Is body shaming predicting poor physical health and is there a gender difference?

Eva Lind Fells Elíasdóttir

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Foreword

Submitted in partial fulfillment of the requirements of the BSc Psychology degree, Reykjavik University, this thesis is presented in the style of an article for submission to a peer-reviewed journal.
Abstract - English

The aim of this study was to examine whether body shame was predicting physical illnesses and negative self-reported physical health. Furthermore, the aim was to examine gender differences regarding body shame, physical illnesses and self-reported physical health. Participants were 92 students in Reykjavik University aged from 20-38. Data was gathered through a questionnaire. The questionnaire included questions about gender, age, self-reported physical health, body shame, and physical illness. The results of the study showed that women were more likely to self-report their health as poor than men. However, women were not more likely to score higher on the body shame scale and report physical illnesses than men. The results also showed that participants who scored high on the body shame scale were not more likely to report physical illnesses, nor were they more likely to self-report their physical health as poor.

Keywords: body shame, physical illness, self-reported physical health

Abstract – Icelandic


Lykilorð: líkamleg skömm, líkamleg veikindi, sjálfsmat á líkamlegri heilsu
Is body shaming predicting poor physical health and is there a gender difference?

Whatever it is that we are doing, we certainly do it with our bodies. From the moment we wake, we are consciously or sub-consciously relying on our body. We may look in the mirror and notice changes in our body, and for some of us, even the most minor changes may impact upon how we feel about ourselves. The image that we have of our bodies’ affects our experience of our bodies in everyday life (Netleton & Watson, 2002).

**Body Shame and Body Image**

Body shame is a concept that is used for the individuals’ self-conscious, negative emotional response against one’s self. It appears in the individuals’ misstep to meet the ideal body standards, and the acknowledgement of this failure (Fredrickson & Roberts, 1997). For women in the western countries, the ideal body contains standards for outward appearance, for an example thinness and youth. Because meeting these standards is important, women may internalize or self-objectify these standards. Many women may feel that they do not meet these standards, resulting in a negative self-directed emotions and one of these emotions is body shame (Fredrickson & Roberts, 1997).

The Objectification theory is one of the theories that have formed much research in the field of body image (Fredrickson & Roberts, 1997). It explains that woman’s life experiences, as well as gender role socialization of sexual objectification, induces them to look at themselves as objects, and increasing inspections of their bodies (Moradi & Huang, 2008). The process increases the exposure of anxiety and body shame. Given that self objectification and body image require the individual to focus their attention to self presentation of their bodies and to enrol in actions that involve personal as well as societal standards, it comes as no surprise that researchers are investigating the prelude and emanation of self conscious emotions regarding the body (Castonguay, Brunet, Ferguson, &
Sabiston, 2012; Noll & Fredrickson, 1998). The Objectification theory posits that self-objectification affects girls, but not boy’s subjective well-being. Although it has been determined that women self-objectify themselves more than men, research on this topic has been limited to women (Grabe, Hyde, & Lindberg, 2007). However, recent cultural developments suggest that the objectification of men regarding their bodies, has been emerging (Grogan, 2010).

Shame related to our bodies is an emotional state that can be quite painful. This may originate from a social rejection from others, as well as the fear of inducing disgust (Roberts & Goldenberg, 2007). Shame is often related to a diversity of maladaptive behavioral, somatic, psychological and subjective experiences (Dickerson, Gruenewald, & Kemeny, 2004; Gilbert, 2007) and therefore, it is an essential emotional state in both research and practice, for interventions regarding body image. However, current research in the area of body image and body shame seems to focus on its effect on psychological health, lacking research on its effects on physical health.

By classifying the influences of positive body image, we might increase the ability to produce successful interventions that are appropriate for both genders. In doing so, we might be able to build up positive body image and improve well being and health (Grogan, 2010).

