorbid perfectionism levels did not predict which adolescent girls subsequently developed either AN or BN.

Research has also explored the idea that perfectionism is a multidimensional personality trait, with several proposals for what dimensions make up the construct as a whole (Frost, Martin, Laharte, & Rosenblate, 1990; Hewitt & Flett, 1991). In the past decade, research has utilized these multidimensional conceptualizations to study perfectionism, and over time the suggestion of two main factors has emerged. Conceptually, these factors are marked by the idea that there is a more *neurotic* form of perfectionism, and a *normal* one (Bardone-Cone et al., 2007). In other words, the

newest conceptualization of perfectionism suggests that there are both adaptive and maladaptive dimensions of this construct.

Two dimensions that have recently been proposed and studied in conjunction with eating disorders are evaluative concerns (EC) perfectionism, comprising self-critical features, and personal standards (PS) perfectionism, which includes the setting of high standards for self (Boone, Soenens, & Braet, 2011). Findings have been mixed when studying these dimensions in relation to eating disorders, with some studies suggesting a differential role for PS and EC perfectionism in relation to ED symptoms (Boone, Soenens, & Braet, 2011), and others suggesting that there is not a clear distinction between the two in terms of ED symptoms (Bardone-Cone et al., 2007).

Bardone-Cone et al. (2007) reviewed the findings regarding the adaptive versus maladaptive multidimensional conceptualization of perfectionism with eating disorders, anxiety, and depression. They found that with other forms of psychopathology (e.g. anxiety, depression) only maladaptive forms of perfectionism were most consistently elevated, whereas within an eating disordered population both maladaptive perfectionism and dimensions that have historically been considered more adaptive (e.g. achievement striving) appeared to be elevated. The authors stated, "[t]his suggests that describing dimensions of perfectionism as positive/adaptive and negative/maladaptive may not be entirely accurate – eating disorders may be one context in which achievement striving ("adaptive") perfectionism is actually negative or maladaptive" (p. 398).

In summary, the literature suggests that the multidimensional idea of perfectionism may not necessarily hold in relation to eating disorders. Furthermore, though perfectionism has been suggested as a predisposing risk factor in the development of eating disorders, there is some disagreement as to the validity of this assertion. Research used to make this argument has relied mostly on self-report through retrospective recall (Bardone-Cone et al., 2007), and studies that have looked at the construct prospectively offer evidence that suggests perfectionism might not necessarily be the predisposing risk factor it has been assumed to be (e.g. Santonastaso, Friederici, & Favaro, 1999; Tyrka et al., 2002). Since perfectionism has so long been thought to be a part of the personality profile of individuals who develop eating disorders, research has assumed this understanding in many models that examine eating pathology. Research is needed that looks at the influence of predisposing cultural variables, such as thin ideal internalization and internalized misogyny, above and beyond the influence of individual personality-based constructs such as perfectionism that imply vulnerability to psychopathology.

The Thin Ideal and Disordered Eating

> In a culture obsessed with attaining the perfect physique, it is not surprising that…women in the United States often internalize ideal cultural representations of the female body and report feeling dissatisfied with their own bodies. Why do women internalize such unrealistic cultural ideals? (Greenleaf & McGreer, 2006, p. 187-188)

This question has plagued the research literature on eating disorders for some time. Feminist theorists have asserted that the social value of woman is in many ways

inseparable from her body, and that it tends to be connected to bearing children and satisfying others sexually (Brown & Jasper, 1993). Historically, there has been a shift from a feminine "ideal" that is more rounded and fertile-looking, to a more thin and muscular look that predominates today (Bordo, 2003). Following industrialization in Western society, a thinner body that symbolized "wealth, independence, freedom…[and] non-reproductive sexuality became valued" (Brown & Jasper, 1993, p. 19). Since body shape and size are connected to a woman's social value or currency in this symbolic way, feminists have argued that women learn to focus on and police their appearance in order to achieve social success (e.g. Bordo, 2003).

Experimental studies have uncovered a strong causal relationship between the preoccupation with a desire to be thin and bulimic symptoms (Groetz, Levine, & Murtten, 2002; Stice, 2002), and a controlled prevention study demonstrated that reducing the level of body dissatisfaction resulted in a reduction in bulimic symptoms (Taylor et al., 2006). Another experimental study found that when vulnerable adolescents were exposed to images of the cultural thin ideal, the exposure was associated with increased negative affect, increased pressure to be thin, and increased body dissatisfaction (Stice, Spangler, & Agras, 2001).

Studies examining the connection between eating disorders and internalized cultural attractiveness beliefs have commonly revealed a significant relationship (e.g. Bradford & Petrie, 2008; Groetz, Levine, & Murtten, 2002; McKnight Investigators, 2003; Stice, Spangler, & Agras, 2001; Stice, 2002). However, while there is evidence that a strong correlation exists, there are still many questions about the details of this relationship and the elements that influence it. The internalization of the thin ideal has

been defined as the extent to which an individual "cognitively 'buys into' socially defined ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals" (Thompson & Stice, 2001, p. 55). Awareness of the thin ideal and its internalization are considered related but distinct constructs, with thin-ideal internalization accounting for significant additional variance in body dissatisfaction and disordered eating above and beyond that explained by thin-ideal awareness (Heinberg, Thompson, & Stormer, 1995). Thus, there appears to be a distinction between the awareness of our culture's idealization of thinness and its actual adoption for women. Understanding this distinction requires both a look into developmental/psychodynamic theories of the individual, and a look at sociocultural theory.

Developmental/Psychodynamic Theory. The concept of internalization is central to developmental and psychodynamic theories, as these conceptualize it as being core to the psychological development of the individual. Object-Relations is one such theory, which posits that an individual takes in psychic representations of the *other,* eventually transforming these representations into a sense of being, or self (Cashdan, 1988). According to Object-Relations Theory, early relationships with primary caregivers provide the central components of this *self as other* internalization. Theorists also believe that internalizations change and mature, and that in addition to human-to-human internalizations, interactions from the environment also become an integral part of the self (Cashdan, 1988). The internalization of the thin ideal in Westernized society surely represents an example of this type of unconscious interplay between self and society. It is a cogent example of how such a societal code can

become integrated into the self in much the same way that one learns behaviors from a parent.

Sociocultural Theory and The Dual Pathway Model. It has been suggested that social psychology itself can be best understood as the study of socialization and its by-products (Lott, 1973). Broadly, this has been defined as "[h]ow people learn the beliefs and attitudes of their groups and how they internalize group expectations for their behavior" (Lott, 1973, p. 919). With regard to the internalization of the thin ideal specificially, modern sociocultural theories are most commonly used to explain the process by which children develop thoughts and feelings about their bodies, and the most often cited influences are parents, peers, and the mass media (Clark & Tiggemann, 2008; Lopez-Guimera, Levine, Sanchez-Carracedo, & Fauquet, 2010). In terms of disordered eating, the sociocultural model that has arguably received the most research focus and empirical support is the dual pathway model (Stice, 1994). The model was once used to describe the development of bulimic symptoms, but has now been applied to a variety of pathological behaviors around food. The dual pathway model posits that internalization of the thin ideal leads to body dissatisfaction and increased risk of disordered eating via dietary restraint or depression, which are considered two distinct pathways (Thompson & Stice, 2001). However, evidence for the dual pathway model is mixed, and recent research with adolescents and preadolescents has provided evidence for a more direct relationship, or link, between thin-ideal internalization and disordered eating attitudes, rather than through the body dissatisfaction-dietary restraint, or body dissatisfaction-depression pathways (Evans, et al, 2010).

In a recent study testing the dual-pathway sociocultural model with preadolescent girls ages 7 to 11, Evans, Tovee, Boothroyd, and Drewett (2010) found that the original model showed a poor fit to the data. Specifically, the path between dietary restraint and depression did not significantly contribute to the model; however, an additional direct path between thin ideal internalization and disordered eating attitudes showed significance and a better fit with the data. The authors hypothesized that there could be several reasons for this. They referred to the perceived social benefits of being thin that may become internalized along with the thin ideal, and they stated that these elements could conceivably motivate disordered eating in the absence of individual psychopathology (i.e. body dissatisfaction, dietary restraint, or depression). This is the only known study conducted with a preadolescent female population assessing the dual pathway model, and the findings raise notable questions as to the possibility of a direct relationship between the internalization of the thin ideal and disordered eating, perhaps prior to the development of any measureable individual psychopathology.

Other models have been proposed and have had limited research support, with a range of interesting findings that continue to highlight the importance of the internalization of the thin ideal. For example, Smolak and Levine (2001) proposed a model which hypothesized that media and peer influences would lead to a change in internal focus on weight and shape for children, and that this would ultimately lead to a change in body image. Clark and Tiggemann (2008) tested this hypothesis and found that the internalization of the thin ideal led 9-12 year-old girls to have a desire to be thinner, and to experience more negative feelings about their bodies in general.

This finding has been replicated with adult and adolescent females as well (Hargreaves & Tiggemann, 2002; Lavin & Cash, 2001).

Longitudinal Data. A landmark, long-term prospective study (McKnight Investigators, 2003) followed over 1,000 girls from grades 6 to 9 at sites in California and Arizona. This study produced compelling findings about the effects of the internalization of the thin ideal in this sample. For the California site, thin body preoccupation and social pressure to be thin clustered as one factor that predicted the onset of a full or partial eating disorder, with a large effect size of 1.2. The findings from the Arizona site suggested that being Hispanic was a moderator; however, social pressure to be thin was a risk factor whether the girls were Hispanic or non-Hispanic. Further support has been given to this finding from a more recent longitudinal study by van den Berg, Neumark-Sztainer, Hannan, & Haines (2007), who followed over 1,300 middle and high school girls for 5 years. In this sample, those young women who reported that they *sometimes* or *often* read magazine articles where dieting and weight loss were discussed were twice as likely to be engaged in unhealthy weight control behaviors, and three times as likely to be engaged in extreme weight-control behaviors at 5-year follow-up. This finding remained significant even when controlling for initial weight control behaviors, demographic features, weight importance, and Body Mass Index (BMI).

Three successive landmark studies pioneered by one of the principal investigators from the McKnight study (2003) were notable for following a very large sample of nearly 7,000 females ages 9-14 for a long period of time (Field, Camargo, Taylor, Berkey, & Colditz, 1999; Field, Camargo, Taylor, Berkey, Roberts, et al.,

2001; Field, Javaras, Anjea, Kitos, et al., 2008). Few studies in the field of eating disorders offer this type of longitudinal data with such a large sample size. At one year follow-up, and when controlling for age and initial BMI, the girls who consciously attempted to follow the thin female ideal presented in the media were 1.6 to 1.9 times more likely to have a preoccupation with their weight, to be continually dieting, and to have used purging behaviors. At the seven-year follow up, females in all age groups who were consciously trying to emulate women in the media were 1.5 times more likely to have started purging, and 2.2 times more likely to binge eat.

Application of the Thin Ideal Across Cultures. Studies assessing disordered eating have historically been skewed toward an overrepresentation of Caucasian women (Striegel-Moore & Bulik, 2007). Perhaps due in part to the assumption that eating disorders are less prevalent among ethnic minority populations, ethnic minorities are far less likely not only to seek treatment for such problems, but to receive treatment as well (Striegel-Moore & Bulik, 2007; Streigel-Moore, et al., 2003). One study assessing race/ethnicity as a marker of eating disorders in a large United States community sample of 2,054 young adult Black and White American women found that all eating disorders were less common among Black women and there were no Black women with AN (Streigel-Moore et al., 2003). Results in this study were confounded by socioeconomic status, as few of the Black women came from affluent households, so that it could not be determined whether SES or race/ethnicity was a more significant contributing factor in the prevalence of EDs for this sample.

An intersectionality perspective honors the complexity of assessing these issues in research and challenges researchers to attend to multiple identities and their impact on the individual. The concept of intersectionality suggests that "social identities, which serve as organizing features of social relations, mutually constitute, reinforce, and naturalize one another" (Shields, 2008, p. 302). When it comes to the study of disordered eating, the field has still arguably not adequately addressed or elucidated the ways that eating disorders impact various populations and how they may manifest differently in these groups. In fact, eating disorders continue to be considered a white, upper-middle class, women's issue, even as their reality seems to be increasingly more complex than this. The intersectionality perspective acknowledges the impossibility of generalizing about women or men by asking "the simple but fundamental question: Which women? Which men?" (Warner & Shields, 2013, p. 810).

Most studies assessing the impact of the thin ideal on disordered eating behaviors utilize a U.S. sample. Two studies assessing large international samples have provided important evidence about the influence of the Westernized thin beauty ideal on disordered eating in other cultures, however. First, a study of approximately 3,000 Spanish girls and young women ages 12 to 21 evaluated risk factors for developing an eating disorder over an 18-month period (Martinez-Gonzales, Gual, Lahortiga, Alonso, et al., 2003). These researchers found that those young women who were readers of fashion magazines were 2.1 times more likely to develop an eating disorder.

Finally, a naturalistic study conducted in Fiji provided arguably some of the most compelling data concerning the development of eating disorders and the influence of the thin ideal as a primary risk factor. This study by Becker, Burwell, Gilman, Herzog, and Hamburg (2002) studied a sample of adolescent girls on the Pacific Islands who had never been exposed to television before. Eleven percent of these girls reported vomiting to control their weight approximately 3 years after television had become widespread on the island, compared to 0% prior. During this time period, the percentage of girls who endorsed high levels of disordered eating attitudes more than doubled, going from 13% to 29%. Traditional Fijian culture does not endorse attempts to shape the female body with diet and exercise, and has a preference for more robust figures (Becker et al. 2002); yet following exposure to television, these authors found that 74% of Fijian girls reported *feeling fat*, and those who had television in their homes were an astonishing three times more likely to endorse disordered eating attitudes.

What Now? Clearly the evidence for the importance of sociocultural messages in the development of eating disorders is strong. In their recent comprehensive review detailing the research regarding the influence of mass media on body image and eating disordered attitudes in females worldwide, Lopez-Guimera, Levine, Sanchez-Carracedo, and Fauquet (2010) stated that:

> Despite nearly 35 years of concern about the relationship between mass media and eating disorders, there remains a strong need for both basic and applied research on the processes and mechanisms that constitute risk and protective factors in regard to the effects of the media on

attitudes and behaviors related to body image and eating behavior in females. (p. 409)

In another comprehensive literature review on risk factors for eating disorders, Streigel-Moore and Bulik (2007) stated, "The corpus of findings from the sociocultural theory of eating disorders literature underscores the importance of preventative and policy interventions designed to decrease exposure to or attenuate the impact of thin-ideal messages" (p. 193). They reminded us that even if it has not been proven that thin ideal messages are a major cause of eating disorders, it is clear that these messages have a seriously negative impact on women and girls. The McKnight Investigators (2003) suggested, "A next step for prevention efforts is to determine what factors contribute to thin body preoccupation and social pressure, and what can be done to reduce them."

Internalized Misogyny

The strength of the relationship between the thin ideal and disordered eating appears well established. However, a relatively new construct, *internalized misogyny,* has emerged in the literature, and while it may be related to the internalization of the thin ideal, it has not yet been examined in this capacity. This construct may help to explain the internalization of the thin ideal for women in our culture, and the development of disordered eating behavior that for some ultimately reaches clinical proportions.

Misogyny refers to the subordination or devaluation of women as a cultural practice that maintains the power of the dominant male group (Piggott, 2004). *Internalized misogyny* refers to the level of sexism and patriarchy that individuals take

in and endorse themselves. Women who internalize more misogyny exhibit distrust of other women and a higher level of respect for males than females (Szymanski, Gupta, Carr, & Stewart, 2009). Like internalized homophobia or internalized racism, and similar to the previously introduced construct of the thin ideal, internalized misogyny denotes beliefs that an individual makes a part of his or her own understanding of the world. For women, internalized misogyny reflects a tendency to align with masculine power, and reject one's own "female-ness" to win patriarchal favor. This results in a fear of femininity and, as such, female-related characteristics are then seen by the individual as weak and vulnerable (Szymanski et al., 2009). As the previously discussed feminist deconstruction of sociocultural messages about women suggests, there is perhaps nothing more representative or symbolic of "female-ness" in our culture than the female body itself.

Internalized misogyny in women has been correlated with lower self-esteem, negative body image, and depression, all of which have a strong relationship with disordered eating (Piggott, 2004; Szymanski and Kashubeck-West, 2008). Syzmanski and Kashubeck-West (2008) found that internalized misogyny was correlated with lower self-esteem, higher psychological distress, and lessened social support for U.S. sexual minority women. In a recent study, Szymanski et al. (2009) found that internalized misogyny intensified the relationship between experiences of external sexism and psychological distress in heterosexual undergraduate women. The researchers also found a significant relationship between internalized misogyny and self-objectification, but determined that the two constructs were conceptually distinct. Self-objectification can best be understood as the internalization of sexually

objectifying experiences that happens as women learn to see themselves as objects to be viewed and evaluated on the basis of appearance (Fredrickson & Roberts, 1997).

In a study assessing the relationship between endorsement of Western beauty practices and ideals, and levels of sexism and hostility towards women, Forbes, Collinsworth, Jobe, Braun, and Wise (2007) discovered that college men and women who endorsed these beauty practices and ideals showed significantly higher levels of hostility towards women, traditional sexism, and hostile sexism. The researchers stated that these results lend support to what they call the BIO hypothesis, or the assertion that "beauty ideals are oppressive" (Forbes et al., 2007, p. 266), and discussed the importance of examining the impact of all beauty ideals and practices on women, not just the thin ideal. However, Forbes et al. (2007) offered compelling support for a study examining the role of internalized misogyny in the internalization of the thin ideal when they stated that "when body dissatisfaction is perceived, not as a problem for an individual, but as a means of enforcing patriarchal control [i.e. misogyny], this perception offers new research opportunities and ultimately new opportunities and techniques for amelioration" (p. 266).

