

Abstract

Previous research has confirmed the contribution of familial factors in the development of disordered eating and body image disturbance. However, less is known about potential protective factors in this context. Accordingly, the present investigation examined the relationships of caregiver eating messages (i.e., restrictive/critical and pressure to eat) with dimensions of body objectification (i.e., body surveillance, appearance control, body shame) and evaluated whether self-compassion impacted these associations. Cross-sectional findings suggest that recollections of caregivers' expressed attitudes about eating during childhood are associated with participants' current experience of objectified body consciousness in emerging adulthood. Self-compassion was found to moderate these relationships. Preliminary results may lead to informing the development of negative body image intervention programming among college women.

Background and Objectives

Caregiver behavior and attitudes affect body image. The Caregiver Eating Messages Scale is a two-factor structure developed to measure a participant's perception of the messages they received from caregivers about what to eat, when to eat, and how much to eat. Findings show that restrictive/critical caregiver messages were negatively associated with familial body acceptance, body appreciation, and intuitive eating. The associations are less consistent with pressure to eat messages (Kroon Van Diest & Tylka, 2010).

Research shows that body surveillance, or viewing the body as an outside observer, and body shame, or feeling shame when the body does not conform to social standards were negatively correlated with some dimensions of wellness in college women. Conversely, higher appearance control, or the belief that one has the ability to effectively manage weight and appearance with sufficient effort indicated higher wellness scores (Sinclair & Myers, 2004).

Findings suggest that self-compassion across three main components: (self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification) may be an adaptive mechanism that increases psychological resiliency and well-being (Neff, 2003). Higher levels of self-compassion are related to lower levels of body image dissatisfaction, higher body image flexibility and intuitive eating (Ferreira, Pinto-Gouveia, & Duarte, 2013; Schoenefeld & Webb, 2013).

The present investigation contributes to existing research analyzing familial factors on eating behaviors and attitudes, as well as determining a potential protective factor for body image disturbance. The primary study objective was to examine whether participants' level of self-compassion affected the association between caregiver eating messages and dimensions of objectified body consciousness (McKinley & Hyde, 1996).

Methods

Participants

The final data set included 322 undergraduate females between the ages of 18-24 years ($M = 19.48$, $SD = 1.46$). Women identified as White or European American (65.3%), African American (20.4%), Hispanic or Latino (5.6%), Asian or Asian American (3.1%), not reported (3.1%), American Indian or Alaska Native (1.5%), and Hawaiian or other Pacific Island (0.9%). They represented freshmen (53.6%), sophomores (23.8%), juniors (12.4%), seniors (9.6%), and beyond senior year or Post-Baccalaureate (0.6%). Also, the mean calculated BMI score fell into the normal weight range ($M = 22.78$, $SD = 4.95$).

Procedures and Measures

Following passive consent, participants completed the following self-report measures administered in an online survey format via Sona Systems: demographic questionnaire, the Self-compassion Scale (Neff, 2003), the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), and the Caregiver Eating Messages Scales (Kroon Van Diest & Tylka, 2010). Body mass index (BMI) was calculated from self-reported heights and weights. Students received course credit in exchange for their participation.

Statistical Analyses

Basic descriptive statistics and Pearson's bivariate correlations were performed to examine the distributional characteristics and linear associations among the primary study variables respectively. Hierarchical linear regression models were computed to test the contribution of restrictive/critical and pressure to eat caregiver messages, self-compassion and their interaction in the prediction of each of the three components of objectified body consciousness adjusted for BMI. The Aiken & West (1991) procedure was used to graph and interpret any significant interaction effects.

Results

Restrictive/critical caregiver eating messages were positively correlated with body shame and negatively correlated with self-compassion and appearance control beliefs (see Table 1).

Pressure to eat caregiver messages were positively related to body shame and negatively associated with appearance control beliefs (see Table 1).

Self-compassion was negatively linked to both reports of body shame and body surveillance (see Table 1).

