CALIFORNIA STATE UNIVERSITY SAN MARCOS

THESIS SIGNATURE PAGE

THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE

MASTER OF ARTS

IN

PSYCHOLOGY

THESIS TITLE: Disordered eating and romantic relationships: Examining the roles of benevolent sexism and self-objectification

AUTHOR: Alanna Devon Milner

DATE OF SUCCESSFUL DEFENSE: May 1, 2013

THE THESIS HAS BEEN ACCEPTED BY THE THESIS COMMITTEE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN PSYCHOLOGY.

Dr. Marie Thomas
THESIS COMMITTEE CHAIR

Dr. Sharon Hamill
THESIS COMMITTEE MEMBER

Dr. Kim Pulvers
THESIS COMMITTEE MEMBER

SIGNATURE

SIGNATURE

SIGNATURE

DATE

DATE

DATE
Disordered Eating and Romantic Relationships: Examining the Roles of Benevolent Sexism and Self-Objectification

Alanna D. Milner

California State University San Marcos
Abstract

It is estimated that about half of all women in college demonstrate eating disturbances that do not meet the clinical threshold for diagnosis (Berg, Frazier & Sherr, 2009). Researchers have speculated that social influences play a large role in the development of eating disorders, especially romantic relationships. Romantic relationships may account for disordered eating through benevolent sexism, which has been found to be related to self-objectification. Self-objectification, in turn, is closely associated with disordered eating. This study investigated: the relationship between self-objectification and benevolent sexism; the relationship between female benevolent sexism and male benevolent sexism; whether self-objectification and benevolent sexism were significant predictors of disordered eating in women, with benevolent sexism adding more predictive value than self-objectification; and, whether male benevolent sexism was a better predictor of disordered eating in women than female benevolent sexism. Eighty-four female undergraduates and their male romantic partners completed questionnaires assessing their levels of benevolent sexism. Women also completed questionnaires examining their self-objectification and disordered eating behaviors. Pearson’s product-moment correlations and hierarchical multiple regressions were used to analyze the hypotheses. The results demonstrated that women’s and their male romantic partner’s levels of benevolent sexism are positively correlated and that surveillance, an aspect of self-objectification, is positively correlated with female benevolent sexism. Finally, self-objectification is a significant predictor of disordered eating in women.
Disordered Eating and Romantic Relationships: Examining the Roles of Benevolent Sexism and Self-Objectification

“Compete. Compare your body to your friends’ and co-workers’ bodies. Are you the thinnest? If not, why not? If you are, think about how jealous they are of you.” This quote was one of 186 from a blog designed to provide advice and motivation on restricting caloric intake to maintain underweight status (“Pro Ana Tips,” n.d.). “Pro-ana” and “pro-mia” (“Ana” is short for anorexia, whereas “mia” stands for bulimia) websites, blogs, and forums are easy to find while surfing the internet. Given the pervasiveness of these online communities, it is no surprise that as many as 10 million women suffer from eating disorders (National Eating Disorders Association [NEDA], 2005), and as many as about half of all college women demonstrate disordered eating behaviors (Berg et al., 2009); that is, problematic eating behaviors that do not quite meet the threshold for clinical diagnosis (NEDA, 2005). The causes of disordered eating are still not understood. Whereas some studies have emphasized genetics and personality factors as predictors (e.g., Baker et al., 2009; Leon, Fulkerson, Perry & Early-Zald, 1995), current studies are turning attention to the role of romantic partners in disordered eating etiology (e.g., Morrison, Doss & Perez, 2009). Specifically, romantic partners have been found to influence the eating behaviors of young women, which may be due to the traditional expectations of the female role in romantic situations (Gralen, Levine, Smolak & Murnen, 1990; Boyes, Fletcher & Latner, 2007). The purpose of this thesis is to explore the relationships between the influence of romantic partners, self-objectification, and disordered eating in females.

This literature review begins by defining disordered eating and identifying factors believed to lead to its incidence. Second, the role of romantic relationships and benevolent sexism within those relationships are considered as factors that may contribute to disordered
eating in college women. Third, a model in which female self-objectification is included as a predictor of disordered eating is outlined. A study to explore this model of disordered eating among college women is then presented.

**Disorders of Eating**

Eating disorders are broadly defined as being consumed with thoughts and behaviors aimed at reducing caloric intake to avoid gaining weight (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Young women are more afflicted by clinical eating disorders than any other age group with approximately .5% to 3% of women diagnosed with eating disorders (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Interestingly, it has been estimated that at least about half of young women reduce their consumption of calories in various ways, such as through laxative use or vomiting (Berg et al., 2009; Worobey, 2002). However, most women with eating disturbances do not meet the threshold for clinical diagnosis, making actual prevalence rates difficult to calculate because these behaviors may be overlooked (Berg et al., 2009).