Internalized misogyny reflects yet another example of how an individual's social context can become unconsciously interpreted and internalized, in this case possibly resulting in a rejection of one's own female self. The thin ideal, while also a form of rejection of "female-ness," manifests this rejection in favor of a controlled physicality reflecting unrealistic levels of thinness and fitness. Indeed, feminist authors (Bordo, 2003; Brown & Jasper, 1993) have alluded to the increasingly muscular and low-fat (i.e., masculine) ideal for the female form that is seen in our

culture. Furthermore, the thin ideal also seems consistent with an unconscious willingness to subjugate oneself through objectification and the primacy of physical appearance. Thus, this construct may be related to, but distinct from, the internalization of misogyny.

Perfectionism, the Thin Ideal, and Internalized Misogyny

As established, perfectionism and the internalization of the thin ideal are constructs that have been strongly linked to both disordered eating behavior and clinical EDs. Also established is that much of the research has focused on the internalization of the thin ideal, and this research often involves attention to the influence of media or individual psychopathology (i.e. perfectionism, body dissatisfaction, dietary restraint, and depression). To date internalized misogyny has not been examined in relationship to disordered eating; however, mixed findings have emerged with respect to the relationship between disordered eating and passive acceptance of traditional gender roles. One study found a significant positive relationship between the two variables (Snyder and Hasbrouck, 1996), while a second study found none (Sabik and Tylka, 2006).

As previously mentioned, internalized misogyny can be understood as related to, but conceptually distinct from self-objectification (Syzmanski et al., 2009). Syzmanski et al. (2009) pointed out "although self-objectification and passive acceptance appear to be important manifestations of the ways in which sexism can be internalized, they fail to attend to a core construct of sexism, which is misogyny or a hatred and devaluation of women" (p. 102). In other words, internalized misogyny can be conceptualized as a variable that lies at the core of many other constructs that

fall under the umbrella of sexism. By examining the influence of internalized misogyny on the internalization of the thin ideal, the current research has the potential to meaningfully inform both prevention programs and treatment models.

In the discussion of their findings, Syzmanski et al. (2009) pointed out the importance of continuing to examine internalized misogyny's role in the relationship between sexism and psychological distress. Eating disorders represent a particularly salient form of psychological distress for women, which manifests in maladaptive behavior. Furthermore, the internalization of the thin ideal would appear to represent both a specific type of internalized sexism and a type of self-objectification. Internalized misogyny may be a core construct that captures and encompasses both of these variables by attending to the devaluation of women that exists in both. It is assumed that the internalization of the thin ideal is likely more potent when an individual unintentionally colludes with her own devaluation and endorses the type of self-hatred that internalized misogyny would engender. It would follow that internalized misogyny could moderate the relationship between internalization of the thin ideal and disordered eating in women, in a model where the relationship between the thin ideal and disordered eating differs depending on the level of internalized misogyny. This model would build on Syzmanski et al.'s findings, which provide a cogent rationale for examining the role of internalized misogyny as it relates to both the internalization of the thin ideal and disordered eating.

Moderators attend to the question of under what circumstances a particular variable most strongly predicts an outcome (Frazier, Tix, & Baron, 2004). Thus, these are variables that could potentially alter the relationship between predictor and

criterion variables. In the relationship between the internalization of the thin ideal and disordered eating, several variables involving individual psychopathology have already been intensively studied; however, psychologists still do not fully understand what causes a particular individual to internalize the thin ideal more strongly than another, and what causes one person to develop an eating disorder while another will not. Furthermore, there have been somewhat inconsistent results in studies looking at the relationship between these variables (e.g. Evans, et al, 2012; Thompson & Stice, 2001). It is customary to look for moderators when there are inconsistent relationships between a predictor and an outcome variable. One possible moderator in the relationship between the internalization of the thin ideal and disordered eating, examining the existing research and theory, is that of internalized misogyny.

The hypothesis tested in this study is that higher levels of internalization of the thin ideal will be positively related to disordered eating behavior, and that this relationship will be stronger for those who endorse higher levels of internalized misogyny. Also taken into account was that perfectionism – considered a personality trait that can reach maladaptive proportions and become somewhat fixed – has been studied extensively as a feature tied to disordered eating and eating disorders. Thus this variable was included in the model in order to remove the variance associated with it, and thereby ascertain the influence of the cultural variables above and beyond this personality feature. In sum, the following hypotheses will be examined:

Hypothesis 1: The combination of the predictor variables (i.e., perfectionism, the internalization of the thin ideal, and internalized misogyny) will significantly and positively predict disordered eating.

Hypothesis 2: The internalization of the thin ideal and internalized misogyny will be significant positive individual predictors of disordered eating, after controlling for the influence of perfectionism.

Hypothesis 3: Internalized misogyny will moderate the relationship between the internalization of the thin ideal and disordered eating.

Method

Participants and Procedures

Participants for this study were recruited through social media via snowball sampling. A link to an electronic survey was shared on Facebook and via the primary researcher's email contact list. Respondents were asked to click on the link and read an informed consent sheet to decide whether they would like to participate, and were also asked to share the recruitment email with their contacts. To prevent response bias, the measures were randomized during electronic administration. As an incentive, the respondents were offered a chance to enter a drawing for one of four $45 Visa gift cards at the completion of the survey. All responses remained totally anonymous, as there was no potentially identifying information collected. The raffle entry asked for email addresses only, and was housed in a separate database to prevent connection with a particular respondent's answers, thereby maintaining the confidentiality of participants.

Initially, 374 women participated in this study by agreeing to take the survey online. However, the final number of participants was 318 after removal of those individuals who dropped out without completing the entire survey, as evidenced by having the majority of an entire scale missing or more. Participants ranged in age from 18-64 years (M = 35.96; SD = 9.59). The majority of the participants identified as Caucasian or White (86.2%, n = 274)), followed by African-American or Black women (4.1%, n = 13), Biracial or Multiracial women (2.8%, n = 9), Asian or Asian American women (2.5%, n = 8), Hispanic or Latina women (1.9%, n = 6), and Native-American or American Indian women (1.3%, n = 4). Participants identified

themselves as either heterosexual (83.0%, *n* =264), bisexual or queer (11.3%, *n* = 36), or lesbian or gay (4.7%, *n* = 15). The respondents' socioeconomic status was represented by three basic categories: 23.6% of participants made up to $45,000 (*n* = 75), 36.8% made between $46,000 and $85,000 (*n* = 117), and 37.7% made over $85,000 (*n* = 120).

Regarding level of education, 34.3% of respondents had their master's degree (*n* = 109), 26.1% had a bachelor's degree (*n* = 83), and 21.7% had a professional or doctoral degree (*n* = 69). Nine percent of participants had completed some college (*n* = 29), while 4.1% had received an associate's degree (*n* = 13), and 3.4% had completed some high school, graduated from high school, or received a GED (*n* = 11). Participants also represented four basic regions of the United States – Central/Midwestern U.S. (40.6%, *n* = 129), Southern U.S. (27.0%, *n* = 86), Western U.S. (14.8%, *n* = 47)), and Northern U.S. (9.7%, *n* = 31), as well as a small contingent representing Europe and Canada (2.8%, *n* = 9).

Approximately 1.9% (*n* = 6) of respondents reported having had bariatric surgery of some kind (i.e. lap-band, gastric bypass, etc.). Respondents were asked about whether they had any health issues that impacted their eating, and 78.4% (*n* = 247) had none, 14.5% (*n* = 46) of respondents indicated some type of health issue that impacted their eating, such as IBS (Irritable Bowel Syndrome), GERD (acid reflux), or a food allergy besides gluten intolerance (peanuts, shellfish, etc.). Approximately 7.0% (*n* = 22) of respondents reported having either Celiac's Disease or some level of gluten intolerance. Finally, respondents were also asked about whether they had

cosmetic surgery, and 92.1% (*n* = 291) had not, while 7.9% (*n* = 25) indicated that they had.

Measures

Eating Attitudes Test. The Eating Attitudes Test (EAT-40; Garner & Garfinkel, 1979) is a 40-item self-report measure that is designed to measure eating disorder symptomatology. The measure assesses several areas of disordered eating, including dieting, bulimia, and oral control, and thus represents the continuum of disordered eating behaviors. Examples of items on this scale include: "I am terrified about being overweight;" "I am aware of the calorie content of foods that I eat;" and "I feel that food controls my life." Although validated with anorexia nervosa patients, the measure has also been useful in identifying eating disturbances in non-clinical samples (e.g. Garner & Garfinkel, 1980), such as the sample for this study.

Responses are scored on a 6-point Likert scale (1 = *never* to 6 = *always*), with higher scores indicating a greater disturbance in eating attitudes and behaviors, and possible scores ranging from 40-240. Scores on the EAT-40 have been significantly correlated with measures of body dissatisfaction, body image disturbance, depression, and somatization(Garner et al., 1982). The scale has shown Cronbach's alpha's of .86 and .88 for non-clinical samples of university and community women respectively (Piran & Thompson, 2008). Cronbach's alpha for scores in this sample was .86.

Multidimensional Perfectionism Scale. Perfectionism was measured with the 35-item Multidimensional Perfectionism Scale (FMPS) by Frost et. al. (1990). Sample items include: "Other people seem to accept lower standards from themselves than I do;" "If I don't do well all the time, then I feel that people will not respect me;" and "If I fail at

something, I feel I am a failure as a person." The FMPS utilizes a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The full scale yields scores that range from 35 to 175, with higher scores indicating more endorsed perfectionism. The questionnaire assesses total perfectionism, or, alternatively, six dimensions of perfectionism including: Concern Over Mistakes (CM), Doubts About Actions (DA), Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC) and Organization (ORG).

For this study, the FMPS total score was used as a global measure of perfectionism, since research suggests that the multidimensional aspect of this construct does not necessarily apply to those with disordered eating (Bardone-Cone et al., 2007). This instrument has been utilized extensively and has good psychometric properties (Bardone-Cone et al., 2007). The FMPS has demonstrated a consistent 6-factor structure across both clinical and non-clinical samples and is highly correlated with other major measures of perfectionism (Frost et al., 1990; Hewett & Flett, 1991; Sassaroli & Ruggerio, 2005). A validation study reported internal consistencies for all the subscales (α = 0.73-0.93) and for the overall scale (α = 0.91) were acceptable (Frost et al., 1993). Cronbach's alpha for the current sample was .93.

Sociocultural Attitudes Toward Appearance Questionnaire – 3. The Sociocultural Attitudes Towards Appearance Questionnaire – 3 (SATAQ-3; Thompson, van den Burg, Roehrig, Guarda, & Heinberg, 2004) was utilized to measure the internalization of the thin ideal. The SATAQ-3 is a 30-item self-report measure that assesses the recognition and acceptance of sociocultural ideals regarding appearance. Example items include: "I would like my body to look like the models

who appear in magazines;" "I've felt pressure from TV or magazines to have a perfect body;" and "Famous people are an important source of information about fashion and 'being attractive.'" Responses are scored on a 5-point Likert scale ranging from 1 (*definitely disagree*) to 5 (*definitely agree*). Items are summed to create four subscales (Information, Pressures, Internalization-Athlete, and Internalization-General) and a total score. The current study utilized the Internalization-General subscale, which contains nine items with possible scores ranging from 9 to 45. It measures how strongly an individual has internalized the norms for weight and shape demonstrated in the media, with higher scores indicating higher internalization of the thin ideal.

Validity has been supported in a development and validation study where results were replicated with two independent samples of college females (Thompson et al., 2004). The authors found that the scale had adequate convergent validity with measures of body image and eating disturbance, and that it assessed internalization of the thin ideal beyond only awareness of it. Studies have utilized the internalization-general subscale as a global measure of internalization of the thin ideal for a non-clinical female population (e.g. Myers et al., 2012). It has demonstrated good internal consistency, with alpha coefficients ranging from 0.89 to 0.94 (Thompson et al., 2004). Cronbach's alpha for the current sample was .93.

Internalized Misogyny Scale. The Internalized Misogyny Scale (IMS, Piggott, 2004) contains three factors and 17 total items. The three factors are: devaluing of women, distrust of women, and gender bias in favor of men. The scale has been validated with feedback from a focus group, exploratory factor analysis, and correlations with a cross-cultural sample of 803 women from five countries (Piggott,

2004), and it has been correlated in the expected direction with measures of modern sexism, internalized heterosexism, body image, depression, self-esteem, psychosexual adjustment, and social desirability (Piggott, 2004). Though the scale was originally normed on a sexual minority female sample, results have been replicated with heterosexual women, suggesting that the construct is valid for both populations (Syzmanski et al., 2009). The IMS is the only known measure for assessing internalized misogyny, and it has displayed good reliability, with reported alpha coefficients for the full scale ranging from 0.88 (Piggott, 2004) to 0.90 (Szymanski et al., 2009). Sample items include: "It is generally safer not to trust other women too much;" and "Generally, I prefer to work with men." The measure utilizes a 7-point Likert-type scale, from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores (range = 17-119) indicate more internalized misogyny.

As stated, validity of the IMS was supported in two studies, one assessing 803 sexual minority women, and one assessing 171 heterosexual women. Feedback was gathered from a focus group in order to create items for the scale. The group consisting of 11 women was asked to generate items by considering how the concept of misogyny influenced both their feelings about themselves and their feelings about other women. Items were retained if they appeared to have face validity and if they were endorsed by at least two or more group members (Piggott, 2004). The factor analysis yielded a final 3-factor solution and 17 total items reflecting the devaluing of women, basic distrust of women, and a gender bias in favor of men. Cross-cultural comparisons of 801 lesbian-identified women from Australia, Canada, England, Finland, and the United States revealed consistent results, with significant correlations

in the expected directions with self-esteem, depression, and measures of psychosocial adjustment. There was a significant positive relationship between internalized misogyny and internalized homophobia for all five comparison countries except England, and significant relationship between body image and internalized misogyny for all countries except Finland and Canada (Piggott, 2004). For the current study, Cronbach's alpha reached .88.

Data Analysis

A hierarchical moderated regression (HMR) model was used to examine whether internalized misogyny moderated the relationship between the internalization of the thin ideal and disordered eating for women, when controlling for perfectionism. This analysis is understood to be the best method for detecting the existence or absence of moderating effects (Aiken & West, 1991). Moderators may or may not be significantly associated with the predictor or the criterion, and the predictor may or may not be related to the criterion (Frazier et al., 2004). Since both predictors were continuous variables, scores were mean centered before examining their interaction effects to reduce multicollinearity between the main effect and the interaction term (Frazier et al., 2004).

Perfectionism was entered at the first step of the model, in order to control for its influence on disordered eating. At step 2, internalized misogyny was entered in order to examine its main effect on disordered eating. In step 3 the internalization of the thin ideal was entered to examine its main effect on disordered eating. In the final step of the model, the product of the mean-centered variables comprising the

interaction term (internalization of the thin ideal X internalized misogyny) was entered to determine any interaction effects.

Results

Issues associated with achieving an adequate level of power for this study were considered and accounted for as much as possible. As previously mentioned, reliability coefficients for all measures used were all above .80, and the sample size was sufficiently large for this analysis ($N = 318$). Observed statistical power for this study reached 1.0 (Soper, 2014). In addition, preliminary analyses were conducted to ensure there were no violations of the assumptions of normality, linearity, multicollinearity, and homoscedasticity. There were no significant outliers evidenced in the data, skewness and kurtosis were considered to be within acceptable ranges, and there was no problematic multicollinearity observed between the predictor variables and the dependent variable of disordered eating.

Prior to conducting a moderation analysis, group differences based on age, ethnic identification, sexual orientation, income, level of education, and US region were explored in relation to disordered eating scores. One-way analyses of variance were used to test for group differences for the categorical predictor variables (i.e.,ethnic identification, sexual orientation, income, level of education, and U.S. region) with disordered eating scores. No significant between-group differences emerged from the data. A Pearson correlation was used to test whether the continuous variable of age was associated with variability on EAT-40 scores, and it was not significantly correlated. Therefore, it was determined that including any demographic control variables was not necessary.

Correlational analyses (see Table 1) were completed to explore relationships among the model variables. Each of the variables was significantly positively

correlated with disordered eating. Perfectionism (r = .45) and the internalization of the thin ideal (r = .47) were correlated at the $p < .01$ level, and internalized misogyny (r = .15) was correlated at the $p < .05$ level with disordered eating (See Table 1). There was a significant correlation between perfectionism and internalized misogyny (r = .23, $p < .01$), while no significant relationship emerged between the internalization of the thin ideal and internalized misogyny.

A hierarchical moderated regression (HMR; see Table 2) model was used to examine whether internalized misogyny moderated the relationship between the internalization of the thin ideal and disordered eating for women, when controlling for perfectionism. In the final model, the total variance in scores explained by the model as a whole was 31.3%, a large effect size (Cohen, 1988). Perfectionism explained 20.3% of the variance in disordered eating at Step 1 of the model, emerging as a statistically significant individual predictor, F (1, 231) = 58.74, $p < .001$, and showing a medium to large effect size (Cohen, 1988). At Step 2, internalized misogyny was entered into the model, and it did not have a significant main effect on disordered eating scores. Internalization of the thin ideal was entered at Step 3, and showed a significant main effect on disordered eating, explaining an additional 10.5% of the variance in EAT-40 scores, F (1, 229) = 34.70, $p < .001$, a small to medium effect size (Cohen, 1988). At the final step, the interaction term emerged as non-significant.

Discussion

This study utilized hierarchical moderated regression (HMR) to test whether internalized misogyny moderates the relationship between the internalization of the thin ideal and disordered eating in a non-clinical female population. To date, no other study has examined this question. Results substantiated the strength of the relationships between perfectionism, the internalization of the thin ideal, and disordered eating, which has been found in previous studies (e.g. Bradford & Petrie, 2008; Groetz, Levine, & Murtten, 2002; McKnight Investigators, 2003; McLaren, Gauvin & White, 2001; Ruggiero, Levi, Ciuna, & Sassaroli, 2003; Sassaroli & Ruggiero, 2005; Stice, Spangler, & Agras, 2001; Stice, 2002). Contrary to what was hypothesized, however, internalized misogyny did not moderate the relationship between the internalization of the thin ideal and level of disordered eating when controlling for perfectionism.

Hypothesis 1 stated that the combination of the predictor variables (i.e., perfectionism, the internalization of the thin ideal, and internalized misogyny) would significantly and positively predict disordered eating. This hypothesis was fully supported by the data. The effect size of the model as a whole was large (Cohen, 1988), which suggests that these variables have an important influence on disordered eating levels in women.