	1	2	3	4	5	6	7	8
1. BMI	-							
2. Age	.15**	-						
3. Self-compassion	-.06	.00	-					
4. Body Surveillance	.05	-.03	-.47**	-				
5. Body Shame	.32**	.09	-.51**	.49**	-			
6. Appearance Control	.01	.02	-.02	.07	-.20**	-		
7. Restrictive/critical Caregiver eating messages	.28**	-.05	-.18**	.09	.41**	-.29**	-	
8. Pressure to eat Caregiver eating messages	.07	.01	-.11	.04	.20**	-.13*	.28**	-
<i>M</i>	22.78	19.48	3.0	4.75	3.38	4.94	2.23	3.1
<i>SD</i>	4.95	1.46	0.63	1.09	1.24	0.92	1.11	1.1

Table 1. Descriptives and Intercorrelations for the Primary Study Variables.

** Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

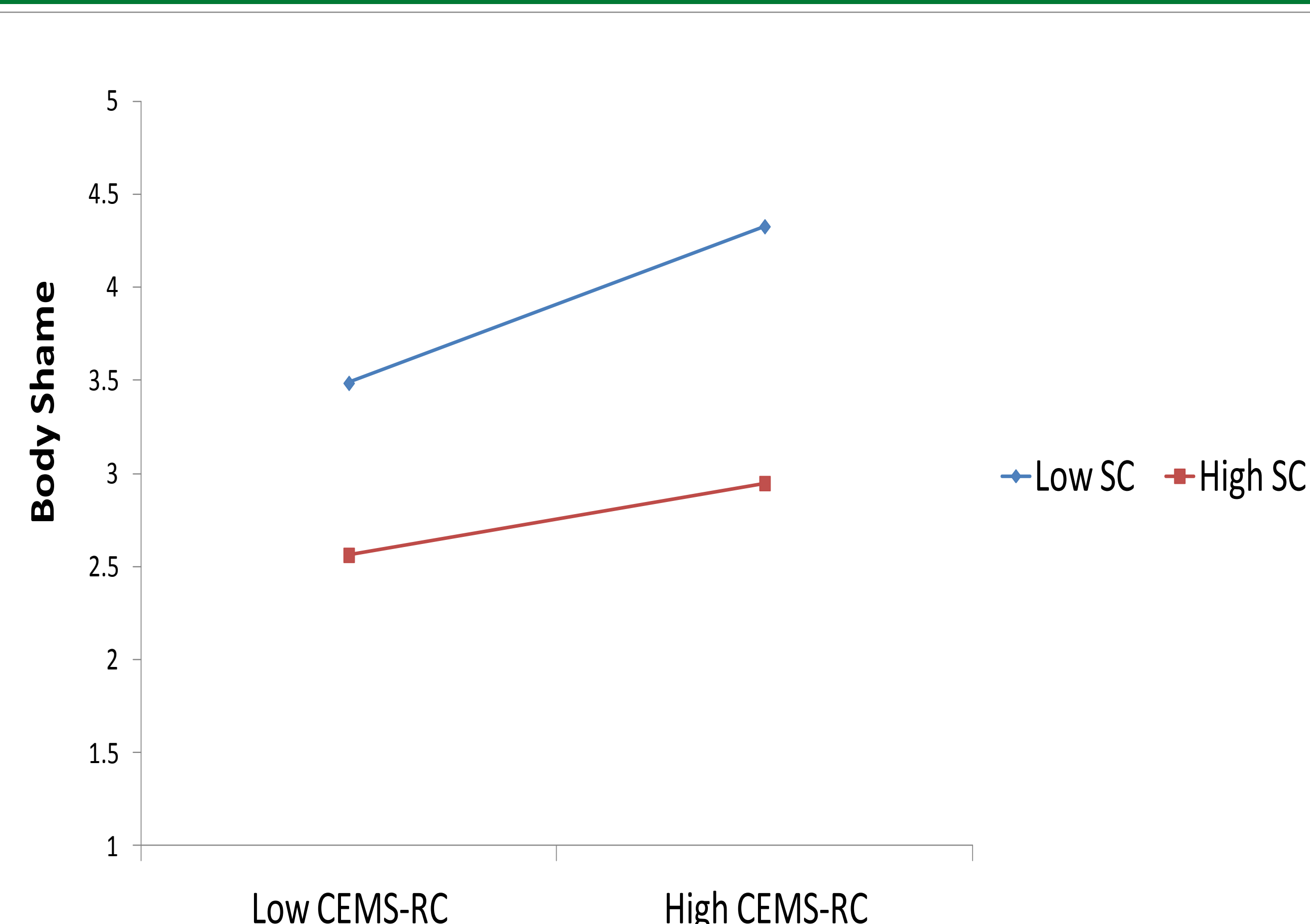


Figure 1. (Above) The Relationship between Restrictive/Critical Caregiver Eating Messages and Body Shame as a Function of Level of Self-compassion.