**Clinically diagnosed eating disorders.** The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders classifies clinical eating disorders into three different types: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (EDNOS; 4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Individuals with anorexia nervosa have levels of body weight that are too low for their age and height, have a fear of gaining weight and have a distorted experience with body weight and shape. Usually women with anorexia also develop amenorrhea. Anorexia nervosa occurs through either restricting food intake or binging and purging. Anorexia nervosa is the most lethal mental disorder, killing more than 10% of people who suffer from it long-term. It has a lifetime prevalence of 0.5% for
women, whereas bulimia nervosa has a lifetime prevalence of 1% to 3% in women. Bulimia nervosa involves binge eating and purging for a minimum of twice a week for 3 months. While binging, the individual feels out of control. Typically, compensatory behaviors follow the binge, such as laxative use or vomiting, and there is an overemphasis on body weight and shape in self-esteem and self-evaluation. Bulimia nervosa is only diagnosed when the individual is not experiencing symptoms of anorexia nervosa. Finally, EDNOS includes disorders that cannot be classified as anorexia nervosa or bulimia nervosa. For example, an individual who meets all diagnostic criteria for anorexia nervosa but has a regular menstrual cycle would be classified as EDNOS. Although the DSM-IV-TR (2000) provides examples of possible cases, an individual diagnosed with EDNOS does not have to meet strict criteria. All eating disorders are far more prevalent in women than in men. Eating disorders also typically afflict people in adolescence to early adulthood (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), making college age women a very susceptible group. Though the prevalence of eating disorders in young adult and adolescent women is high, an even more alarming number of young women exhibit disordered eating behaviors, or eating disorders that do not meet the clinical threshold.

**Disordered eating.** Researchers have described the elements of nonclinical disordered eating in various ways. Some researchers provide a definition that utilizes generic statements about disturbed eating, such as “pathogenic eating and weight control behaviors” (Greenleaf, Petrie, Carter & Reel, 2009). Agencies such as the National Eating Disorders Association (2005) simply acknowledge that there are eating disorders that do not meet criteria for diagnosis but are still dangerous. Similarly, the National Eating Disorders Information Centre (2008) explains that disordered eating is a broad range of abnormal eating behaviors, which can include symptoms of
clinical eating disorders. Although these definitions are somewhat helpful, they give little detail about what disordered eating entails.

In order to clarify the concept of disordered eating, many researchers use the model of a continuum of eating disturbances. According to a review by Scarano and Kalodner-Martin (1994), eating behaviors occur along a continuum, with normal eating behaviors at one end, disordered eating in the middle, and diagnosable eating disorders at the opposite end. The continuum hypothesis states that eating disturbances differ in terms of severity, not quality. Research has supported the validity of the continuum hypothesis. Although they utilized a limited sample, Tylka and Subich (1999) found that women with no disordered eating behaviors, some disordered eating, or full eating disorders, differed linearly on other psychological constructs that are related to disordered eating. For instance, women who reported having eating disorders scored higher on neuroticism than women with disordered eating, and women with disordered eating scored higher on neuroticism than women with no disordered eating symptoms. Similarly, Franko and Omori (1999) found that women who were probable bulimics, intensive dieters, casual dieters, or non-dieters, all differed in severity of depression, dysfunctional bulimic thinking, and eating attitudes, lending support to the continuum hypothesis.

While helping to clarify the concept of disordered eating, the continuum hypothesis led to the creation of a variety of different terms and definitions to explain nonclinical eating disturbances. Some researchers have classified women as asymptomatic (normal eaters), symptomatic (those who show disordered eating), and eating disordered (those who have been or could be diagnosed; Mintz, O’Halloran, Mulholland & Schneider, 1997; Tylka & Subich, 1999). Others have included EDNOS in their definitions of disordered eating (Cotrufo, Monteleone, Castaldo & Maj, 2004; Latzer, Witzum & Stein, 2008). Cotrufo, Monteleone, Castaldo and Maj
(2004) also divided disordered eating (the middle of the continuum) into two types: partial and subclinical. In their study, partial anorexia nervosa met all criteria for the disorder except amenorrhea and body weight loss, whereas subclinical bulimia nervosa met all criteria but lack of control during purging and a high frequency of binging and purging. Their definitions of subclinical anorexia and bulimia were the same as the definitions of the partial versions, except only one of the two criteria were not met. In other words, the subclinical definitions included one more clinical criterion than the partial definitions. Alternatively, other researchers distinguished “subthreshold” eating disorders as meeting all symptoms of a particular disorder but at a lower rate than needed for clinical diagnosis, whereas partial eating disorders were defined as those in which individuals reported only some of the symptoms of a specific eating disorder (Stice, Marti, Shaw & Jaconis, 2009). Although the definitions of disordered eating in the previous studies are not identical, it seems that all describe eating disturbances that do not meet a clinical threshold.