Hypothesis 2 stated that the internalization of the thin ideal and internalized misogyny would be significant positive individual predictors of disordered eating, after controlling for the influence of perfectionism. Perfectionism was responsible for a significant amount of variance in disordered eating scores, with a medium to large

effect size. This was not an unexpected finding, and it adds to the existing robust body of literature on the importance of this construct. Hypothesis 2 was partially supported by the data, such that the internalization of the thin ideal emerged as a significant individual predictor of disordered eating after controlling for perfectionism, but internalized misogyny did not. Previous research underscores the relationship between self-objectification and internalized misogyny (Szymanski et al, 2009), as well as the influence of levels of feminist values (Snyder & Hasbrouk, 1996) and feminist identity development (Sabik & Tylka, 2006) on disordered eating behavior. It was hypothesized that internalized misogyny would be a construct encapsulating a core element of these other constructs: the devaluing of women in our culture. Perhaps a construct such as internalized sexism, which includes both a hostile and a benevolent component, would have more accurately captured the full spectrum of these core beliefs, especially given the more subtle nature of benevolent sexism measures.

It is also important to note that scores on the disordered eating measure for this sample clustered towards the non-clinical end of the scale ($M = 98.63$), suggesting that this sample shows primarily healthy eating patterns. It may be that in a non eating-disordered population such as the one seen in this sample, a main effect and interaction effect for internalized misogyny cannot be detected since there is not a high enough level of disordered eating in these individuals. Given this, future research with a clinical population would be useful in examining the questions studied here, and may find support for the hypotheses in this study. It is also possible that level of internalized misogyny truly does not impact the relationship between the

internalization of the thin ideal and disordered eating, which may speak to the importance of the internalization of the thin ideal on women even outside of other internalized beliefs. Indeed, the main effect of the thin ideal was statistically significant after controlling for perfectionism, suggesting that it significantly contributed to disordered eating behavior after perfectionism has been controlled. This data suggests that whether women are perfectionistic or not, the internalization of the thin ideal significantly contributes to disordered eating behavior.

Much research has focused on perfectionism as a necessary component in disordered eating that rises to a clinical level, and has indicated that perfectionism is a central feature of eating disorders (Davis, 1997; Davis, Claridge, & Fox, 2000; McLaren, Gauvin & White, 2001; Ruggiero, Levi, Ciuna, & Sassaroli, 2003; Sassaroli & Ruggiero, 2005). Although the data supports the assertion that perfectionism is certainly influential, the results of this study also suggest that perhaps all women are susceptible to the influence of the thin ideal, such that it puts them at risk of disordered eating which could reach clinical proportions. Recalling that one of the most accepted statistical realities of eating disorders is that partial-syndrome EDs tend to progress to full-syndrome for 14%-46% of individuals (Shisslak, Crago, & Estes, 1995), the assertion that attenuating thin ideal messages is a necessary continued goal for therapists, educators, and all those with influence over how these messages are offered, seen, and interpreted is underscored.

Finally, hypothesis 3 stated that internalized misogyny would moderate the relationship between the internalization of the thin ideal and disordered eating. No interaction effects emerged, therefore, hypotheses 3 was not supported by the data. In

this sample, internalized misogyny did not moderate the relationship between the internalization of the thin ideal and disordered eating for women.

It is of note, however, that internalized misogyny had a small but significant correlation with disordered eating, despite not exhibiting a main effect once perfectionism had been entered, and not showing an interaction effect with the internalization of the thin ideal. An intriguing link that emerged from the data, however, was the significant correlation between perfectionism and internalized misogyny. This was unexpected, and suggests that perhaps further exploration is needed regarding the relationship between these two variables in conjunction with disordered eating. Why would someone who is perfectionistic also exhibit high levels of internalized misogyny? One possibility is that inherent in the idea of being "perfect" is the desire to embody more socially valued traits; generally, traits that are considered more stereotypically "masculine" are more highly valued in Western culture than those considered more "feminine" (Bordo, 2003).

In this study, perfectionism was significantly correlated with all three variables of interest: the internalization of the thin ideal, internalized misogyny, and disordered eating. So it is a possibility that internalized misogyny plays some role in disordered eating behavior after all, though not in the manner hypothesized. Internalized misogyny may work through perfectionism, given its strong correlation with this variable. As mentioned, although the role of perfectionism has been extensively explored in the literature, the overwhelming majority of these studies have relied on retrospective recall (Bardone-Cone et al. 2007). In fact, the only two known studies assessing premorbid perfectionism and disordered eating have revealed mixed results

(Santonastaso, Friederici, & Favaro, 1999; Tyrka, et al, 2002), suggesting that perhaps there is more to this relationship than previously assumed. It is possible that internalized misogyny could actually serve as a moderator or mediator variable in this important relationship, and further research would be useful in continuing to explore this phenomenon, in order to elucidate the nature of this relationship more fully.

There are several limitations that pertain to the current study. First, it is known to be notoriously difficult to detect interaction effects in non-experimental psychological research designs (Sabik &Tylka, 2006). Given this, there are a couple of issues that may have impacted the detection of these effects in this study. First, the respondents for this study were accessed through snowball sampling methods. This method does not allow for a truly representative community sample to be accessed.

Also, the data suggests that this particular sample is highly educated, with over 81.1% of respondents having obtained a bachelor's, a masters, or a doctoral/professional degree. Given this large percentage, it is a possibility that this population would have been more sensitized to the kinds of questions asked on the internalized misogyny measure due to their level of education. The scale exhibits high face value validity, such that it is fairly easy to ascertain what it is attempting to measure. It is possible that the education level of the participants and the high face value validity of the measure were factors in influencing responses to misogyny items. Participants who are highly educated might simply exhibit less internalized misogyny overall, due to the benefits of the critical thinking that a college education can engender, or they might be inclined to answer in more socially acceptable ways.

The addition of a social desirability measure may have helped control for this confounding issue, by measuring the tendency to respond in a way that will be perceived favorably by others. Regardless of level of education, acceptance of diet mentality and the thin ideal would seem to be more socially acceptable than outward acceptance and endorsement of misogynistic thinking. Thin ideal attitudes are more aggressively promoted by the health and fitness, dieting, cosmetics, and fashion industries than misogyny, an arguably more insidious and carefully concealed attitude. The IMS utilizes some items from the hostile sexism inventory (Piggott, 2004), and these items convey a fairly overtly harsh attitude towards women. Even with the assurance of anonymity, it may be difficult for individuals to admit to themselves that they agree with such attitudes or opinions.

Furthermore, the IMS, though validated and normed on a large, international sample, has not been widely utilized in other studies since its inception. In fact, only one published study was located utilizing the scale (Syzmanski et al., 2009). The current study results indicated that the IMS was not associated with the internalization of the thin ideal or disordered eating in the manner hypothesized, which adds to the current research understanding; however, further research is needed to explore its relationship with other variables in order to understand it more fully.

Other limitations of this study must also be acknowledged. First, the sample consisted of very few women of color, which does not allow for these results to be generalized to a diverse ethnic population. Future research would benefit from continuing to explore the influence of perfectionism, internalized misogyny, and the internalization of the thin ideal on women of color. It is also important to examine the

influence of these variables on sexual minority women, women falling below the poverty line, and non-collegiate women, all groups that were underrepresented in this particular sample. In addition, this study did not include males, and more research is needed to examine and understand disordered eating in men. In keeping with intersectionality theory and associated models (Shields, 2008; Warner & Shields, 2013), qualitative research methodology would be useful for exploring the internalization of the thin ideal and misogyny as these sociocultural variables come in contact with variously located identities such as those mentioned above.

For this study, self-report measures were utilized, which are susceptible to inaccurate responding as they rely on the perceptions of respondents who may have differing levels of self-awareness and different ideas of what constitutes low, medium, and high levels of agreement with a particular attitude or belief. Additionally, the data was gathered entirely through electronic means, utilizing an internet-based, quantitative survey. Mixed methods may have provided a more complete picture when looking at such subjective variables as those examined here, and as mentioned, may have allowed for a more nuanced treatment of the intersections between gender, race, ethnicity, sexual orientation, SES, and other salient identities. Finally, the non-experimental design of this research means that causality cannot be inferred in this study. It cannot be stated with assurance that perfectionism and the internalization of the thin ideal cause disordered eating behavior when in fact the reverse could be true, or alternatively, a curvilinear relationship could exist between these variables.

Despite these limitations, the results of this study add to the literature by pointing out the importance of internalization of the thin ideal and perfectionism as

they increase the vulnerability to disordered eating behavior for all women, and as they apply to behaviors that could lead to clinically-diagnosable eating disorders for some. Furthermore, no other study to date has examined the role of internalized misogyny as it relates to these constructs. Thus, the present study contributes to the current body of available research, while also providing information suggesting possible additional avenues of exploration.

REFERENCES

Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions.* Thousand Oaks, CA: Sage.

Agras, W.S., Bryson, S., Hammer, L.D., & Kraemer, H.C. (2007). Childhood risk factors for thin body preoccupation and social pressure to be thin. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 171-178.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: DSM-IV-TR. Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-V. Washington, DC: American Psychiatric Publishing.

Bardone-Cone, A.M., Wonderlich, S.A., Frost, R.O., Bulik, C.M., Mitchell, J.E., Uppala, S., et al. (2007). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review, 27,* 384-405.

Becker, A.E., Burwell, R.A., Gilman, S.E., Herzog, D.B., & Hamburg. (2002). Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. *British Journal of Psychiatry, 180,* 509-514.

Boone, L., Soenens, B., & Braet, C. (2011). Perfectionism, body dissatisfaction, and bulimic symptoms: the intervening role of perceived pressure to be thin and thin ideal internalization. *Journal of Social and Clinical Psychology, 30*(10), 1043-1068.

Bordo, S. (2003). *Unbearable weight: Feminism, western culture, and the body.* Berkeley and Los Angeles, CA: University of California Press.

Bradford, J.W., & Petrie, T.A. (2008). Sociocultural factors and the development of disordered eating: A longitudinal analysis of competing hypotheses. *Journal of Counseling Psychology, 55*(2), 246-262.

Brown, C., & Jasper, K. (1993). *Consuming passions: Feminist approaches to weight preoccupation and eating disorders.* Toronto, Ontario: Second Story Press.

Cashdan, S. (1988). *Object relations therapy: Using the relationship*. New York, NY: W.W. Norton & Company.

Clark, L., & Tiggemann, M. (2008). Sociocultural and individual psychological predictors of body image in young girls: a prospective study. *Developmental Psychology, 44*(4), 1124-1134.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences.* New York: Academic Press.

Costin, C. (1997). *The eating disorder sourcebook: a comprehensive guide to the causes, treatments, and preventions of eating disorders.* Los Angeles, CA: Lowell House.

Davis, C. (1997). Normal and neurotic perfectionism in eating disorders: An interactive model. *International Journal of Eating Disorders, 22*, 421-426.

Davis, C., Claridge, G., & Fox, J. (2000). Not just a pretty face: Physical attractiveness and perfectionism in the risk for eating disorders. *International Journal of Eating Disorders, 27*, 63-73.

Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 41,* 727-736.

Enns, C.Z. (2004). *Feminist theories and feminist psychotherapies: Origins, themes, and diversity* (2nd ed.). New York: Haworth Press.

Evans, D.L, Foa, E.B, Gur, R.E., Hendin, H., O'Brien, C.P, Seligman, M.E., & Walsh, T. (Eds.). (2005). *Treating and preventing adolescent mental health disorders.* New York: Oxford University Press.

Evans, E.H., Tovee, M.J., Boothroyd, L.G., & Drewett, R.F. (2012). Body dissatisfaction and disordered eating attitudes in 7 to 11 year-old girls: Testing a sociocultural model. *Body Image, 10,* 8-15.

Ferrari, J.R., & Mautz, W.T. (1997). Predicting perfectionism: Applying tests of rigidity. *Journal of Clinical Psychology, 53*, 1-6.

Field, A.E., Camargo, C.A., Taylor, B., Berkey, C.S., & Colditz, G.A. (1999). Relation of peer and media influences to the development of purging behaviors among preadolescent and adolescent girls. *Archives of Pediatrics and Adolescent Medicine, 153,* 1184-1189.

Field, A.E., Camargo, C.A., Taylor, B., Berkey, C.S., Roberts, S.B., & Colditz, G.A. (2001). Peer, parent, and media influences on development of weight concerns and frequent dieting among preadolescent and adolescent girls and boys. *Pediatrics, 107,* 54-60.

Field, A.E., Javaras, K.M., Anjea, P., Kitos, N., Camargo, C.A., Jr., Taylor, C.B., & Laird, N.M. (2008). Family, peer, and media predictors of becoming eating disordered. *Archives of Pediatrics and Adolescent Medicine, 162,* 574-579.

Forbes, G.B., Collinsworth, L.L., Jobe, R.L., Braun, K.D., & Wise, L.M. (2007). Sexism, hostility towards women, and endorsement of beauty ideals and practices: Are beauty ideals associated with oppressive beliefs? *Sex Roles, 56,* 265-273.

Frazier, P.A., Tix, A.P., & Baron, K.E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology, 51,* 115-134.

Fredrickson, B.L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly, 19,* 93-104.

Frost, R.O., Marten, P., Lahart, C.M., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research, 14,* 449-468.

Garner, D.M., & Garfinkel, P.E. (1979). The Eating Attitude Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9,* 273-279.

Garner, D.M., & Garfinkel, P.E. (1980). Sociocultural factors in the development of anorexia nervosa. *Psychological Medicine, 10,* 647-656.

Greenleaf, C., & McGreer, R. (2006). Disordered eating attitudes and self-objectification among physically active and sedentary female college students. *The Journal of Psychology, 140*(3), 187-198.

Groetz, L.M., Levine, M.P., & Murtten, S.K. (2002). The effects of experimental presentation of thin media images on body dissatisfaction: A meta-analytic review. *International Journal of Eating Disorders, 31,* 1-16.

Guille, C., & Chrisler, J.C. (1999). Does feminism serve a protective function against eating disorders? *Journal of Lesbian Studies, 3,* 141-148.

Hargreaves, D., & Tiggemann, M. (2002). The role of appearance schematicity in the development of adolescent body dissatisfaction. *Cognitive Therapy and Research, 26,* 691-700.

Heinberg, L.J., Thompson, J.K., & Stormer, S. (1995). Development and validation of the sociocultural attitudes towards appearance questionnaire. *International Journal of Eating Disorders, 17,* 81-89.

Hesse-Biber, S., Leavy, P., Quinn, C.E., & Zoino, J. (2006). The mass marketing of disordered eating and Eating Disorders: The social psychology of women, thinness, and culture. *Women's Studies International Forum, 29,* 208-224.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60,* 456−470.

Hewitt, P.L., & Genest, M. (1990). The ideal self: Schematic processing of perfectionistic content in dysphoric university students. *Journal of Personality and Social Psychology, 59*, 802-808.

Hopkinson, R.A. & Lock, J. (2004). Athletics, perfectionism, and disordered eating. *Eating and Weight Disorders, 9*(2), 99-106.

Lavin, M.A., & Cash, T. (2001). Effects of exposure to information about appearance, stereotyping, and discrimination on women's body images. *International Journal of Eating Disorders, 29,* 51-58.

Lopez-Guimera, G., Levine, M.P., Sanchez-Carracedo, D., & Fauquet, J. (2010). Influence of mass media on body image and eating disordered attitudes and behaviors in females: A review of effects and processes. *Media Psychology, 13,* 387-416.

Lott, A.J. (1973). Social psychology. In B. Wolman (Ed.), *Handbook of general psychology,* (pp. 919-932). New Jersey: Prentice Hall.

Martinez-Gonzales, M.A., Gual, P., Lahortiga, F., Alonso, Y., Irala-Estevez, J., & Cervera, E. (2003). Parental factors, mass media influences, and the onset of eating disorders in a prospective population-based cohort. *Pediatrics, 111,* 315-320.

McKnight Investigators (2003). Risk factors for the onset of eating disorders in adolescent girls: Results of the McKnight Longitudinal Risk Factor Study. *American Journal of Psychiatry, 160,* 248-254.

McLaren, L., Gauvin, L., & White, D. (2001). The role of perfectionism and excessive commitment to exercise in explaining dietary restraint: Replication and extension. *International Journal of Eating Disorders, 29*, 307-313.

Miller, K.E. (2000). Treatment guideline for eating disorders. *American Family Physician, 62,* 185-186.

Miller-Day, M., & Marks, J.D. (2006). Perceptions of parental communication orientation, perfectionism, and disordered eating behaviors of sons and daughters. *Health Communication, 19*(2), 153-163.

Moradi B., Dirks, D., & Matteson, A.V. (2005). Roles of sexual objectification experiences and internalization of standards of beauty in eating disorder symptomatology: A test and extension of objectification theory. *Journal of Counseling Psychology, 52,* 420-428.

Morrison, T.G., Sheehan, E.E. (2009). Gender related discourses as mediators in the association between internalization of the thin-body ideal and indicants of body dissatisfaction and disordered eating. *Psychology of Women Quarterly, 33,* 374-383.

Myers, T.A., Ridolfi, D.R., Crowther, J.H., & Ciesla, J.A. (2012). The impact of appearance-focused social comparisons on body image disturbance in the naturalistic environment: The roles of thin ideal internalization and feminist beliefs. *Body Image, 9,* 342-351.

Peck, L.D., & Lightsey Jr., O. (2008). The eating disorders continuum, self-esteem, and perfectionism. *Journal of Counseling and Development, 86,* 184-192.

Piggott, M. (2004). *Double jeopardy: Lesbians and the legacy of multiple stigmatized identities.* Psychology Strand at Swinburne University of Technology, Australia: Unpublished thesis.

Piran, N., Thompson, S. (2008). A study of the adverse social experiences model to the development of eating disorders. *International Journal of Health Promotion & Education, 46,* 65-71.

Ruggiero, G.M., Levi, D., Ciuna, A., & Sassaroli, S. (2003). Stress situation reveals association between perfectionism and drive for thinness. *International Journal of Eating Disorders, 34*, 220-226.

Russell, G.F.M., Szmukler, G.I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry, 44,* 1047-1056.