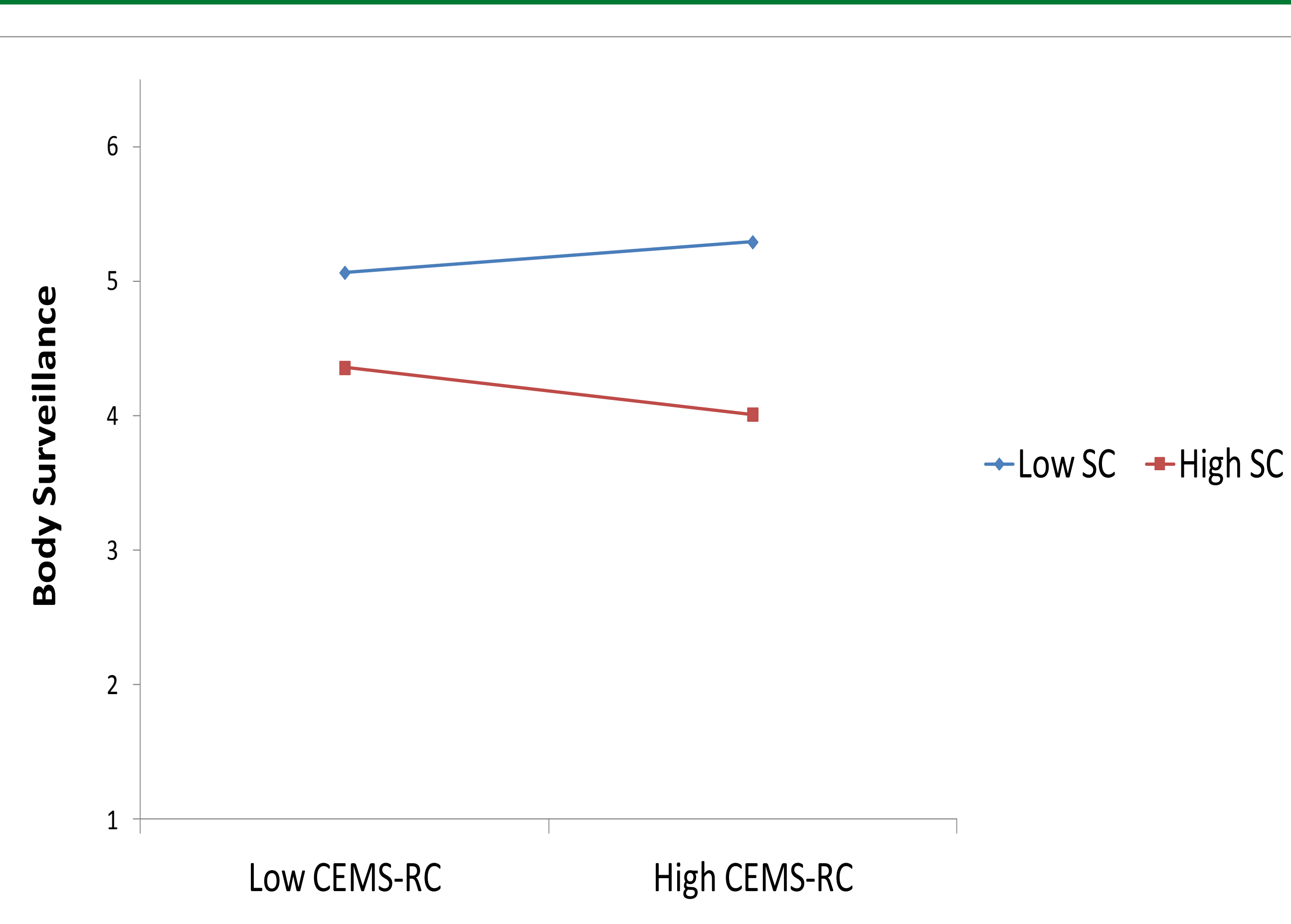


Figure 2. (Above) The Relationship between Restrictive/Critical Caregiver Eating Messages and Body Surveillance as a Function of Level of Self-compassion.