Physical Health, Perceived Health and Self-reported Health

Previous studies have linked shame to poor psychological health, for an example depression (Grabe, Hyde, & Lindberg, 2007), as well as eating disorders (Tiggemann & Slater, 2001). Furthermore, shame is also related to poor physical health, indicative of deregulations of the immune system (Kamen & Seligman, 1987). A few numbers of studies have been conducted on the consequences of body shame on physical health. However,
researchers are starting to think that body shame or the tendency to judge our body harshly, is not just affecting our mental states, but also actually causing physical illnesses.

A study made by Jean M. Lamont (2015), tested whether body shaming was predicting poor physical health. That is, by promoting attitudes that are negative against bodily processes and therefore decreasing health assessments and having an impact on physical health. The results indicated that body shaming predicted poor self-rated health. Body shame also predicted expansion in infections and symptoms (Lamont, 2015). However, body shame might develop in perception of poor health and future research might consider employing methods to assess health outcomes that do not build on self-reports of health. These findings raise some important questions that need to be answered, for example how much health toll body shame is taking. That is something that we do not know yet. However, the results suggest that body shame could harm our physical health and we could use that as a motivation to love our bodies (Lamont, 2015).

It should be noted that previous studies regarding health research indicate that women continuously report poorer physical health than men (Gijsbers van Wijk, Huisman, & Kolk, 1999). This difference usually consists of higher self-reports of both illness behavior and physical symptoms by women. Further research on this difference is needed, but it has been suggested that mood states might mediate these gender differences in self-reports of health (Gijsbers van Wijk, Huisman, & Kolk, 1999).

Perceived health is an essential predictor of health, and a great interest is in self-assessed health during adolescence. A previous study made by Meland, Haugland, & Breidablik (2007), tested the relationship between body image and perceived negative health in adolescence, with the focus on gender and age differences (Meland, Haugland, & Breidablik, 2007). It has been suggested, that adolescents who have a negative body image are more prone to perceive their health as poor (Alsaker, 1992). The results showed that perceived
negative health increased with age, and that girls were more prone to report negative health, compared to boys (Meland et al., 2007).

**Gender differences**

Men who lack masculinity are often considered feminine (Grogan & Richards, 2002). Previous studies imply that 50% to 71% of male undergraduates are not satisfied with their bodies and 90% of them would like to be more muscular (Frederick et al., 2007). Furthermore, men in all age groups have the desire for masculinity (Fisher, Dunn, & Thompson, 2002) and they report negative body image when exposed to images of the ideal male body (Marian M. Morry, 2001), as well as the ideal female body (Lavine, Wagner, & Sweeney, 1999). In the light of such images, both men and women might be in greater exposure of developing persistent body shame (Frederick et al., 2007).

A previous study explained gender differences in body esteem using the Objectified Body Consciousness or OBC scale. The results indicated that the relation among body shame, body esteem and body surveillance were stronger for women, than for men. Women scored higher both on body surveillance and in body shame, than did men (Poulin, Hand, Boudreau, & Santor, 2005). Further research on gender differences regarding body image and body shame is needed, to address what could be causing these differences.

**The current study**

The aim of this study was to examine whether body shame was predicting physical illnesses, as well as negative self-reported physical health. Furthermore, the aim was to examine gender differences regarding body shame, physical illnesses and self-reported physical health.

Based on the above literature, the following hypotheses were tested: (1) compared to men, women are more likely to score higher on the body shame scale, self-report their
physical health as poor and report physical illnesses, (2) participants who score high on the body shame scale, are more likely to report physical illnesses, compared to participants who score low on the body shame scale, and (3) participants who score high on the body shame scale, are more likely to self-report their physical health as poor, compared to participants that score low on the body shame scale.

Method

Participants

The participants were 92 undergraduate psychology and sports science students in Reykjavik University. Participants were 30 males and 62 females, aged from 20 to 38. The mean age was 24.70 (SD = 4.03). Participants were chosen with a convenience sample, wherein two departments within Reykjavik University were selected to participate. All students in these departments were invited to participate in the study. Participants were asked to read a detailed information sheet about the study, in which they were made aware of that their answers to the questionnaire were equivalent to their approval of participation in the study. Participation was voluntary and no compensation was given.