Sabik, N.J., & Tylka, T.L. (2006). Do feminist identity styles moderate the relation between perceived sexist events and disordered eating? *Psychology of Women Quarterly, 30*, 77-84.

Santonastaso, P., Friederici, S., & Favaro, A. (1999). Full and partial syndromes in eating disorders: A 1-year prospective study of risk factors among female students. *Psychopathology, 32,* 50−56.

Sassaroli, S., & Ruggiero, G.M. (2005). The role of stress in the association between low self esteem, perfectionism, and worry, and eating disorders. *International Journal of Eating Disorders, 37*, 135-141.

Shields, S.A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59,* 301-311.

Shisslak, C.M., Crago, M., & Estes, L. (1995). The spectrum of eating disturbances. *International Journal of Eating Disorders, 18,* 209-219.

Smolak, L., & Levine, M.P. (2001). Body image in children. In J. Thompson & L. Smolak (Eds.), *Body image, eating disorders and obesity in youth: Assessment, prevention & treatment* (pp. 41-66). Washington DC: American Psychological Association.

Snyder, R., & Hasbrouck, L. (1996). Feminist identity, gender traits, and symptoms of disturbed eating among college women. *Psychology of Women Quarterly, 20*, 593-598.

Soper, D. (2014). Post-hoc statistical power calculator. http://www.danielsoper.com/statcalc3/calc.aspx?id=9.

Steinhausen, H.C. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry, 159,* 1284-1293.

Stice, E. (1994). Review of the evidence for a sociocultural model of bulimia nervosa and an exploration of the mechanisms of action. *Clinical Psychology Review, 14,* 633-661.

Stice, E. (2002). Risk and maintenance factors for eating pathology: a meta-analytic review. *Psychological Bulletin, 128,* 825-848.

Stice, E., Spangler, D., & Agras, W.S. (2001). Exposure to media-portrayed thin-ideal images adversely effect vulnerable girls: a longitudinal experiment. *Journal of Social and Clinical Psychology, 20*, 270-288.

Striegel-Moore, R.H., & Bulik, C.M. (2007). Risk factors for eating disorders. *American Psychologist, 62*(3), 181-198.

Striegel-Moore, R.H., Dohm, F., Kraemer, H., Taylor, C., Daniels, S., Crawford, P., & Schreiber, G. (2003). Eating disorders in White and Black women. *American Journal of Psychiatry, 160,* 1326-1331.

Szymanski, D.M., Gupta, A., Carr, E.R., & Stewart, D. (2009). Internalized misogyny as a moderator of the link between sexist events and women's psychological distress. *Sex Roles, 61*, 101-109.

Szymanski, D.M., & Kashubeck-West, S. (2008). Mediators of the relationship between internalized oppressions and lesbian and bisexual women's psychological distress. *The Counseling Psychologist, 36*, 575-594.

Taylor, C.B., Bryson, S., Luce, K.H., et al. (2006). Prevention of eating disorders in at-risk college-age women. *Archives of General Psychiatry, 63,*881-888.

Thompson, J.K., van den Burg, P., Roehrig, M., Guarda, A.S., & Heinberg, L.J. (2004). The sociocultural attitudes towards appearance scale – 3 (SATAQ-3): Development and validation. *International Journal of Eating Disorders, 35,* 293-304.

Thompson, J.K., & Stice, E. (2001). Thin-ideal internalization: Mounting evidence for a new risk factor for body-image disturbance and eating pathology. *Current Directions in Psychological Science, 10,* 181-183.

Tylka, T.L., & Subich, L.M. (1999). Exploring the construct validity of the eating disorder continuum. *Journal of Counseling Psychology, 46,* 268-276.

Tyrka, A. R., Waldron, I., Graber, J. A., & Brooks-Gunn, J. (2002). Prospective predictors of the onset of anorexic and bulimic syndromes. *International Journal of Eating Disorders, 32,* 282−290.

Van den Berg, P., Neumark-Sztainer, D., Hannan, P. J., & Haines, J. (2007). Is dieting advice from magazines helpful or harmful? Five-year associations with weight- control behaviors and psychological outcomes in adolescents. *Pediatrics, 119*, 30–37.

Warner, L.R., Shields, S.A. (2013). The intersections of sexuality, gender, and race: Identity research at the crossroads. *Sex Roles, 68*, 803-810.

Westerberg, J., Edlund, B., & Ghaderi, A. (2008). A 2-year longitudinal study of eating attitudes, BMI, perfectionism, asceticism, and family climate in adolescent girls and their parents. *Eating and Weight Disorders, 13*(2), 64-72.

Wilson, G.T., Grilo, C.M., & Vitousek, K.M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199-216.

APPENDIX A: TABLE 1

Table 1

Means, Standard Deviations, and Intercorrelations for Women on Variables of Interest

VARIABLE	*M*	*SD*	*α*	*1*	*2*	*3*	*4*
1. Disordered Eating	98.63	18.52	.86	--	.45**	.47**	.15*
2. Perfectionism	104.98	20.89	.93		--	.39**	.23**
3. Thin Ideal	26.34	8.86	.93			--	.07
4. Misogyny	43.51	15.95	.88				--

*p < .05, **p < .01

APPENDIX B: TABLE 2

Table 2

Hierarchical Multiple Regression Analysis for Variables Predicting EAT-40 Scores in Women

IV	Step	R^2	ΔR^2	*F* Change	*df*	*B*	*SE B*	*β*
Perfectionism	1	.20	.20	58.74**	(1, 231)	.40	.05	.45
Misogyny	2	.21	.00	.67	(1, 230)	.06	.07	.05
Thin Ideal	3	.31	.11	34.70**	(1, 229)	.73	.12	.35
Thin Ideal X Misogyny	4	.31	.00	1.11	(1, 228)	-.01	.01	-.06

*p < .05, **p < .01

APPENDIX C: IRB APPROVAL LETTER

The UNIVERSITY of OKLAHOMA

Institutional Review Board for the Protection of Human Subjects

Approval of Initial Submission – Exempt from IRB Review – AP01

Date: October 23, 2013 **IRB#:** 3603

Principal Investigator: Shelby R Johnson, BA **Approval Date:** 10/22/2013

Exempt Category: 2

Study Title: Internalization Patterns and Eating Habits for Women

On behalf of the Institutional Review Board (IRB), I have reviewed the above-referenced research study and determined that it meets the criteria for exemption from IRB review. To view the documents approved for this submission, open this study from the *My Studies* option, go to *Submission History*, go to *Completed Submissions* tab and then click the *Details* icon.

As principal investigator of this research study, you are responsible to:

- Conduct the research study in a manner consistent with the requirements of the IRB and federal regulations 45 CFR 46.
- Request approval from the IRB prior to implementing any/all modifications as changes could affect the exempt status determination.
- Maintain accurate and complete study records for evaluation by the HRPP Quality Improvement Program and, if applicable, inspection by regulatory agencies and/or the study sponsor.
- Notify the IRB at the completion of the project.

If you have questions about this notification or using iRIS, contact the IRB @ 405-325-8110 or irb@ou.edu.

Cordially,

Lara Mayeux

Lara Mayeux, Ph.D.
Chair, Institutional Review Board

APPENDIX D: DEMOGRAPHIC FORM

Demographic Information

1. What is your gender?
    a. Male
    b. Female

2. What is your age? _____

3. What ethnicity do you consider yourself?
    a. African American
    b. Hispanic or Latino/Latina
    c. Asian American
    d. Native American or American Indian
    e. Caucasian
    f. Biracial
    g. Multiracial
    h. Other (Please Specify) _____

4. How do you describe you sexual orientation?
    a. Bisexual
    b. Heterosexual
    c. Lesbian or Gay
    d. Other (please specify) _____

5. What is your approximate yearly household income?
    a. Less than $25,000
    b. $25,000 - $35,000
    c. $36,000 - $45,000
    d. $46,000 - $55,000
    e. $56,000 - $65,000
    f. $66,000 - $75,000
    g. $76,000 - $85,000
    h. Over $85,000

6. What is the highest level of education you have completed?
    a. Some High School
    b. High School Graduate or equivalent (i.e. GED)
    c. Some College
    d. Associate's Degree
    e. Bachelor's Degree
    f. Master's Degree
    g. Professional or Doctoral Degree

7. What state/province do you live in? _____

APPENDIX E: THE EATING ATTITUDES TEST

The Eating Attitudes Test (EAT)

Scale:

1	2	3	4	5	6
Never	**Rarely**	**Sometimes**	**Often**	**Very Often**	**Always**

1. I like eating with other people.
2. I prepare foods for others but do not eat what I cook.
3. I become anxious prior to eating.
4. I am terrified about being overweight.
5. I avoid eating when I am hungry.
6. I find myself preoccupied with food.
7. I have gone on eating binges where I feel that I may not be able to stop.
8. I cut my food into small pieces.
9. I am aware of the calorie content of foods that I eat.
10. I particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice etc.).
11. I feel bloated after meals.
12. I feel that others would prefer if I ate more.
13. I vomit after I have eaten.
14. I feel extremely guilty after eating.
15. I am preoccupied with a desire to be thinner.
16. I exercise strenuously to burn off calories.
17. I weigh myself several times a day.
18. I like my clothes to fit tightly.

19. I enjoy eating meat.

20. I wake up early in the morning.

21. I eat the same foods day after day.

22. I think about burning up calories when I exercise.

23. I have regular menstrual periods.

24. Other people think that I am too thin.

25. I am preoccupied with the thought of having fat on my body.

26. I take longer than others to eat my meals.

27. I enjoy eating at restaurants.

28. I take laxatives.

29. I avoid foods with sugar in them.

30. I eat diet foods.

31. I feel that food controls my life.

32. I display self control around food.

33. I feel that others pressure me to eat.

34. I give too much time and thought to food.

35. I suffer from constipation.

36. I feel uncomfortable after eating sweets.

37. I engage in dieting behavior.

38. I like my stomach to be empty

39. I enjoy trying new rich foods.

40. I have the impulse to vomit after meals.

APPENDIX F: THE FROST MULTIDIMENSIONAL PERFECTIONISM SCALE

Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990)

Strongly Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Strongly Agree
1	2	3	4	5

____ 1. My parents set very high standards for me.

____ 2. Organization is very important to me.

____ 3. As a child, I was punished for doing things less than perfect.

____ 4. If I do not set the highest standards for myself, I am likely to end up a second-rate person.

____ 5. My parents never tried to understand my mistakes.

____ 6. It is important to me that I be thoroughly competent in everything that I do.

____ 7. I am a neat person.

____ 8. I try to be an organized person.

____ 9. If I fail at work/school, then I am a failure as a person.

____ 10. I should be upset if I make a mistake.

____ 11. My parents wanted me to be the best at everything.

____ 12. I set higher goals than most people.

____ 13. If someone does a task at work/school better than I, then I feel like I failed the whole task.

____ 14. If I fail partly, it is as bad as being a complete failure.

____ 15. Only outstanding performance is good enough in my family.

____ 16. I am very good at focusing my efforts at attaining a goal.

____ 17. Even when I do something very carefully, I often feel that it is not quite right.

____ 18. I hate being less than the best at things.

____ 19. I have extremely high goals.

____ 20. My parents have expected excellence from me.

____ 21. People will probably think less of me if I make a mistake.

____ 22. I never felt like I could meet my parents' expectations.

____ 23. If I do not do as well as other people, it means I am an inferior human being.

____ 24. Other people seem to accept lower standards from themselves than I do..

____ 25. If I do not do well all the time, people will not respect me.

____ 26. My parents have always had higher expectations for my future than I have.

____ 27. I try to be a neat person.

____ 28. I usually have doubts about the simple everyday things I do.

____ 29. Neatness is very important to me.

____ 30. I expect higher performance in my daily tasks than most people.

____ 31. I am an organized person.

____ 32. I tend to get behind in my work because I repeat things over and over.

____ 33. It takes me a long time to do something "right."

____ 34. The fewer mistakes I make, the more people will like me.

____ 35. I never felt like I could meet my parents' expectations.

APPENDIX G: THE SOCIOCULTURAL ATTITUDES TOWARDS APPEARANCE SCALE

SOCIOCULTURAL ATTITUDES TOWARDS APPEARANCE SCALE - 3 (SATAQ-3)

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

Definitely Disagree = 1 Mostly Disagree = 2 Neither Agree Nor Disagree = 3 Mostly Agree = 4 Definitely Agree = 5

1. TV programs are an important source of information about fashion and "being attractive." _____
2. I've felt pressure from TV or magazines to lose weight. _____
3. I do not care if my body looks like the body of people who are on TV. _____
4. I compare my body to the bodies of people who are on TV. _____
5. TV commercials are an important source of information about fashion and "being attractive." _____
6. I do not feel pressure from TV or magazines to look pretty. _____
7. I would like my body to look like the models who appear in magazines. _____
8. I compare my appearance to the appearance of TV and movie stars. _____
9. Music videos on TV are not an important source of information about fashion and "being attractive." _____
10. I've felt pressure from TV and magazines to be thin. _____
11. I would like my body to look like the people who are in movies. _____
12. I do not compare my body to the bodies of people who appear in magazines. _____
13. Magazine articles are not an important source of information about fashion and "being attractive." _____
14. I've felt pressure from TV or magazines to have a perfect body. _____
15. I wish I looked like the models in music videos. _____
16. I compare my appearance to the appearance of people in

magazines. _____

17. Magazine advertisements are an important source of information about fashion and "being attractive." _____
18. I've felt pressure from TV or magazines to diet. _____
19. I do not wish to look as athletic as the people in magazines. _____
20. I compare my body to that of people in "good shape." _____
21. Pictures in magazines are an important source of information about fashion and "being attractive." _____
22. I've felt pressure from TV or magazines to exercise. _____
23. I wish I looked as athletic as sports stars. _____
24. I compare my body to that of people who are athletic. _____
25. Movies are an important source of information about fashion and "being attractive." _____
26. I've felt pressure from TV or magazines to change my appearance. _____
27. I do not try to look like the people on TV. _____
28. Movie starts are not an important source of information about fashion and "being attractive." _____
29. Famous people are an important source of information about fashion and "being attractive." _____
30. I try to look like sports athletes. _____

APPENDIX H: THE INTERNALIZED MISOGYNY SCALE

INTERNALISED MISOGYNY SCALE (Piggott, 2004)

	Strongly Disagree 1	Moderately Disagree 2	Slightly Disagree 3	Neutral 4	Slightly Agree 5	Moderately Agree 6	Strongly Agree 7
1. Women exaggerate problems they have at work	☐	☐	☐	☐	☐	☐	☐
2. Women are too easily offended	☐	☐	☐	☐	☐	☐	☐
3. Women seek to gain power by getting control over men	☐	☐	☐	☐	☐	☐	☐
4. When women lose to men in a fair competition, they typically complain about being discriminated against	☐	☐	☐	☐	☐	☐	☐
5. It is generally safer not to trust women too much.	☐	☐	☐	☐	☐	☐	☐
6. When it comes down to it a lot of women are deceitful	☐	☐	☐	☐	☐	☐	☐
7. I think that most women would lie just to get ahead.	☐	☐	☐	☐	☐	☐	☐
8. I am sure I get a raw deal from other women in my life	☐	☐	☐	☐	☐	☐	☐
9. Sometimes other women bother me by just being around.	☐	☐	☐	☐	☐	☐	☐
10. I believe that most women tell the truth	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree 1	Moderately Disagree 2	Slightly Disagree 3	Neutral 4	Slightly Agree 5	Moderately Agree 6	Strongly Agree 7
11. When I am in a group consisting of equal numbers of men and women and a woman dominates the conversation I feel uncomfortable.	☐	☐	☐	☐	☐	☐	☐
12. I am uncomfortable when I hear a woman speaking with authority on male dominated topics such as football or horseracing	☐	☐	☐	☐	☐	☐	☐
13. I prefer to listen to male radio announcers than female.	☐	☐	☐	☐	☐	☐	☐
14. The intellectual leadership of a community should be largely in the hands of men	☐	☐	☐	☐	☐	☐	☐
15. I prefer to work for a male boss.	☐	☐	☐	☐	☐	☐	☐
16. If I were to beat another woman for a job I would feel more satisfied than if I beat a man.	☐	☐	☐	☐	☐	☐	☐
17. Generally, I prefer to work with men.	☐	☐	☐	☐	☐	☐	☐

APPENDIX I: PROSPECTUS

Perfectionism, The Thin Ideal, and the Development of Disordered Eating:

Does Internalized Misogyny Play a Role?

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Abstract

Research has consistently shown a relationship between both perfectionism and the internalization of the thin ideal with disordered eating behavior. The relationship between internalized misogyny and disordered eating behavior has not been examined, though internalized misogyny has been shown to be associated with other correlates of disordered eating, including low self-esteem, negative body image, and self-objectification. The purpose of this research study is to determine whether internalized misogyny moderates the relationship between the internalization of the thin ideal and disordered eating behavior, when controlling for the influence of perfectionism. Participants will be approximately 250 females from a community sample. Hierarchical multiple regression analysis will be utilized to examine internalized misogyny's role as a moderator in the relationship between the internalization of the thin ideal and disordered eating.

"Psychopathology is the final outcome of all that is wrong with a culture." -- Jules Henry

Chapter 1: Introduction

Eating Disorders: Prevalence and Current Statistics

Current literature estimates that between 2 and 10 million people have clinically diagnosable eating disorders (Bordo, 2003; Miller-Day & Marks, 2006), a significant number by any standard of measurement. Experts conclude that between 1% and 3% of women suffer from eating disorders, and that prevalence rates for men are approximately one tenth of those for women (Evans et al., 2005). Given this large disparity, female gender has been cited as perhaps the most obvious and salient risk factor for developing an eating disorder (Evans et al., 2005). In agreement, Striegel-Moore and Bulik (2007) suggested that "the single best predictor of risk for developing an eating disorder is being female" (p. 182).