Body Shame:

- CEMS-Restrictive/Critical and Self-compassion Model:** 44.5% of the variance was accounted for by the full model. BMI ($R^2\Delta = 12.3\%$, $p < .001$; $B = .06$, $p < .001$), Self-compassion ($R^2\Delta = 21\%$, $p < .001$; $B = -.90$, $p < .001$), CEMS-Restrictive/Critical ($R^2\Delta = 11\%$, $p < .001$; $B = .27$, $p < .001$), and its interaction with Self-compassion ($R^2\Delta = 1\%$, $p < .05$; $B = -.16$, $p < .05$; see Figure 1) were all significant predictors.
- CEMS-Pressure to Eat and Self-compassion Model:** 38.5% of the variance was explained by the full model. BMI ($R^2\Delta = 12.3\%$, $p < .001$; $B = .08$, $p < .001$), CEMS-Pressure to Eat ($R^2\Delta = 3\%$, $p < .01$; $B = .13$, $p < .05$), and Self-compassion ($R^2\Delta = 23.3\%$, $p < .001$; $B = -.94$, $p < .001$) were all significant predictors.

Body Surveillance:

- CEMS-Restrictive/Critical and Self-compassion Model:** 23.1% of the variance was accounted for by the full model. Self-compassion ($R^2\Delta = 20\%$, $p < .001$; $B = -.79$, $p < .001$) and its interaction with CEMS-Restrictive/Critical ($R^2\Delta = 2\%$, $p < .05$; $B = -.20$, $p < .05$; see Figure 2) were both significant predictors.
- CEMS-Pressure to Eat and Self-compassion Model:** 21.4% of the variance was explained by the full model. Self-compassion was a significant predictor ($R^2\Delta = 21\%$, $p < .001$; $B = -.77$, $p < .001$).

Appearance Control:

- CEMS-Restrictive/Critical and Self-compassion Model:** The full model only explained 11.3% of the variance. CEMS-Restrictive/Critical ($R^2\Delta = 10\%$, $p < .001$; $B = -.29$, $p < .001$) was a significant predictor.
- CEMS-Pressure to Eat and Self-compassion Model:** The full model accounted for only 2% of the variance. CEMS-Pressure to Eat was a marginally-significant predictor ($R^2\Delta = 1\%$, $p = .08$; $B = -.10$, $p = .051$).

Conclusions & Implications

Low self-compassion may serve as a risk factor in the relationship between restrictive/critical caregiver eating messages and body shame.

High self-compassion may act as a buffer in the relationship between restrictive/critical caregiver eating messages and body surveillance.

Results begin to shed light on potential protective factors in the relationship between socio-environmental influences on dimensions of objectified body consciousness.

Study findings have implications for negative body image prevention/treatment among at-risk college women.

Limitations

- Self-report and volunteer bias
- Limited ethnic diversity
- Ambiguity surrounding the sex of the caregiver: maternal versus paternal influences are not clear

Future Directions

- Examining potential ethnic and BMI differences in the models tested
- Clarifying the influence of maternal versus paternal eating messages
- Gathering caregivers' actual perceptions of the eating messages they communicated to their daughters
- Integrating qualitative and longitudinal study designs

References

- Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park, CA: Sage.
- Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. *Eating Behaviors, 14*, 207-210.
- Kroon Van Diest, A. M., & Tylka, T. L. (2010). The Caregiver Eating Messages Scale: Development and psychometric investigation. *Body Image, 7*, 317-326.
- McKinley, N. M., & Hyde, J. S. (1996). The Objectified Body Consciousness Scale. *Psychology of Women Quarterly, 20*, 181-215.
- Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*, 223-250.
- Schoenefeld, S. J., & Webb, J. B. (2013). Self-compassion and intuitive eating in college women: examining the contributions of distress tolerance and body image acceptance and action. *Eating Behaviors, 14*, 493-496.
- Sinclair, S. L., & Myers, J. E. (2004). The relationship between objectified body consciousness and wellness in a group of college women. *Journal of College Counseling, 7*, 150-161.

Acknowledgments

We wish to thank the UNC Charlotte Department of Psychology and the UNC Charlotte Health Psychology Ph. D. Program for their financial support.