Instruments and measures

Participants completed a questionnaire, which included questions regarding gender, age, self-reported physical health, body shame, and physical illness.

Self-reported physical health. One question regarded participant’s physical health, where they were asked to self-report their physical health. Answer options to the question were 1 = “Poor”, 2 = “Reasonable”, 3 = “Good” and 4= “Very good”.

Body shame. Body shame was measured using the The Objectified Body Consciousness Scale (OBCS), which is a self-report measure of body consciousness. The scale has a total of 24 statements and three subscales, including body surveillanve, body shame and appearance
control beliefs. One of the subscales, including four statements in the questionnaire, was used to measure participants’ body shame. Participants were asked to read each statement and mark the option that described their attitude or behavior the best. They were asked (1) if they thought that something was wrong with them when they did not have control over their weight, (2) if they felt ashamed when they had not bothered to look their best, (3) if they felt like a terrible person when they did not look as good as they could, and (4) if they would feel ashamed if others really knew their weight. Answer options to these statements were 1 = “Strongly Disagree”, 2 = “Disagree”, 3 = “Somewhat Disagree”, 4 = “Neither Agree nor Disagree”, 5 = Somewhat Agree”, 6 = “Agree” and 7 = “Strongly agree”. These four items were then computed into one variable. The scale ranged from 4-28, whereas a lower score indicated a lower body shame, and a higher score indicated a higher body shame. A factor analysis was performed and indicated that the questions loaded on one component and the loadings ranged from 0.443 to 0.802. Cronbach’s Alpha for the body shame scale was rather poor α= 0.57. It should be noted that the questions from The Objectified Body Consciousness Scale (OBCS) had never been translated into Icelandic before, and therefore this was the first time that questions from that scale were used in Icelandic to my awareness.

**Physical illness.** Nine questions regarded participants’ physical illness. They were asked how often they had been aware of headache, dizziness, back pain, nausea or upset stomach, numbness or tingling somewhere in the body, pain in the stomach, joint pain, shivering and pain in hands or feet, in the last 30 days. Answer options to these questions were 1 = “Almost never”, 2 = “Rarely”, 3 = “Sometimes” and 4 = “Often”. These nine items were then computed into one variable, wherein a higher score indicated more frequency of physical illnesses. A factor analysis was performed and indicated that the questions loaded on two components. In the first component the loadings ranged from 0.024 to 0.820 and in the
second component the loadings ranged from 0.013 to 0.903. Cronbach’s Alpha was good $\alpha = 0.82$.

**Procedure**

The study was sent to The Data Protection Authority, and The National Bioethics Committee provided the permission for the study (VSN-16-030). Data collection took place 25 to 28 April. The questionnaire was distributed to participants in an electronic format and it was hosted on a special website. Several teachers in the psychology and sport science departments had approved to distribute the questionnaire to their students. The teachers sent the students a URL with information about the study and the questionnaire itself.

Participation was voluntary. It was expected that it would take participants about 15-20 minutes to complete the questionnaire. When participants entered the given URL, they were asked to read a detailed information sheet about the purpose of the study and its implementation, in which they were made aware of that their answers to the questionnaire were equivalent to their approval of participation in the study. The information sheet also made participants aware of that they could opt out at any given time and that they could contact the person responsible for the study, if they felt any discomfort. After participants had completed the questionnaire they were thanked for their participation.

**Data analysis**

An Independent-Sample T Test was performed to examine whether women were on average more likely to score higher on the body shame scale, self-report their health as poor and report physical illness, compared to men.

A two-way ANOVA was performed to examine the effect of gender and body shame on physical illness, as well as the effect of gender and body shame on self-reported physical health. The main effects and the interaction effect were examined. The body shame scale was
divided into two groups with a median split, where 1 = low score on the body shame scale, and 2 = high score on the body shame scale.