Eating disorders (ED) remain the most lethal of psychiatric disorders, with anorexia exhibiting the highest mortality rate of all mental disorders (Costin, 1997; Streigel-Moore & Bulik, 2007). Estimates are that somewhere between 5% and 10% of those affected by eating disorders eventually die of related causes (Steinhausen, 2002), and some research suggests this number may be closer to 20% if eventual suicide is a consideration (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). Additionally, these disorders are some of the most difficult to treat, as no form of psychotherapy or psychopharmacology has been proven efficacious in the treatment of Anorexia Nervosa (AN), and only minimal success has been established with treatments for Bulimia Nervosa (BN; Wilson, Grilo, & Vitousek, 2007). One of the most accepted

risk factors for the treatment of AN is the duration of symptomatology, such that the longer a patient has been restricting their food intake, the poorer their long-term prognosis for complete recovery (Eisler et al., 2000; Russell et al., 1987).

Longitudinal studies suggest that 14%-46% of those with partial syndrome eating disorders progress to full syndrome within 1-2 years (Shisslak et al., 1995). Thus, early signs of disturbed eating attitudes may be potential predictors of more serious eating disturbances later in adolescence and young adulthood (Westerberg, Edlund, & Ghaderi, 2008). Furthermore, there is evidence that concerns about weight and shape regularly occur in girls as early as the third grade (Agras et al., 2007), and that between 40% and 50% of girls age 7 to 11 years select a preferred or "ideal" body that is thinner than their own (Evans, Tovee, Boothroyd, & Drewett, 2012). Taken together, this data supports the importance of continued research on disordered eating, with an emphasis on early indicators and variables that may preclude, alter, or otherwise impact the development of a full-blown eating disorder. It follows that inquiry focused on disordered eating behaviors, not solely on clinically diagnosable eating disorders, is called for by an abundance of documented research evidence.

The growing number of eating disorders diagnosed and treated each year, and the poor prognosis for recovery (Miller, 2000), suggest that current research and training have not adequately prepared practitioners to understand, identify, and effectively treat such issues. The best current therapeutic practices display inadequate impact with regard to effective treatment of these problems. Much of the emphasis has been on the psychopathology of the individual, and considerable research has focused on developmental factors that shape personality traits. Perfectionism is one

personality trait that has been consistently linked to disordered eating in the research literature. *Perfectionism* is best understood as a series of distinguishing characteristics such as an overwhelming motivation to be perfect, a tendency to set and hold unrealistic standards, compulsive strivings, all-or-none thinking regarding success and failure, a neurotic obsession with flaws and past failures, and a desire for infallibility manifested in an intolerance for mistakes, as well as a perception of even minor mistakes as failures (Ferrari & Mautz, 1997; Hewitt & Genest, 1990; Sassaroli & Ruggiero, 2005). Multiple studies (e.g., Peck & Lightsey Jr., 2008; Boone, Soenens, & Braet, 2011) have identified this variable, considered a personality trait that can reach maladaptive proportions, as part of the psychological makeup of individuals who suffer from EDs.

The lack of treatment progress for EDs suggests that unidentified elements may be influential in the formation of eating disorders and the disordered eating patterns that lead to them. Thus, an important arena for current research involves a social psychological perspective that seeks to better understand the interplay between the psychology of the individual and their sociocultural context. In particular, psychologists and researchers could benefit from understanding how this context is interpreted and internalized for individuals who display eating disturbances, above and beyond the influence of personality-based psychopathology.

Furthermore, it is well known and widely documented that most women in Westernized culture experience dissatisfaction with their bodies regardless of their actual weight, shape, or size (Morrison & Sheahan, 2009). The link between the internalization of the Westernized thin ideal and disordered eating behavior has also

been strongly supported in the literature (Bradford & Petrie, 2008; Stice, Spangler, & Agras, 2001; Stice, 2002). The internalization of the thin ideal is seen as the extent to which an individual "cognitively 'buys into' socially defined ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals" (Thompson & Stice, 2001, p. 55). However, not all women who internalize thin ideal messages and who are dissatisfied with their bodies develop disordered eating. Further research is still needed to examine the link between the thin ideal and disordered eating behavior and the factors that intensify, modify, or otherwise alter that relationship. In addition, it is important to continue to examine how Westernized cultural messages interact to impact women outside of the influence of individual personality traits, familial variables, and biological factors, which have received a lion's share of the attention in the literature to date.

Feminist constructs provide an important avenue to deconstruct this relationship, since these inherently recognize the importance of the internalization of cultural messages and how they impact the experience of an individual and their resulting behavior. Internalized misogyny is one such construct that may have an impact on how strongly the thin ideal becomes internalized and thus how intensely disordered eating manifests itself. *Misogyny* refers to the subordination or devaluation of women as a cultural practice that maintains the power of the dominant male group (Piggott, 2004). *Internalized misogyny* refers to the level of sexism and patriarchy that individuals take in and endorse.

Statement of Problem

In the interest of expanding the current framework for understanding and treating eating disorders, this study seeks to examine whether internalized misogyny serves as a moderator in the relationship between the internalization of the thin ideal and disordered eating in a community sample of females when controlling for the influence of perfectionism. It is hoped that the resulting information can inform treatment approaches by way of both recognizing and attending to important internalized cultural messages when treating individuals affected by both disordered eating and eating disorders.

Chapter 2: Review of the Literature

Feminist Cultural Analyses and Disordered Eating

Hesse-Biber et al (2006), suggested that we "neither negate nor dismiss the psychological aspects of Eating Disorders. Rather the focus is to *expand* the framework of causality to include 'culturally-induced' manifestations of these disorders" (p. 209). In the case of eating disorders, this focus has begun to involve an examination of the positive reinforcement of the thin body ideal in Westernized culture, and how this idealized body affects eating patterns (Bordo, 2003; Bradford & Petrie, 2008). Studies have shown that the internalization of the thin ideal is correlated with higher levels of disordered eating patterns in women and young girls (Bradford & Petrie, 2008; Stice, Spangler, & Agras, 2001; Stice, 2002).

Feminist theorists recognized the impact of culture on the individual when asserting that *The Personal is Political*. This is a central tenet that undergirds all feminist theoretical models, and as such is agreed upon as a fundamental guidepost for understanding that the experiences of individuals are fully embedded within – and thus reflective of – cultural context. Furthermore, feminist therapists recognize that intrapsychic symptoms and problems often arise as a response to surviving in and coping with oppressive circumstances (Enns, 2004). Traditional psychological models for understanding individual psychopathology may recognize the impact of cultural variables, but tend to primarily recognize and treat psychological problems as originating from, and residing within, the individual. Resulting treatment models thus tend to focus on individual psychopathology rather than fully recognizing and deconstructing cultural pathology. Enns (2004) warned that:

> If clients are encouraged to look exclusively inside themselves for clues about the origins and dynamics of their problems, they are also more inclined to blame themselves, and to respond by adjusting to or changing themselves to fit the circumstances around them. (p. 11)

Research has shown that a number of mental health disorders, including depression, anxiety, and eating disorders, are significantly more prevalent in women than men (Sabik & Tylka, 2006). In addition, in the case of eating disorders one could argue that the line between culturally sanctioned behavior and severe mental illness seems blurry at best, since extreme dieting, over-exercising, and undue focus on weight and shape continue to be encouraged – and arguably even valued – behaviors within the culture at large (Bordo, 2003). Like a piece of fabric that has been so tightly woven that its individual fibers become nearly invisible, the influence of patriarchy is often difficult to recognize (Bordo, 2003). Thus, while sociocultural context is acknowledged as a contributing factor in the development of disordered eating, treatment models generally fail to fully address culture or feminist consciousness (Shisslak, Crago, & Estes 1995; Sabik & Tylka, 2006). This is likely due, in part, to the complexity and invisibility of such variables, and the difficulty inherent in attempting to understand them.

A discussion regarding the cultural treatment of the body – and the female body in particular – seems essential when conceptualizing treatment approaches. Yet, these and other cultural elements are often not incorporated when approaching the creation and implementation of treatment models (e.g. Linehan, 1993). Thus, feminist contributions are often not included as treatment for EDs is aligned with the medical

model, which views these problems as similar to other "diseases." Indeed, the historical tendency for psychology as a discipline to minimize the impact of the environment on psychopathology is striking, and feminists have long critiqued how the "focus on the intrapsychic tends to pathologize and privatize. There is a long history of blaming women (i.e. calling them 'sick' or 'crazy') for symptoms that are in large part responses to oppression and victimization" (Ellis & Murphy, 1994, p. 55). In a classic statement defining goals for feminist therapy, Klein (1976) stated "Not all symptoms are neurotic. Pain in response to a bad situation is adaptive, not pathological" (p. 90).

Considering the examination of the influence of culture on women's experiences that feminist research and literature provides, and the reality that eating disorders are a primarily female phenomenon, feminist constructs and research may provide rich and important information in the continued discourse surrounding eating disorders. Few other mental illnesses seem to "land" on the female body in such a tangible way. Gross (1986) offers compelling points about how the female body writes and defines the female experience overall:

> The female body is inscribed socially, and most often, individually experienced as a lacking, incomplete or inadequate body….Women's oppression is generated in part by these systems of patriarchal morphological inscription – that is, by a patriarchal symbolic order – or part by internalized, psychic representations of this inscribed body, and in part as a result of the different behaviors, values, and norms that result from these different morphologies and psychologies (p. 142).

Other feminist researchers have suggested that an examination of the history of western thought reveals a "deep hatred and fear of the body…[such that] [t]his somatophobia is understood by some feminists to be specifically masculine and intimately related to gynophobia and misogyny" (Gatens, 1999, p. 228). Foucault's (1977) work laid some of the groundwork for understanding how this now-invisible historical structure has become its own self-propelling mechanism. As he stated:

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he is his own overseer, each individual thus exercising this surveillance over, and against himself. (p. 155)

Bordo (2003) has openly asserted the relationship between the power of patriarchy in our culture and the development of disordered eating in women. She calls the "relentless pursuit of excessive thinness…an attempt to embody certain values, to create a body that will speak for the self in a meaningful and powerful way" (p. 67). Interestingly, her work was groundbreaking in the 1980's, and though several decades have passed, many of the arguments she posited appear to have even more support now than they did then. In particular, she decoded and deconstructed the increasingly slender and muscular idealized female form, which has become nothing if not more emaciated, fat-free, carved-out, and boy-like than could have even been imagined in the 1980's. Bordo argued a type of internalized misogyny when she posited that:

> On the gender/power axis the female body appears, then, as the unknowing medium of the historical ebbs and flows of the fear of woman as 'too much.' That, as we have seen, is how the anorectic experiences her female, bodily self: as voracious, wanton, needful of forceful control by her male will. p. 163

In support of the importance of feminist consciousness, several research studies have identified that feminist identification may play a protective role against various types of disordered eating. Among adult women, Guille and Chrisler (1999) found that higher levels of acceptance of traditional gender roles was positively correlated with compulsive eating, whereas higher levels of commitment to feminist activism was negatively correlated with compulsive eating. Identification with feminist values was negatively associated with bulimic symptomatology among college women in a study conducted by Snyder and Hasbrouk (1996). In a study looking at the moderator effects of feminist identity styles on disordered eating, Sabik and Tylka (2006) found that for women low in *Synthesis* and *Active Commitment* to feminist identity, perceived lifetime and recent sexist events were positively related to disordered eating, and for women high on both feminist identity styles, perceived lifetime and recent sexist events were not related to disordered eating. Furthermore, Synthesis, reflecting integration of a positive self-concept including positive attributes associated with women and transcendence of traditional gender roles, buffered the relationship between perceived recent sexist events and perceived lifetime sexist events and disordered eating. Finally, Active Commitment, reflecting commitment to social change and the belief that men are equal to, but not the same as, women, also

buffered the relationships between both perceived lifetime sexist events and recent sexist events and disordered eating.

A recent study evaluated the roles of internalization of the thin ideal and feminist beliefs on (a) appearance-focused social comparisons and (b) body image disturbance, for undergraduate women (Myers, Ridolfi, Crowhter, & Ciesla, 2012). Myers et al. wanted to gather data on comparisons that occur in a naturalistic environment rather than a laboratory setting. They also sought to eliminate the bias that occurs with retrospective recall, and so utilized ecological momentary assessment (EMA) to gather samples with a PDA device at the moment they occurred in the environment. They found a strong association between what is termed *upward appearance focused comparisons* (i.e., when women compare themselves to perceived superior targets) and body dissatisfaction for all women, but found that feminist beliefs did offer some protection. Women high in feminist beliefs experienced significantly less state body dissatisfaction than women low in feminist beliefs, when making what was termed a *lateral comparison* (i.e. comparing themselves to a perceived similar target); and only women low in feminist beliefs engaged in greater body checking behavior in response to upward comparisons. Myers et al. (2012) stated that "[g]iven that body checking has been shown to be associated with eating disorder symptoms, these findings are cause for optimism, as upward comparisons are not associated with the behavioral component for women with feminist beliefs" (p. 349). This evidence provides the groundwork for the argument that feminist beliefs may provide a protective barrier against disordered eating, and that feminist constructs are of value in the continued discourse around eating disorders.

Disordered Eating versus Eating Disordered

The classification system for eating disorders has placed the psychological community at odds with itself. Many support the usefulness of the diagnostic categories that are currently practiced, but others make a case for the establishment of new methods for categorizing these problems. *The Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (DSM-IV-TR; APA, 2000) has formed the basis for the classification system that is currently utilized in the treatment of mental health. However, in the case of eating disturbances, there is evidence that the *DSM-IV-TR* inadequately captures the reality with which we are faced. As a result, there has been recent intense debate within the discipline as to how best to classify individuals who present for treatment with eating disordered behavior. In fact, the *DSM-V* (APA, 2013), published this year, contains massive restructuring of all the diagnostic categories related to eating disorders, reflecting the continued need for a better understanding of these issues in our field. Up until the recent DSM restructuring, the diagnostic categories were anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS). AN is marked by a refusal to maintain a body weight of at least 85% of what is expected for someone of the same height, while BN is characterized by recurrent episodes of binge eating followed by "compensatory" behavior such as vomiting, laxative or diuretic use, or compulsive exercise. Other diagnostic criteria within these two categories, such as the necessity for amenorrhea for a period of 3 months and body weight of less than 85% of a minimally normal weight for age and height to receive a diagnosis of AN, and the requirement that compensatory or purging behavior occur at least 2 times weekly for 3 months for a

diagnosis of BN, have caused the majority of individuals who present with an eating disorder to be diagnosed EDNOS. This is due in part to the fact that the diagnostic criteria have been fairly narrow and specific in nature.

DSM-V (APA, 2013) has broadened and relaxed the criteria for both AN and BN in an attempt to remediate this issue. In addition, Binge Eating Disorder (BED) has been added as an official diagnostic category. These diagnostic categories now form a classification scheme that is mutually exclusive, and the stated rationale is that "despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs" (p. 329). According to the new criteria, intense fear of gaining weight and a disturbance in the way body weight and shape are experienced are still markers of AN, but amenorrhea is no longer a requirement, and it is no longer a necessity that an individual's weight fall below 85% of what is minimally expected. Instead, an individual must be at what is termed *significantly low weight*, or a weight that is anything less than what is minimally normal or expected. For BN, compensatory behaviors now need only occur once per week for at least 3 months to receive a diagnosis. In addition, both AN and BN now include specifiers for partial and full remission. Due to the unfortunate reality that many insurance companies have only recently begun to cover ED treatment at all, there is a lack of clarity as to how readily these new diagnostic criteria will be adopted within the field as a whole.

A growing body of research suggests that each classified disorder represents only one point on a continuum of disordered eating behaviors on which all women find themselves functioning (Bordo, 2003; Peck & Lightsey Jr., 2008; Tylka &

Subich, 1999). Additionally, researchers who support this conceptualization purport that the continuum ranges from asymptomatic, through symptomatic, and finally to eating disordered at its most extreme, regardless of the specific ED behaviors exhibited (Tylka & Subich, 1999). They stress that only such a perspective adequately captures the full range of disturbed eating behaviors.

The continuum model of eating disordered behavior boasts convincing arguments in its favor. As previously mentioned, the majority of patients diagnosed with an ED have been given a diagnosis of Eating Disorder Not Otherwise Specified (EDNOS). This category, intended to be a residual diagnostic category, has become the diagnosis for the majority of individuals seeking treatment (Peck & Lightsey Jr., 2008; Streigel-Moore & Bulik, 2007). This disconcerting reality is causing psychologists and researchers to take notice of the problematic qualities of the current classification system. As Streigel-Moore and Bulik (2007) asserted, there are "significant flaws in our nosology…[as] we have failed to characterize adequately the core pathology profiles that comprise the eating disorders" (p. 193).

Feminist theorists (e.g. Brown & Jasper, 1993; Bordo, 2003) have posited that only a matter of degree divides those women who diet, exercise, count calories, and focus on their weight and shape from those who exhibit full-fledged AN or BN. They argue that the diagnostic system pathologizes and our culture stigmatizes these disorders even while praising and approving of those women who display similar behaviors in an attempt to attain the culturally prescribed ideal body (Brown & Jasper, 1993). Data has also suggested that, for many women who struggle with a clinically diagnosable eating disorder at one discrete point, the diagnosis or the behavior profile

is likely to change over a lifetime (Brown & Jasper, 1993). Brown & Jasper (1993) reminded us that "these shifts are not uncommon and suggest that the psychological underpinnings remain quite similar, regardless of what form the weight preoccupation takes" (p. 58).

Thus far, a great deal of research has focused on the diagnostic categories of Anorexia Nervosa and Bulimia Nervosa, within a medical model perspective that sees these disorders as categorically and fundamentally different. This has made these problems easier to study with randomized controlled clinical trials; however, the reality is that treatment methods are currently disappointing in their effectiveness, and this evidence suggests that researchers may be on the wrong track overall (Miller, 2000; Wilson, Grilo, & Vitousek, 2007). With this in mind, this study views disordered eating as a continuous variable, representing all types of pathological eating behavior, and not understood by binge/purge or restricting behavior specifically or categorically, in an effort to explore variables that could impact treatment for those struggling with disordered eating.

Perfectionism and Disordered Eating

As previously discussed, *Perfectionism* is best understood as a series of distinguishing characteristics such as an overwhelming motivation to be perfect, a tendency to set and hold unrealistic standards, compulsive strivings, all-or-none thinking regarding success and failure, a neurotic obsession with flaws and past failures, and a desire for infallibility manifested in an intolerance for mistakes, as well as a perception of even minor mistakes as failures (Ferrari & Mautz, 1997; Hewitt & Genest, 1990; Sassaroli & Ruggiero, 2005). It is most often considered a personality

style that can reach maladaptive proportions. Perfectionism has been linked with higher suicide rates, irrational black and white thinking, and rigid adherence to impossible standards for self and others (Ferrari & Mautz, 1997). Due to its strong association with disordered eating and eating disorders, perfectionism has been a focus of research attention for some time (e.g. Bardone-Cone et al., 2007; Davis, 1997; Davis, Claridge, & Fox, 2000; Hopkinson & Lock, 2004). However, according to Kenney-Benson and Pomerantz (2005), "Although the consequences of perfectionism have received much attention, the origins of such an orientation are just beginning to be explored…Therefore, how it is that individuals develop a perfectionistic orientation is still not entirely clear" (p. 24). In other words, much like eating disorders themselves, there are still considerable lingering questions regarding the etiology of perfectionism.

Research suggests that one of the many consequences of perfectionism appears to be a predisposition for an eating disorder, and that it is a trait that tends to persist after recovery (Bardone-Cone et al., 2007). Some propose that a tendency towards perfectionism may lead one young woman to develop an eating disorder, while another who lacks the drive to be perfect may not. When Hopkinson and Lock (2004) studied female athletes, they asserted that the highest risk factor for eating disorders was perfectionism. Indeed, the research consensus is that perfectionism seems to be one of the most predictable predisposing risk factors in the development of an eating disorder (McLaren, Gauvin & White, 2001; Ruggiero, Levi, Ciuna, & Sassaroli, 2003; Sassaroli & Ruggiero, 2005), and that perfectionism is a central feature of eating disorders (Davis, 1997; Davis, Claridge, & Fox, 2000). However, data assessing

whether premorbid perfectionism predicts eating disorders is limited and exhibits significant limitations. A recent meta-analytic review of the literature regarding perfectionism and eating disorders showed that most of the data used to assess this relationship has relied on retrospective recall rather than utilizing prospective longitudinal designs (Bardone-Cone et al. 2007), which begs the question as to whether perfectionism is a premorbid, predisposing risk factor for eating disorders or is a feature that develops alongside eating pathology.

Although perfectionism is one form of individual psychopathology that has been widely researched in conjunction with disordered eating, "[i]t is not clear….whether the general psychopathology associated with EDs is a cause, an effect, or a correlate of the ED itself" (Shisslak, Crago, & Estes, 1995). Only two known studies have assessed premorbid perfectionism with a longitudinal design prior to onset of an ED. In a study by Tyrka, Waldron, Graber, and Brooks-Gunn (2002), premorbid perfectionism was a significant prospective predictor of AN, but not BN. However, in a study by Santonastaso, Friederici, and Favaro (1999), premorbid perfectionism levels did not predict which adolescent girls subsequently developed either AN or BN. Such mixed results indicate that the role of perfectionism is not clear-cut.

Research has also explored the idea that perfectionism is a multidimensional personality trait, with several proposals for what dimensions make up the construct as a whole. Since the early 1990's, many dimensions of perfectionism have been proposed and studied in the conceptualization of perfectionism as a multidimensional construct. Dimensions of perfectionism that have been most extensively researched

and utilized come from two specific assessment tools. First, the Frost Multidimensional Perfectionism Scale (FMPS; Frost, Martin, Laharte, & Rosenblate, 1990) proposes six dimensions of perfectionism: Concern Over Mistakes, Personal Standards, Family Criticism, Parental Expectations, Doubts About Actions, and Organization. The second, the Hewitt and Flett Multidimensional Perfectionism Scale (Hewitt and Flett MPS; Hewitt & Flett, 1991) proposes three dimensions: Self-Oriented, Socially-Prescribed, and Other-Oriented Perfectionism. In the past decade, research has utilized these multidimensional conceptualizations to study perfectionism, and over time the suggestion of two main factors has emerged. Conceptually, these factors are marked by the idea that there is a more *neurotic* form of perfectionism, and a *normal* one (Bardone-Cone et al., 2007). In other words, the newest conceptualization of perfectionism suggests that there are both adaptive and maladaptive dimensions of this construct.

Two dimensions that have recently been proposed and studied in conjunction with eating disorders are evaluative concerns (EC) perfectionism, comprising self-critical features, and personal standards (PS) perfectionism, which includes the setting of high standards for self (Boone, Soenens, & Braet, 2011). Findings have been mixed when studying these dimensions in relation to eating disorders, with some studies suggesting a differential role for PS and EC perfectionism in relation to ED symptoms (Boone, Soenens, & Braet, 2011), and others suggesting that there is not a clear distinction between the two in terms of ED symptoms (Bardone-Cone et al., 2007).

Bardone-Cone et al. (2007) reviewed the findings regarding the adaptive versus maladaptive multidimensional conceptualization of perfectionism with eating disorders, anxiety, and depression. They found that with other forms of psychopathology (e.g. anxiety, depression) only maladaptive forms of perfectionism were most consistently elevated, whereas within an eating disordered population both maladaptive perfectionism and dimensions that have historically been considered more adaptive (e.g. achievement striving) appeared to be elevated. The authors stated, "[t]his suggests that describing dimensions of perfectionism as positive/adaptive and negative/maladaptive may not be entirely accurate – eating disorders may be one context in which achievement striving ("adaptive") perfectionism is actually negative or maladaptive" (p. 398).

In summary, the literature suggests that the multidimensional idea of perfectionism may not necessarily hold in relation to eating disorders. Furthermore, though perfectionism has been suggested as a predisposing risk factor in the development of eating disorders, there is some disagreement as to the validity of this assertion. Research used to make this argument has relied mostly on self-report through retrospective recall (Bardone-Cone et al., 2007), and studies that have looked at the construct prospectively offer evidence that suggests perfectionism might not necessarily be the predisposing risk factor it has been assumed to be (e.g. Santonastaso, Friederici, & Favaro, 1999; Tyrka et al., 2002). Since perfectionism has so long been thought to be a part of the personality profile of individuals who develop eating disorders, research has assumed this understanding in many models that examine eating pathology. Research is needed that looks at the influence of

predisposing cultural variables, such as thin ideal internalization and internalized misogyny, above and beyond the influence of individual personality-based constructs, such as perfectionism that imply vulnerability to psychopathology.

The Thin Ideal and Disordered Eating

> In a culture obsessed with attaining the perfect physique, it is not surprising that…women in the United States often internalize ideal cultural representations of the female body and report feeling dissatisfied with their own bodies. Why do women internalize such unrealistic cultural ideals? (Greenleaf & McGreer, 2006, p. 187-188)

This question has plagued the research literature on eating disorders for some time. Feminist theorists have asserted that the social value of woman is in many ways inseparable from her body, and that it tends to be connected to bearing children and satisfying others sexually (Brown & Jasper, 1993). Historically, there has been a shift from a feminine "ideal" that is more rounded and fertile-looking, to a more thin and muscular look that predominates today (Bordo, 2003). Following industrialization in Western society, a thinner body that symbolized "wealth, independence, freedom…[and] non-reproductive sexuality became valued" (Brown & Jasper, 1993, p. 19). Since body shape and size are connected to a woman's social value or currency in this symbolic way, feminists have argued that women learn to focus on and police their appearance in order to achieve social success (e.g. Bordo, 2003).

Studies examining the connection between eating disorders and internalized cultural attractiveness beliefs have commonly revealed a significant relationship (e.g. Bradford & Petrie, 2008; Groetz, Levine, & Murtten, 2002; McKnight Investigators,

2003; Stice, Spangler, & Agras, 2001; Stice, 2002). However, while there is evidence that a strong correlation exists, there are still many questions about the details of this relationship and the elements that influence it. The internalization of the thin ideal has been defined as the extent to which an individual "cognitively 'buys into' socially defined ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals" (Thompson & Stice, 2001, p. 55). Awareness of the thin ideal and its internalization are considered related but distinct constructs, with thin-ideal internalization accounting for significant additional variance in body dissatisfaction and disordered eating above and beyond that explained by thin-ideal awareness (Heinberg, Thompson, & Stormer, 1995). Thus, there appears to be a distinction between the awareness of our culture's idealization of thinness and its actual adoption for women. Understanding this distinction requires a look into both developmental/psychodynamic theories of the individual, and a look at sociocultural theory.

Developmental/Psychodynamic Theory. The concept of internalization is central to developmental and psychodynamic theories, as these conceptualize it as being core to the psychological development of the individual. Object-Relations is one such theory, which posits that an individual takes in psychic representations of the *other,* eventually transforming these representations into a sense of being, or self (Cashdan, 1988). According to Object-Relations Theory, early relationships with primary caregivers provide the central components of this *self as other* internalization. Theorists also believe that internalizations change and mature, and that in addition to human-to-human internalizations, interactions from the environment also become an

integral part of the self (Cashdan, 1988). Cashdan (1988) referred to sociologist George Herbert Mead when he stated:

> The individual self is the mechanism by which society becomes incorporated into the human psyche. Because the self is constructed out of relationships with others and therefore involves the internalization of societal codes and conventions, it can be considered a miniature society within the individual. As mother and child are inextricably bound in object relations theory, so self and society are bound up in symbolic interaction. (p. 49)

The internalization of the thin ideal in Westernized society surely represents an example of this type of unconscious interplay between self and society. It is a cogent example of how such a societal code can become integrated into the self in much the same way that one learns behaviors from a parent.

Sociocultural Theory and The Dual Pathway Model. It has been suggested that social psychology itself can be best understood as the study of socialization and its by-products (Lott, 1973). Broadly, this has been defined as "[h]ow people learn the beliefs and attitudes of their groups and how they internalize group expectations for their behavior" (Lott, 1973, p. 919). With regard to the internalization of the thin ideal specificially, modern sociocultural theories are most commonly used to explain the process by which children develop thoughts and feelings about their bodies, and the most often cited influences are parents, peers, and the mass media (Clark & Tiggemann, 2008; Lopez-Guimera, Levine, Sanchez-Carracedo, & Fauquet, 2010). In terms of disordered eating, the sociocultural model that has arguably received the most

research focus and empirical support is the dual pathway model (Stice, 1994). The model was once used to describe the development of bulimic symptoms, but has now been applied to a variety of pathological behaviors around food. The dual pathway model posits that internalization of the thin ideal leads to body dissatisfaction and increased risk of disordered eating via dietary restraint or depression, which are considered two distinct pathways (Thompson & Stice, 2001). However, evidence for the dual pathway model is mixed, and recent research with adolescents and preadolescents has provided evidence for a more direct relationship, or link, between thin-ideal internalization and disordered eating attitudes, rather than through the body dissatisfaction-dietary restraint, or body dissatisfaction-depression pathways (Evans, et al, 2010).

Experimental studies have uncovered a strong causal relationship between the preoccupation with a desire to be thin and bulimic symptoms (Groetz, Levine, & Murtten, 2002; Stice, 2002), and a controlled prevention study demonstrated that reducing the level of body dissatisfaction resulted in a reduction in bulimic symptoms (Taylor et al., 2006). Another experimental study found that when vulnerable adolescents were exposed to images of the cultural thin ideal, the exposure was associated with increased negative affect, increased pressure to be thin, and increased body dissatisfaction (Stice, Spangler, & Agras, 2001).

In a recent study testing the dual-pathway sociocultural model with preadolescent girls ages 7 to 11, Evans, Tovee, Boothroyd, and Drewett (2010) found that the original model showed a poor fit to the data. Specifically, the path between dietary restraint and depression did not significantly contribute to the model; however,

an additional direct path between thin ideal internalization and disordered eating attitudes showed significance and a better fit with the data. The authors hypothesized that there could be several reasons for this. They referred to the perceived social benefits of being thin that may become internalized along with the thin ideal, and they stated that these elements could conceivably motivate disordered eating in the absence of individual psychopathology (i.e. body dissatisfaction, dietary restraint, or depression). This is the only known study conducted with a preadolescent female population assessing the dual pathway model, and the findings raise notable questions as to the possibility of a direct relationship between the internalization of the thin ideal and disordered eating, perhaps prior to the development of any measureable individual psychopathology.

Other models have been proposed and have had limited research support, with a range of interesting findings that continue to highlight the importance of the internalization of the thin ideal. For example, Smolak and Levine (2001) proposed a model which hypothesized that media and peer influences would lead to a change in internal focus on weight and shape for children, and that this would ultimately lead to a change in body image. Clark and Tiggemann (2008) tested this hypothesis and found that the internalization of the thin ideal led 9-12 year-old girls to have a desire to be thinner, and to experience more negative feelings about their bodies in general. This finding has been replicated with adult and adolescent females as well (Hargreaves & Tiggemann, 2002; Lavin & Cash, 2001).

Longitudinal Data. A landmark, long-term prospective study (McKnight Investigators, 2003) followed over 1,000 girls from grades 6 to 9 at sites in California

and Arizona. This study produced compelling findings about the effects of the internalization of the thin ideal in this sample. For the California site, thin body preoccupation and social pressure to be thin clustered as one factor that predicted the onset of a full or partial eating disorder, with a large effect size of 1.2. The findings from the Arizona site suggested that being Hispanic was a moderator; however, social pressure to be thin was a risk factor whether the girls were Hispanic or non-Hispanic. Further support has been given to this finding from a more recent longitudinal study by van den Berg, Neumark-Sztainer, Hannan, & Haines (2007), who followed over 1,300 middle and high school girls for 5 years. In this sample, those young women who reported that they *sometimes* or *often* read magazine articles where dieting and weight loss were discussed were twice as likely to be engaged in unhealthy weight control behaviors, and three times as likely to be engaged in extreme weight-control behaviors at 5-year follow-up. This finding remained significant even when controlling for initial weight control behaviors, demographic features, weight importance, and Body Mass Index (BMI).

Three successive landmark studies pioneered by one of the principal investigators from the McKnight study (2003) were notable for following a very large sample of nearly 7,000 females ages 9-14 for a long period of time (Field, Camargo, Taylor, Berkey, & Colditz, 1999; Field, Camargo, Taylor, Berkey, Roberts, et al., 2001; Field, Javaras, Anjea, Kitos, et al., 2008). Few studies in the field of eating disorders offer this type of longitudinal data with such a large sample size. At one year follow-up, and when controlling for age and initial BMI, the girls who consciously attempted to follow the thin female ideal presented in the media were 1.6

to 1.9 times more likely to have a preoccupation with their weight, to be continually dieting, and to have used purging behaviors. At the seven-year follow up, females in all age groups who were consciously trying to emulate women in the media were 1.5 times more likely to have started purging, and 2.2 times more likely to binge eat.

Application of the Thin Ideal Across Cultures. Studies assessing disordered eating have historically been skewed toward an overrepresentation of Caucasian women (Striegel-Moore & Bulik, 2007). Perhaps due in part to the assumption that eating disorders are less prevalent among ethnic minority populations, ethnic minorities are far less likely not only to seek treatment for such problems, but to receive treatment as well (Striegel-Moore & Bulik, 2007; Streigel-Moore, et al., 2003). One study assessing race/ethnicity as a marker of eating disorders in a large United States community sample of 2,054 young adult Black and White American women found that all eating disorders were less common among Black women and there were no Black women with AN (Streigel-Moore et al., 2003). Results in this study were confounded by socioeconomic status, as few of the Black women came from affluent households, so that it could not be determined whether SES or race/ethnicity was a more significant contributing factor in the prevalence of EDs for this sample.

Most studies assessing the impact of the thin ideal on disordered eating behaviors utilize an U.S. sample. Two studies assessing large international samples have provided important evidence about the influence of the Westernized thin beauty ideal on disordered eating in other cultures, however. First, a study of approximately 3,000 Spanish girls and young women ages 12 to 21 evaluated risk factors for

developing an eating disorder over an 18-month period (Martinez-Gonzales, Gual, Lahortiga, Alonso, et al., 2003). These researchers found that those young women who were readers of fashion magazines were 2.1 times more likely to develop an eating disorder.

Finally, a naturalistic study conducted in Fiji provided arguably some of the most compelling data concerning the development of eating disorders and the influence of the thin ideal as a primary risk factor. This study by Becker, Burwell, Gilman, Herzog, and Hamburg (2002) studied a sample of adolescent girls on the Pacific Islands who had never been exposed to television before. Eleven percent of these girls reported vomiting to control their weight approximately 3 years after television had become widespread on the island, compared to 0% prior. During this time period, the percentage of girls who endorsed high levels of disordered eating attitudes more than doubled, going from 13% to 29%. Traditional Fijian culture does not endorse attempts to shape the female body with diet and exercise, and has a preference for more robust figures (Becker et al. 2002); yet following exposure to television, these authors found that 74% of Fijian girls reported *feeling fat*, and those who had television in their homes were an astonishing three times more likely to endorse disordered eating attitudes.

What Now? Clearly the evidence for the importance of sociocultural messages in the development of eating disorders is strong. In their recent comprehensive review detailing the research regarding the influence of mass media on body image and eating disordered attitudes in females worldwide, Lopez-Guimera, Levine, Sanchez-Carracedo, and Fauquet (2010) stated that:

> Despite nearly 35 years of concern about the relationship between mass media and eating disorders, there remains a strong need for both basic and applied research on the processes and mechanisms that constitute risk and protective factors in regard to the effects of the media on attitudes and behaviors related to body image and eating behavior in females. (p. 409)

In another comprehensive literature review on risk factors for eating disorders, Streigel-Moore and Bulik (2007) stated, "The corpus of findings from the sociocultural theory of eating disorders literature underscores the importance of preventative and policy interventions designed to decrease exposure to or attenuate the impact of thin-ideal messages" (p. 193). They reminded us that even if it has not been proven that thin ideal message are a major cause of eating disorders, it is clear that these messages have a seriously negative impact on women and girls. The McKnight Investigators (2003) suggested, "A next step for prevention efforts is to determine what factors contribute to thin body preoccupation and social pressure, and what can be done to reduce them."

Internalized Misogyny

The strength of the relationship between the thin ideal and disordered eating appears well-established. However, a relatively new construct, *internalized misogyny,* has emerged in the literature, which may bear a close relationship with the internalization of the thin ideal, but has not yet been examined in this capacity. This construct may help to explain the internalization of the thin ideal for women in our

culture, and the development of disordered eating behavior that for some ultimately reaches clinical proportions.