**Results**

Table 1 shows descriptive statistics for the measures used in the study. The table indicates means and standard deviations for self-report on physical health, physical illness and body shame, for men and women separately. Looking at the table it can be seen that there is not a big difference in the means between the genders. There was a statistically significant difference in the means between genders in self-reported physical health, \((t)_{88} = 2.39, p = 0.02\), wherein women were more likely to self-report their physical health as poor. There was not a statistically significant difference in the means between genders in physical illness, \((t)_{84} = -0.17, p = 0.87\), or body shame, \((t)_{66} = -0.98, p = 0.33\).

Table 1.

*Descriptive Statistics for the measures self-report on physical health, physical illness, and body shame, by gender*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range</td>
<td>n</td>
</tr>
<tr>
<td>Self-reported physical health</td>
<td>1-4</td>
<td>30</td>
</tr>
<tr>
<td>Physical illness</td>
<td>9-36</td>
<td>29</td>
</tr>
<tr>
<td>Body shame</td>
<td>4-28</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 2 shows the effect of gender and body shame on physical illness. A two-way ANOVA was conducted to examine the main effects and interaction effect. There was not a statistically significant main effect of gender on physical illness, \(F(1, 82) = 0.004, p = 0.95\).
and body shame on physical illness, $F(1, 82) = 0.030, p = 0.86$. There was not a statistically significant interaction between the effects of gender and body shame on physical illness, $F(1, 82) = 0.262, p = 0.61$.

Table 2.

*The effect of gender and body shame on physical illness*

<table>
<thead>
<tr>
<th>Body shame</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>11</td>
<td>15.82</td>
<td>4.99</td>
<td>24</td>
<td>15.25</td>
<td>5.34</td>
<td>35</td>
<td>15.43</td>
<td>5.17</td>
</tr>
<tr>
<td>High</td>
<td>18</td>
<td>15.39</td>
<td>4.91</td>
<td>33</td>
<td>16.12</td>
<td>5.87</td>
<td>51</td>
<td>15.86</td>
<td>5.51</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>15.55</td>
<td>4.86</td>
<td>57</td>
<td>15.75</td>
<td>5.62</td>
<td>86</td>
<td>15.69</td>
<td>5.35</td>
</tr>
</tbody>
</table>

Table 3 shows the effect of gender and body shame on self-reported physical health. A two-way ANOVA was conducted to examine the main effects and interaction effect. There was a statistically significant main effect of gender on self-reported physical health, $F(1, 86) = 4.400, p = 0.039$. There was not a statistically significant main effect of body shame on self-reported physical health, $F(1, 86) = 0.475, p = 0.49$. There was not a statistically significant interaction between the effects of gender and body shame on self-reported physical health, $F(1, 86) = 0.591, p = 0.44$.

Table 3.

*The effect of gender and body shame on self-reported physical health*

<table>
<thead>
<tr>
<th>Body shame</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>11</td>
<td>3.27</td>
<td>0.65</td>
<td>24</td>
<td>3.04</td>
<td>0.69</td>
<td>35</td>
<td>3.11</td>
<td>0.68</td>
</tr>
<tr>
<td>High</td>
<td>19</td>
<td>3.53</td>
<td>0.70</td>
<td>36</td>
<td>3.03</td>
<td>0.84</td>
<td>55</td>
<td>3.20</td>
<td>0.83</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>3.43</td>
<td>0.68</td>
<td>60</td>
<td>3.03</td>
<td>0.78</td>
<td>90</td>
<td>3.17</td>
<td>0.77</td>
</tr>
</tbody>
</table>
Discussion

In this study the influences of body shame on physical illness and self-reported physical health were examined, as well as examining differences between genders. Interest was in examining how a higher level of body shame might be predicting physical illnesses, and a more negative self-reported health.

The first hypothesis was that women were more likely to score higher on the body shame scale, self-report their physical health as poor and report physical illnesses, compared to men. The results of the study indicated that women were more likely to self-report their health as poor, compared to men. However, women were not more likely to score higher on the body shame scale and report physical illnesses, compared to men. These results are in line with previous studies regarding self-reported physical health, for example, Meland, Haugland, & Breidablik (2007) found that girls were more prone to self-report their physical health as negative, compared to boys. However, these results are not in line with previous studies regarding body shame and physical illnesses. For example, Poulin, Hand, Boudreau, & Santor, (2005) found that women scored higher on the body shame scale, than did men and Gijsbers van Wijk, Huisman, & Kolk (1999) reported that women continuously reported poorer physical health with higher reports of both illness behaviour as well as physical symptoms, than men.

The second hypothesis was that participants who scored high on the body shame scale were more likely to report physical illnesses, compared to participants who scored low on the body shame scale. The results of the study indicated that participants who scored high on the body shame scale were not more likely to report physical illnesses than participants who scored low on the body shame scale. These results are not in line with previous studies, for example, Lamont (2015) indicated that body shame predicted expansion in infection as well as symptoms. Furthermore, Kamen & Seligman (1987) reported that shame is related to poor
physical health, indicative of deregulations of the immune system. To my knowledge, previous studies have not examined the effect of both gender and body shame on physical illness, and therefore it is not possible to compare the results of this study with previous research conducted on both men and women. This points out the importance of examining this relationship between genders.

The third hypothesis was that participants who scored high on the body shame scale, were more likely to self-report their physical health as poor, compared to participants that scored low on the body shame scale. The results of the study indicated that participants who scored high on the body shame scale were not more likely to self-report their physical health as poor, compared to participants who scored low on the body shame scale. These results are not in line with previous studies, for example, the results from Jean M. Lamont’s (2015) study indicated that body shaming predicted poor self-reported physical health. However, body shame might develop in perception of poor health and future research should bear that in mind (Lamont, 2015).

This study has some limitations that need to be addressed. First of all, the study was cross sectional and had relatively few participants, and therefore causal inferences could not be concluded. It would have been preferable to have a random sample with more participants. Also, the questionnaire was rather long and one-third of participants chose not to answer the questions that were supposed to measure participants’ body shame, which undoubtedly had some impact on the results of the study. It had also been interesting to examine this subject in a broader age range, because the results show that most participants were not experiencing a major illness at the time the study was conducted. It would be interesting to examine body shame in the elderly and whether body shame is related to physical illness in that age group. Another limitation of this study is that the internal validity for the body shame scale was
rather poor, suggesting that the instrument needs further testing and future studies should bear that in mind.

Although this study has some limitations, it also has its strength. First of all, the results highlight the importance of studying body shame among both men and women. The study demonstrates that women are not more likely to experience body shame than men, and that is something that future research should focus on, that is to examine body shame among both men and women. Another strength of this study is that this was the first time, to my knowledge, that research on exactly this topic has been conducted in Iceland. That is, to examine if body shame is predicting physical illnesses as well as negative self-reported physical health. Additionally, this was also the first time that the body shame scale was used in Icelandic to my awareness.

In conclusion, further research is required on this topic to better understand the relationship between body shame and physical illness. The results of this study indicate that men are just as likely to score high on the body shame scale as women. Studies regarding body shame have mainly been performed on women through the years; however, research on men seems to be increasing in this area. This might be because it has been stated that women objectify their bodies more than men (Grabe, Hyde, & Lindberg, 2007), but recent cultural developments suggest that the objectification of men regarding their bodies, has been emerging. Thus, The Objectification Theory may also be relevant for men, but not only for women (Grogan, 2010). This topic is certainly interesting and the results of this study highlight the importance that more research should be conducted on body shame and the effect on physical health, to better understand the impact of our attitudes to our own bodies. We only have one body and if merely changing our thoughts about our bodies can help us to cope better with life, then it is certainly something that future research should focus on examining.
References