Misogyny refers to the subordination or devaluation of women as a cultural practice that maintains the power of the dominant male group (Piggott, 2004). *Internalized misogyny* refers to the level of sexism and patriarchy that individuals take in and endorse themselves. Women who internalize more misogyny exhibit distrust of other women and a higher level of respect for males than females (Szymanski, Gupta, Carr, & Stewart, 2009). Like internalized homophobia or internalized racism, and like the previously introduced construct of the thin ideal, internalized misogyny denotes the beliefs that an individual makes a part of his or her own understanding of the world. For women, internalized misogyny reflects a tendency to align with masculine power, and reject one's own "female-ness" to win patriarchal favor. This results in a fear of femininity and, as such, female-related characteristics are then seen by the individual as weak and vulnerable (Szymanski et al., 2009). As the previously discussed feminist deconstruction of sociocultural messages about women suggests, there is perhaps nothing more representative or symbolic of "female-ness" in our culture than the female body itself.

Internalized misogyny has been correlated in women with lower self-esteem, negative body image, and depression, all of which have a strong relationship with disordered eating (Piggot, 2004; Szymanski and Kashubeck-West, 2008). Syzmanski and Kashubeck-West (2008) found that internalized misogyny was correlated with lower self-esteem, higher psychological distress, and lessened social support for U.S. sexual minority women. In a recent study, Szymanski et al. (2009) found that

internalized misogyny intensified the relationship between experiences of external sexism and psychological distress in heterosexual undergraduate women. The researchers also found a significant relationship between internalized misogyny and self-objectification, but determined that the two constructs were conceptually distinct. Self-objectification can best be understood as the internalization of sexually objectifying experiences that happens as women learn to see themselves as objects to be viewed and evaluated on the basis of appearance (Fredrickson & Roberts, 1997).

In a study assessing the relationship between endorsement of Western beauty practices and ideals and levels of sexism and hostility towards women, Forbes, Collinsworth, Jobe, Braun, and Wise (2007) discovered that college men and women who endorsed these beauty practices and ideals showed significantly higher levels of hostility towards women, traditional sexism, and hostile sexism. The researchers stated that these results lend support to what they call the BIO hypothesis, or the assertion that "beauty ideals are oppressive" (Forbes et al., 2007, p. 266), and discussed the importance of examining the impact of all beauty ideals and practices on women, not just the thin ideal. However, Forbes et al. (2007) offered compelling support for a study examining the role of internalized misogyny in the internalization of the thin ideal when they state that "when body dissatisfaction is perceived, not as a problem for an individual, but as a means of enforcing patriarchal control [i.e. misogyny], this perception offers new research opportunities and ultimately new opportunities and techniques for amelioration" (p. 266).

Internalized misogyny reflects yet another example of how an individual's social context can become unconsciously interpreted and internalized, in this case

possibly resulting in a rejection of one's own female self. The thin ideal, while also a form of rejection of "female-ness," manifests this rejection in favor of a controlled physicality reflecting unrealistic levels of thinness and fitness. Indeed, feminist authors (Bordo, 2003; Brown & Jasper, 1993) have alluded to the increasingly muscular and low-fat (i.e., masculine) ideal for the female form that is seen in our culture. Furthermore, the thin ideal also seems consistent with a willingness to subjugate oneself through objectification and the primacy of physical appearance. Thus, this construct may be related to, but distinct from, the internalization of misogyny. It would follow that internalized misogyny could moderate the relationship between internalization of the thin ideal and disordered eating in women, in a model where higher levels of internalized misogyny and the internalization of the thin ideal correspond to increases in disordered eating behavior.

Perfectionism, the Thin Ideal, and Internalized Misogyny

As established, perfectionism and the internalization of the thin ideal are constructs that have been strongly linked to both disordered eating behavior and clinical EDs. Also established is that much of the research has focused on the internalization of the thin ideal, and this research often involves attention to the influence of media or individual psychopathology (i.e. perfectionism, body dissatisfaction, dietary restraint, and depression). To date internalized misogyny has not been examined in relationship to disordered eating; however, mixed findings have emerged with respect to the relationship between disordered eating and passive acceptance of traditional gender roles. One study found a significant positive

relationship between the two variables (Snyder and Hasbrouck, 1996), while a second study found none (Sabik and Tylka, 2006).

As previously mentioned, internalized misogyny can be understood as related to, but conceptually distinct from self-objectification (Syzmanski et al., 2009). Syzmanski et al. (2009) pointed out "although self-objectification and passive acceptance appear to be important manifestations of the ways in which sexism can be internalized, they fail to attend to a core construct of sexism, which is misogyny or a hatred and devaluation of women" (p. 102). In other words, internalized misogyny can be conceptualized as a variable that lies at the core of many other constructs that fall under the umbrella of sexism. By examining the influence of internalized misogyny on the internalization of the thin ideal, the current research has the potential to meaningfully inform both prevention programs and treatment models.

In the discussion of their findings, Syzmanski et al. (2009) pointed out the importance of continuing to examine internalized misogyny's role in the relationship between sexism and psychological distress. Eating disorders represent a particularly salient form of psychological distress for women, which manifests in maladaptive behavior. Furthermore, the internalization of the thin ideal would appear to represent both a specific type of internalized sexism and a type of self-objectification. Internalized misogyny is a core construct that captures and encompasses both of these variables by attending to the devaluation of women that exists in both. It is assumed that the internalization of the thin ideal is likely more potent when an individual unintentionally colludes with her own devaluation and endorses the type of self-hatred that internalized misogyny would engender. It would follow that building on

Syzmanski et al.'s findings provides a cogent rationale for examining the role of internalized misogyny as it relates to both the internalization of the thin ideal and disordered eating. In sum, the following hypotheses will be examined:

Hypothesis 1: Perfectionism, the internalization of the thin ideal, and internalized misogyny will be significantly positively correlated with disordered eating.

Hypothesis 2: The internalization of the thin ideal and internalized misogyny will be significant positive individual predictors of disordered eating, after controlling for the influence of perfectionism.

Hypothesis 3: Internalized misogyny will moderate the relationship between the internalization of the thin ideal and disordered eating.

Chapter 3: Method

Participants and Procedures

Participants will consist of approximately 250 females ages 18-64 recruited via sampling on social media websites and through email, and participation will be voluntary and include informed consent. Individuals will be asked to complete a self-report survey administered online, consisting of demographic questions and survey instruments assessing disordered eating, internalized misogyny, internalization of the thin ideal, and perfectionism. Participants will access the survey via a link posted on social media websites or within an email. They will also be asked to repost the link or forward to other females via email, in order to obtain a community sample. It is anticipated that the maximum amount of time needed to complete the survey will be approximately 20 minutes. As an incentive to participate, $100 gift cards will be offered to two randomly selected participants. Following completion of the survey, participants will be taken to a separately linked page that will allow them to provide a mailing address only, in order to receive a gift card. No other identifying information will be collected, and the database storing the mailing addresses will be separate from, and in no way traceable to, any individual's survey answers.

Data will be collected via Survey Monkey, which allows for the primary investigator to create an electronic, internet-based questionnaire to be distributed online. The primary investigator will create and maintain the survey, and will be the only individual with access to the survey data. Data will be collected, housed, and maintained through the use of Survey Monkey's secure server. All potential participants will be provided with a link to the electronic survey, and data will be

anonymous through the design of the survey, whereby not even the primary investigator will be able to trace any individual's survey answers to potential identifying information that would compromise their anonymity. Participants will be made aware of this level of anonymity during the informed consent process.

Measures

Eating Attitudes Test. The Eating Attitudes Test (EAT-26; Garner, Olmstead, Bohr, & Garfinkel, 1982) is a 26-item self-report measure that is designed to measure eating disorder symptomatology. The measure assesses several areas of disordered eating, including dieting, bulimia, and oral control, and thus represents the continuum of disordered eating behaviors. Examples of items on this scale include: "I am terrified about being overweight;" "I am aware of the calorie content of foods that I eat;" and "I feel that food controls my life." Although validated with anorexia nervosa patients, the measure has also been useful in identifying eating disturbances in non-clinical samples (Sabik & Tylka, 2006), such as the sample for this study. Responses are scored on a 5-point Likert scale (1 = *never* to 6 = *always*), with higher scores indicating a greater disturbance in eating attitudes and behaviors, and possible scores ranging from 26-156. This scoring method is consistent with several studies assessing a non-clinical population (e.g. Moradi, Dirks, & Matteson, 2005; Sabik & Tylka, 2006) The EAT-26 has shown high internal consistency with a non-clinical, community, female sample ($\alpha = 0.91$; Sabik & Tylka, 2006).

Multidimensional Perfectionism Scale. Perfectionism will be measured with the 35-item Multidimensional Perfectionism Scale (FMPS) by Frost et. al. (1990). Sample items include: "Other people seem to accept lower standards from themselves than I do;"

"If I don't do well all the time, then I feel that people will not respect me;" and "If I fail at something, I feel I am a failure as a person." The FMPS utilizes a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The full scale yields scores that range from 35 (not perfectionistic) to 175 (highly perfectionistic), with higher scores indicating more endorsed perfectionism. The questionnaire assesses total perfectionism, or, alternatively, six dimensions of perfectionism including: Concern Over Mistakes (CM), Doubts About Actions (DA), Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC) and Organization (ORG). Internal consistency for all the subscales ($\alpha = 0.73$-0.93) and for the overall scale ($\alpha = 0.91$) are acceptable (Frost et al., 1993). For this study, the FMPS total score will be used as a global measure of perfectionism, since research suggests that the multidimensional aspect of this construct does not necessarily apply to those with disordered eating (Bardone-Cone et al., 2007).

Sociocultural Attitudes Toward Appearance Questionnaire – 3. The Sociocultural Attitudes Towards Appearance Questionnaire – 3 (SATAQ-3; Thompson, van den Burg, Roehrig, Guarda, & Heinberg, 2004) will be utilized to measure the internalization of the thin ideal. The SATAQ-3 is a 30-item self-report measure that assesses the recognition and acceptance of sociocultural ideals regarding appearance. Example items include: "I would like my body to look like the models who appear in magazines;" "I've felt pressure from TV or magazines to have a perfect body;" and "Famous people are an important source of information about fashion and 'being attractive.'" Responses are scored on a 5-point Likert scale ranging from 1 (*definitely disagree*) to 5 (*definitely agree*). Items are summed to create four subscales (Information, Pressures, Internalization-Athlete, and Internalization-General) and a

Total score. The scale has demonstrated good reliability, with alpha coefficients ranging from 0.89 to 0.94 (Thompson et al., 2004). The current study will utilize the Internalization-General subscale, which specifically assesses the internalization of the thin ideal and shows high reliability ($\alpha = .94$; Myers et al., 2012). The Internalization-General subscale contains nine items, with possible scores ranging from 9 to 45, and measures how strongly an individual has internalized the norms for weight and shape demonstrated in the media.

Internalized Misogyny Scale. The Internalized Misogyny Scale (IMS, Piggot, 2004) contains three factors and 17 total items. The three factors are: devaluing of women, distrust of women, and gender bias in favor of men. The scale has been validated with feedback from a focus group, exploratory factor analysis, and correlations with a cross-cultural sample of 803 women from five countries (Piggot, 2004), and the scale has been correlated in the expected direction with measures of modern sexism, internalized heterosexism, body image, depression, self-esteem, psychosexual adjustment, and social desirability (Piggot, 2004). Though the scale was originally normed on a sexual minority female sample, results have been replicated with heterosexual women, suggesting that the construct is valid for both populations (Syzmanski et al., 2009). The IMS is the only known measure for assessing internalized misogyny, and it displays good reliability, with reported alpha coefficients for the full scale ranging from 0.88 (Piggot, 2004) to 0.90 (Szymanski et al., 2009). Sample items include: "It is generally safer not to trust other women too much;" and "Generally, I prefer to work with men." The measure utilizes a 7-point Likert-type

scale, from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores indicate more internalized misogyny.

Data Analysis

Moderators attend to the question of under what circumstances a particular variable most strongly predicts an outcome (Frazier, Tix, & Baron, 2004). Thus, these are variables that could potentially alter the relationship between predictor and criterion variables. In the relationship between the internalization of the thin ideal and disordered eating, several variables involving individual psychopathology have already been intensively studied; however, we still do not fully understand what causes a particular individual to internalize the thin ideal more strongly than another, and what causes one person to develop an eating disorder while another will not. Because perfectionism has been suggested as a personality construct that causes disordered eating to rise to a clinical level, this study will control for perfectionism in the interest of examining the influence of sociocultural variables (i.e., internalization of the thin ideal, internalized misogyny) once perfectionism is accounted for.

Hierarchical multiple regression analysis will be utilized to examine whether internalized misogyny moderates the relationship between the internalization of the thin ideal and disordered eating. Significant demographic variables will be entered at the first step of the model, if necessary. Perfectionism will be entered at the next step, in order to control for its influence on disordered eating. At step 3, the internalization of the thin ideal will be entered to examine its relationship with disordered eating. Internalized misogyny will be entered next in the model, to determine the main effects.

In the final step, the interaction term (internalization of the thin ideal X internalized misogyny) will be entered in the model to determine any interaction effects.

References

Agras, W.S., Bryson, S., Hammer, L.D., & Kraemer, H.C. (2007). Childhood risk factors for thin body preoccupation and social pressure to be thin. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 171-178.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: DSM-IV-TR. Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-V. Washington, DC: American Psychiatric Publishing.

Bardone-Cone, A.M., Wonderlich, S.A., Frost, R.O., Bulik, C.M., Mitchell, J.E., Uppala, S., et al. (2007). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review, 27,* 384-405.

Becker, A.E., Burwell, R.A., Gilman, S.E., Herzog, D.B., & Hamburg. (2002). Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. *British Journal of Psychiatry, 180,* 509-514.

Boone, L., Soenens, B., & Braet, C. (2011). Perfectionism, body dissatisfaction, and bulimic symptoms: the intervening role of perceived pressure to be thin and thin ideal internalization. *Journal of Social and Clinical Psychology, 30*(10), 1043-1068.

Bordo, S. (2003). *Unbearable weight: Feminism, western culture, and the body.* Berkeley and Los Angeles, CA: University of California Press.

Bradford, J.W., & Petrie, T.A. (2008). Sociocultural factors and the development of disordered eating: A longitudinal analysis of competing hypotheses. *Journal of Counseling Psychology, 55*(2), 246-262.

Brown, C., & Jasper, K. (1993). *Consuming passions: Feminist approaches to weight preoccupation and eating disorders.* Toronto, Ontario: Second Story Press.

Cashdan, S. (1988). *Object relations therapy: Using the relationship*. New York, NY: W.W. Norton & Company.

Clark, L., & Tiggemann, M. (2008). Sociocultural and individual psychological predictors of body image in young girls: a prospective study. *Developmental Psychology, 44*(4), 1124-1134.

Costin, C. (1997). *The eating disorder sourcebook: a comprehensive guide to the causes, treatments, and preventions of eating disorders.* Los Angeles, CA: Lowell House.

Davis, C. (1997). Normal and neurotic perfectionism in eating disorders: An interactive model. *International Journal of Eating Disorders, 22*, 421-426.

Davis, C., Claridge, G., & Fox, J. (2000). Not just a pretty face: Physical attractiveness and perfectionism in the risk for eating disorders. *International Journal of Eating Disorders, 27*, 63-73.

Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 41,* 727-736.

Ellis & Murphy (1994). The impact of misogyny and homophobia on therapy with women. In M. Mirkin (Ed.), *Women in Context,* New York: The Guilford Press.

Enns, C.Z. (2004). *Feminist theories and feminist psychotherapies: Origins, themes, and diversity* (2nd ed.). New York: Haworth Press.

Evans, D.L, Foa, E.B, Gur, R.E., Hendin, H., O'Brien, C.P, Seligman, M.E., & Walsh, T. (Eds.). (2005). *Treating and preventing adolescent mental health disorders.* New York: Oxford University Press.

Evans, E.H., Tovee, M.J., Boothroyd, L.G., & Drewett, R.F. (2012). Body dissatisfaction and disordered eating attitudes in 7 to 11 year-old girls: Testing a sociocultural model. *Body Image, 10,* 8-15.

Ferrari, J.R., & Mautz, W.T. (1997). Predicting perfectionism: Applying tests of rigidity. *Journal of Clinical Psychology, 53*, 1-6.

Field, A.E., Camargo, C.A., Taylor, B., Berkey, C.S., & Colditz, G.A. (1999). Relation of peer and media influences to the development of purging behaviors among preadolescent and adolescent girls. *Archives of Pediatrics and Adolescent Medicine, 153,* 1184-1189.

Field, A.E., Camargo, C.A., Taylor, B., Berkey, C.S., Roberts, S.B., & Colditz, G.A. (2001). Peer, parent, and media influences on development of weight concerns and frequent dieting among preadolescent and adolescent girls and boys. *Pediatrics, 107,* 54-60.

Field, A.E., Javaras, K.M., Anjea, P., Kitos, N., Camargo, C.A., Jr., Taylor, C.B., & Laird, N.M. (2008). Family, peer, and media predictors of becoming eating disordered. *Archives of Pediatrics and Adolescent Medicine, 162,* 574-579.

Focault, M. (1977). The eye of power. In C. Gordon (Ed. and Trans.), *Power/Knowledge.* New York: Pantheon

Forbes, G.B., Collinsworth, L.L., Jobe, R.L., Braun, K.D., & Wise, L.M. (2007). Sexism, hostility towards women, and endorsement of beauty ideals and practices: Are beauty ideals associated with oppressive beliefs? *Sex Roles, 56,* 265-273.

Frazier, P.A., Tix, A.P., & Baron, K.E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology, 51,* 115-134.

Fredrickson, B.L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly, 19,* 93-104.

Frost, R.O., Heimberg, R.G., Hold, C.S., Mattia, J.I., & Neubauer, A.L. (1993). A comparison of two measures of perfectionism. *Personality and Individual Differences, 14*, 119-126.

Frost, R.O., Marten, P., Lahart, C.M., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research, 14,* 449-468.

Garner, D.M., Olmstead, M.P., Bohr, Y., & Garfinkel, P.E. (1982). The Eating Attitude Test: Psychometric features and clinical correlates. *Psychological Medicine, 12,* 871-878.

Gatens, M. (1999). Power, bodies, and difference. In J. Price & M. Shildrick (Eds.), *Feminist Theory and the Body.* New York: Routledge.

Greenleaf, C., & McGreer, R. (2006). Disordered eating attitudes and self-objectification among physically active and sedentary female college students. *The Journal of Psychology, 140*(3), 187-198.

Groetz, L.M., Levine, M.P., & Murtten, S.K. (2002). The effects of experimental presentation of thin media images on body dissatisfaction: A meta-analytic review. *International Journal of Eating Disorders, 31,* 1-16.

Gross, E. (1986). Philosophy, subjectivity, and the body: Kristeva and Irigaray. In C. Pateman & E. Gross (Eds.), *Feminist Challenges: Social and Political Theory,* Sydney: Allen & Unwin.

Guille, C., & Chrisler, J.C. (1999). Does feminism serve a protective function against eating disorders? *Journal of Lesbian Studies, 3,* 141-148.

Hargreaves, D., & Tiggemann, M. (2002). The role of appearance schematicity in the development of adolescent body dissatisfaction. *Cognitive Therapy and Research, 26,* 691-700.

Hesse-Biber, S., Leavy, P., Quinn, C.E., & Zoino, J. (2006). The mass marketing of disordered eating and Eating Disorders: The social psychology of women, thinness, and culture. *Women's Studies International Forum, 29,* 208-224.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60,* 456−470.

Hewitt, P.L., & Genest, M. (1990). The ideal self: Schematic processing of perfectionistic content in dysphoric university students. *Journal of Personality and Social Psychology, 59*, 802-808.

Hopkinson, R.A. & Lock, J. (2004). Athletics, perfectionism, and disordered eating. *Eating and Weight Disorders, 9*(2), 99-106.

Kenney-Benson, G.A., & Pomerantz, E.M. (2005). The role of mothers' use of control in children's perfectionism: Implications for the development of children's depressive symptoms. *Journal of Personality, 73*(1), 23-46.

Klein, M.H. (1976). Feminist concepts of therapy outcome. *Psychotherapy: Theory, research and practice, 13*, 89-95.

Lavin, M.A., & Cash, T. (2001). Effects of exposure to information about appearance, stereotyping, and discrimination on women's body images. *International Journal of Eating Disorders, 29,* 51-58.

Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder.* New York, NY: Guilford Press.

Lopez-Guimera, G., Levine, M.P., Sanchez-Carracedo, D., & Fauquet, J. (2010). Influence of mass media on body image and eating disordered attitudes and behaviors in females: A review of effects and processes. *Media Psychology, 13,* 387-416.

Lott, A.J. (1973). Social psychology. In B. Wolman (Ed.), *Handbook of general psychology,* (pp. 919-932). New Jersey: Prentice Hall.

Martinez-Gonzales, M.A., Gual, P., Lahortiga, F., Alonso, Y., Irala-Estevez, J., & Cervera, E. (2003). Parental factors, mass media influences, and the onset of

eating disorders in a prospective population-based cohort. *Pediatrics, 111,* 315-320.

McKnight Investigators (2003). Risk factors for the onset of eating disorders in adolescent girls: Results of the McKnight Longitudinal Risk Factor Study. *American Journal of Psychiatry, 160,* 248-254.

McLaren, L., Gauvin, L., & White, D. (2001). The role of perfectionism and excessive commitment to exercise in explaining dietary restraint: Replication and extension. *International Journal of Eating Disorders, 29*, 307-313.

Miller, K.E. (2000). Treatment guideline for eating disorders. *American Family Physician, 62,* 185-186.

Miller-Day, M., & Marks, J.D. (2006). Perceptions of parental communication orientation, perfectionism, and disordered eating behaviors of sons and daughters. *Health Communication, 19*(2), 153-163.

Moradi B., Dirks, D., & Matteson, A.V. (2005). Roles of sexual objectification experiences and internalization of standards of beauty in eating disorder symptomatology: A test and extension of objectification theory. *Journal of Counseling Psychology, 52,* 420-428.

Myers, T.A., Ridolfi, D.R., Crowther, J.H., & Ciesla, J.A. (2012). The impact of appearance-focused social comparisons on body image disturbance in the naturalistic environment: The roles of thin ideal internalization and feminist beliefs. *Body Image, 9,* 342-351.

Peck, L.D., & Lightsey Jr., O. (2008). The eating disorders continuum, self-esteem, and perfectionism. *Journal of Counseling and Development, 86,* 184-192.

Piggott, M. (2004). *Double jeopardy: Lesbians and the legacy of multiple stigmatized identities.* Psychology Strand at Swinburne University of Technology, Australia: Unpublished thesis.

Ruggiero, G.M., Levi, D., Ciuna, A., & Sassaroli, S. (2003). Stress situation reveals association between perfectionism and drive for thinness. *International Journal of Eating Disorders, 34*, 220-226.

Russell, G.F.M., Szmukler, G.I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry, 44,* 1047-1056.

Sabik, N.J., & Tylka, T.L. (2006). Do feminist identity styles moderate the relation between percieved sexist events and disordered eating? *Psychology of Women Quarterly, 30*, 77-84.

Santonastaso, P., Friederici, S., & Favaro, A. (1999). Full and partial syndromes in eating disorders: A 1-year prospective study of risk factors among female students. *Psychopathology, 32,* 50−56.

Sassaroli, S., & Ruggiero, G.M. (2005). The role of stress in the association between low self esteem, perfectionism, and worry, and eating disorders. *International Journal of Eating Disorders, 37*, 135-141.

Shisslak, C.M., Crago, M., & Estes, L. (1995). The spectrum of eating disturbances. *International Journal of Eating Disorders, 18,* 209-219.

Smolak, L., & Levine, M.P. (2001). Body image in children. In J. Thompson & L. Smolak (Eds.), *Body image, eating disorders and obesity in youth: Assessment,*

prevention & treatment (pp. 41-66). Washington DC: American Psychological Association.

Snyder, R., & Hasbrouck, L. (1996). Feminist identity, gender traits, and symptoms of disturbed eating among college women. *Psychology of Women Quarterly, 20*, 593-598.

Steinhausen, H.C. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry, 159,* 1284-1293.

Stice, E. (1994). Review of the evidence for a sociocultural model of bulimia nervosa and an exploration of the mechanisms of action. *Clinical Psychology Review, 14,* 633-661.

Stice, E. (2002). Risk and maintenance factors for eating pathology: a meta-analytic review. *Psychological Bulletin, 128,* 825-848.

Stice, E., Spangler, D., & Agras, W.S. (2001). Exposure to media-portrayed thin-ideal images adversely effect vulnerable girls: a longitudinal experiment. *Journal of Social and Clinical Psychology, 20*, 270-288.

Striegel-Moore, R.H., & Bulik, C.M. (2007). Risk factors for eating disorders. *American Psychologist, 62*(3), 181-198.

Striegel-Moore, R.H., Dohm, F., Kraemer, H., Taylor, C., Daniels, S., Crawford, P., & Schreiber, G. (2003). Eating disorders in White and Black women. *American Journal of Psychiatry, 160,* 1326-1331.

Szymanski, D.M., Gupta, A., Carr, E.R., & Stewart, D. (2009). Internalized misogyny as a moderator of the link between sexist events and women's psychological distress. *Sex Roles, 61*, 101-109.

Szymanski, D.M., & Kashubeck-West, S. (2008). Mediators of the relationship between internalized oppressions and lesbian and bisexual women's psychological distress. *The Counseling Psychologist, 36*, 575-594.

Taylor, C.B., Bryson, S., Luce, K.H., et al. (2006). Prevention of eating disorders in at-risk college-age women. *Archives of General Psychiatry, 63,*881-888.

Thompson, J.K., van den Burg, P., Roehrig, M., Guarda, A.S., & Heinberg, L.J. (2004). The sociocultural attitudes towards appearance scale – 3 (SATAQ-3): Development and validation. *International Journal of Eating Disorders, 35,* 293-304.

Thompson, J.K., & Stice, E. (2001). Thin-ideal internalization: Mounting evidence for a new risk factor for body-image disturbance and eating pathology. *Current Directions in Psychological Science, 10,* 181-183.

Tylka, T.L., & Subich, L.M. (1999). Exploring the construct validity of the eating disorder continuum. *Journal of Counseling Psychology, 46,* 268-276.

Tyrka, A. R., Waldron, I., Graber, J. A., & Brooks-Gunn, J. (2002). Prospective predictors of the onset of anorexic and bulimic syndromes. *International Journal of Eating Disorders, 32,* 282−290.

Van den Berg, P., Neumark-Sztainer, D., Hannan, P. J., & Haines, J. (2007). Is dieting advice from magazines helpful or harmful? Five-year associations with weight- control behaviors and psychological outcomes in adolescents. *Pediatrics, 119*, 30–37.

Westerberg, J., Edlund, B., & Ghaderi, A. (2008). A 2-year longitudinal study of eating attitudes, BMI, perfectionism, asceticism, and family climate in adolescent girls and their parents. *Eating and Weight Disorders, 13*(2), 64-72.

Wilson, G.T., Grilo, C.M., & Vitousek, K.M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199-216.

Appendix A: Measures

Demographic Information

8. What is your gender?
    a. Male
    b. Female

9. What is your age? _____

10. What ethnicity do you consider yourself?
    a. African American
    b. Hispanic or Latino/Latina
    c. Asian American
    d. Native American or American Indian
    e. Caucasian
    f. Biracial
    g. Multiracial
    h. Other (Please Specify) _____

11. How do you describe you sexual orientation?
    a. Bisexual
    b. Heterosexual
    c. Lesbian or Gay
    d. Other (please specify) _____

12. What is your approximate yearly household income?
    a. Less than $25,000
    b. $25,000 - $35,000
    c. $36,000 - $45,000
    d. $46,000 - $55,000
    e. $56,000 - $65,000
    f. $66,000 - $75,000
    g. $76,000 - $85,000
    h. Over $85,000

13. What is the highest level of education you have completed?
    a. Some High School
    b. High School Graduate or equivalent (i.e. GED)
    c. Some College
    d. Associate's Degree
    e. Bachelor's Degree
    f. Master's Degree
    g. Professional or Doctoral Degree

14. What state/province do you live in? _____

The Eating Attitude Test (EAT)

Scale:

1	2	3	4	5	6
Never	**Rarely**	**Sometimes**	**Often**	**Very Often**	**Always**

41. I like eating with other people.

42. I prepare foods for others but do not eat what I cook.

43. I become anxious prior to eating.

44. I am terrified about being overweight.

45. I avoid eating when I am hungry.

46. I find myself preoccupied with food.

47. I have gone on eating binges where I feel that I may not be able to stop.

48. I cut my food into small pieces.

49. I am aware of the calorie content of foods that I eat.

50. I particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice etc.).

51. I feel bloated after meals.

52. I feel that others would prefer if I ate more.

53. I vomit after I have eaten.

54. I feel extremely guilty after eating.

55. I am preoccupied with a desire to be thinner.

56. I exercise strenuously to burn off calories.

57. I weigh myself several times a day.

58. I like my clothes to fit tightly.

59. I enjoy eating meat.

60. I wake up early in the morning.

61. I eat the same foods day after day.

62. I think about burning up calories when I exercise.

63. I have regular menstrual periods.

64. Other people think that I am too thin.

65. I am preoccupied with the thought of having fat on my body.

66. I take longer than others to eat my meals.

67. I enjoy eating at restaurants.

68. I take laxatives.

69. I avoid foods with sugar in them.

70. I eat diet foods.

71. I feel that food controls my life.

72. I display self control around food.

73. I feel that others pressure me to eat.

74. I give too much time and thought to food.

75. I suffer from constipation.

76. I feel uncomfortable after eating sweets.

77. I engage in dieting behavior.

78. I like my stomach to be empty

79. I enjoy trying new rich foods.

80. I have the impulse to vomit after meals.

Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990)

Strongly Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Strongly Agree
1	2	3	4	5

____ 1. My parents set very high standards for me.

____ 2. Organization is very important to me.

____ 3. As a child, I was punished for doing things less than perfect.

____ 4. If I do not set the highest standards for myself, I am likely to end up a second-rate person.

____ 5. My parents never tried to understand my mistakes.

____ 6. It is important to me that I be thoroughly competent in everything that I do.

____ 7. I am a neat person.

____ 8. I try to be an organized person.

____ 9. If I fail at work/school, then I am a failure as a person.

____ 10. I should be upset if I make a mistake.

____ 11. My parents wanted me to be the best at everything.

____ 12. I set higher goals than most people.

____ 13. If someone does a task at work/school better than I, then I feel like I failed the whole task.

____ 14. If I fail partly, it is as bad as being a complete failure.

____ 15. Only outstanding performance is good enough in my family.

____ 16. I am very good at focusing my efforts at attaining a goal.

____ 17. Even when I do something very carefully, I often feel that it is not quite right.

____ 18. I hate being less than the best at things.

____ 19. I have extremely high goals.

____ 20. My parents have expected excellence from me.

____ 21. People will probably think less of me if I make a mistake.

____ 22. I never felt like I could meet my parents' expectations.

____ 23. If I do not do as well as other people, it means I am an inferior human being.

____ 24. Other people seem to accept lower standards from themselves than I do..

____ 25. If I do not do well all the time, people will not respect me.

____ 26. My parents have always had higher expectations for my future than I have.

____ 27. I try to be a neat person.

____ 28. I usually have doubts about the simple everyday things I do.

____ 29. Neatness is very important to me.

____ 30. I expect higher performance in my daily tasks than most people.

____ 31. I am an organized person.

____ 32. I tend to get behind in my work because I repeat things over and over.

____ 33. It takes me a long time to do something "right."

____ 34. The fewer mistakes I make, the more people will like me.

____ 35. I never felt like I could meet my parents' expectations.

SOCIOCULTURAL ATTITUDES TOWARDS APPEARANCE SCALE - 3 (SATAQ-3)

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

Definitely Disagree = 1 Mostly Disagree = 2 Neither Agree Nor Disagree = 3 Mostly Agree = 4 Definitely Agree = 5

30. TV programs are an important source of information about fashion and "being attractive." _____
31. I've felt pressure from TV or magazines to lose weight. _____
32. I do not care if my body looks like the body of people who are on TV. _____
33. I compare my body to the bodies of people who are on TV. _____
34. TV commercials are an important source of information about fashion and "being attractive." _____
35. I do not feel pressure from TV or magazines to look pretty. _____
36. I would like my body to look like the models who appear in magazines. _____
37. I compare my appearance to the appearance of TV and movie stars. _____
38. Music videos on TV are not an important source of information about fashion and "being attractive." _____
39. I've felt pressure from TV and magazines to be thin. _____
40. I would like my body to look like the people who are in movies. _____
41. I do not compare my body to the bodies of people who appear in magazines. _____
42. Magazine articles are not an important source of information about fashion and "being attractive." _____
43. I've felt pressure from TV or magazines to have a perfect body. _____
44. I wish I looked like the models in music videos. _____
45. I compare my appearance to the appearance of people in magazines. _____
46. Magazine advertisements are an important source of information about fashion

and "being attractive." _____

47. I've felt pressure from TV or magazines to diet. _____
48. I do not wish to look as athletic as the people in magazines. _____
49. I compare my body to that of people in "good shape." _____
50. Pictures in magazines are an important source of information about fashion and "being attractive." _____
51. I've felt pressure from TV or magazines to exercise. _____
52. I wish I looked as athletic as sports stars. _____
53. I compare my body to that of people who are athletic. _____
54. Movies are an important source of information about fashion and "being attractive." _____
55. I've felt pressure from TV or magazines to change my appearance. _____
56. I do not try to look like the people on TV. _____
57. Movie starts are not an important source of information about fashion and "being attractive." _____
58. Famous people are an important source of information about fashion and "being attractive." _____

30. I try to look like sports athletes. _____

INTERNALISED MISOGYNY SCALE (Piggott, 2004)

	Strongly Disagree 1	Moderately Disagree 2	Slightly Disagree 3	Neutral 4	Slightly Agree 5	Moderately Agree 6	Strongly Agree 7
1. Women exaggerate problems they have at work	☐	☐	☐	☐	☐	☐	☐
2. Women are too easily offended	☐	☐	☐	☐	☐	☐	☐
3. Women seek to gain power by getting control over men	☐	☐	☐	☐	☐	☐	☐
4. When women lose to men in a fair competition, they typically complain about being discriminated against	☐	☐	☐	☐	☐	☐	☐
5. It is generally safer not to trust women too much.	☐	☐	☐	☐	☐	☐	☐
6. When it comes down to it a lot of women are deceitful	☐	☐	☐	☐	☐	☐	☐
7. I think that most women would lie just to get ahead.	☐	☐	☐	☐	☐	☐	☐
8. I am sure I get a raw deal from other women in my life	☐	☐	☐	☐	☐	☐	☐
9. Sometimes other women bother me by just being around.	☐	☐	☐	☐	☐	☐	☐
10. I believe that most women tell the truth	☐	☐	☐	☐	☐	☐	☐
11. When I am in a group consisting of equal numbers of men and women and	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree 1	Moderately Disagree 2	Slightly Disagree 3	Neutral 4	Slightly Agree 5	Moderately Agree 6	Strongly Agree 7
a woman dominates the conversation I feel uncomfortable.							
12. I am uncomfortable when I hear a woman speaking with authority on male dominated topics such as football or horseracing	☐	☐	☐	☐	☐	☐	☐
13. I prefer to listen to male radio announcers than female.	☐	☐	☐	☐	☐	☐	☐
14. The intellectual leadership of a community should be largely in the hands of men	☐	☐	☐	☐	☐	☐	☐
15. I prefer to work for a male boss.	☐	☐	☐	☐	☐	☐	☐
16. If I were to beat another woman for a job I would feel more satisfied than if I beat a man.	☐	☐	☐	☐	☐	☐	☐
17. Generally, I prefer to work with men.	☐	☐	☐	☐	☐	☐	☐