Whereas there is no universal definition of disordered eating, all definitions do have the same underlying theme. Most researchers broadly define disordered eating as eating disturbances that fall somewhere between people who have no problems with eating and those who have clinical eating disorders. This idea will be applied to the definition used in the current study, such that disordered eating will be defined as disturbances in eating behaviors and attitudes that have not been previously diagnosed as either anorexia nervosa or bulimia nervosa. Although technically a diagnosable eating disorder, EDNOS will be included in the operationalization of disordered eating as it may be used to diagnose eating disturbances that do not meet the clinical threshold for anorexia and bulimia nervosa. Therefore, for the purposes of the study, subclinical and partial eating disorders will be considered disordered eating, as they
may not be diagnosed as full-syndrome clinical eating disorders. Specifically, the eating disturbances involved in disordered eating include such behaviors as an “obsession with body weight and shape, excessive restrictive eating, skipping meals, laxative and diet pill use, cycles of binge eating and dieting, self-induced vomiting, and excessive exercise” (Massey-Stokes, 2008, p. 58-59). All of these behaviors are performed to reduce the number of calories gained from dietary intake (Massey-Stokes, 2008). It is important to consider the variety of negative outcomes that may result from disordered eating.

**Outcomes associated with disordered eating.** Many researchers have found that negative psychological side effects are related to disordered eating. People who report binge eating describe experiencing more distress from everyday hassles than do those who do not binge eat (Crowther, Snaftner, Bonifazi & Shepherd, 2001). Additionally, women who had recovered from disordered eating (either clinical or nonclinical) still demonstrate lower health and self-esteem than those with no history of disordered eating (Striegel-Moore, Seeley & Lewinsohn, 2003). Finally, women with bulimic symptoms show higher levels of neuroticism and urgency than women who do not display bulimic symptoms (Fischer, Smith, Annus & Hendricks, 2007). Collectively, these studies illustrate the negative psychological outcomes associated with disordered eating.

Certain physical health outcomes have also been associated with disordered eating. Women who report having bulimic symptoms that do not reach clinical threshold, as well as other severe weight control behaviors, had more impairment in performing everyday activities due to their health compared to women with no such symptoms (Mond et al., 2006). Women who are normal weight or underweight and still have a desire to become thinner also show negative health related outcomes related to alcohol than women who do not wish to lose weight.
(Dams-O’Connor, Martens & Anderson, 2006). Specifically, women who did not need to lose weight but still wanted to be thinner were more likely to endure forced copulation as a result of alcohol consumption as opposed to women who did not desire further weight loss. Additionally, temporary and chronic gastrointestinal complications have been found to result from specific symptoms of eating disorders, such as laxative abuse and restriction of food intake (Robinson, 2000). Although these findings exemplify the link between eating disturbances and health consequences, other researchers have found that disordered eating behaviors may predict even more detrimental future outcomes.

In their review of studies assessing the progression of disordered eating, Shisslak, Crago and Estes (1995) demonstrated that disordered eating behaviors can develop into full-blown eating disorders. The results of several longitudinal studies indicated that advancement from partial eating disorders and pathological dieting to full eating disorders occurred in 14 – 46% of the cases (Shisslak et al., 1995). Others have found that subclinical cases may actually remit over time, but that partial cases of eating disorders (defined as one type of disordered eating) are stable and can develop (Cotrufo et al., 2004). The above studies provide sufficient evidence that disordered eating behaviors are not healthy and are linked to detrimental outcomes. Therefore, one important question to address is what predicts these eating disturbances?

**Social Predictors of Disordered Eating**

A wide range of possible causes for disordered eating behaviors have been examined. Some believe that genetic and biological components are involved (Baker et al., 2009; Gapin, Etnier, & Tucker, 2009; Klump, McGue, & Iacono, 2000; Klump, Suisman, Burt, McGue, & Iacono, 2009; Suisman, Burt, McGue, Iacono, & Klump, 2011). Others have found that culture and ethnicity may produce differences in the development of disordered eating in young women
(Akan & Grilo, 1994; Edwards-Hewitt & Gray, 1993; Sanderson, Wallier, Stockdale, & Yopyk, 2008; Wood & Petrie, 2010). Possible environmental causes have even been examined, especially the influence of media exposure on adolescents and young women (Bissell, 2004; McCabe, Ricciardelli, Mellor, & Ball, 2005). Psychological variables, such as negative affect, and personality factors, such as poor interoceptive awareness, have been determined to have an influence in disordered eating symptoms experienced by young women (Jackson & Chen, 2011; Johnson & Petrie, 1996; Kent, Waller, & Dagnan, 1997; Leon, Fulkerson, Perry, & Early-Zald, 1995; Logio, 2003). Whereas all of these factors are important, there has been considerable attention paid to the social influences involved in the development of disordered eating attitudes and behaviors. In particular, studies have focused on the role of families, peers, and romantic partners.

**Familial predictors of disordered eating.** Families influence the eating behaviors of girls and young women. Worobey (2002) emphasizes that a mother’s focus on her own weight appears to be directly and extremely influential on her daughter’s weight and eating concerns. Weight-related teasing, mother’s weight talk, and mother’s dieting have also been shown to be related to body dissatisfaction, unhealthy weight control behaviors, and binge eating in girls (Neumark-Sztainer et al., 2010). Even encouraging comments about losing weight from parents, especially from mothers, have been found to increase body dissatisfaction and symptoms of bulimia in adolescent and young adult females (Kluck, 2010). Other researchers have examined familial processes that are not directly related to eating activities. Gillett, Harper, Larson, Berrett and Hardman (2009) demonstrated that constraining family rules regarding behaviors such as kindness, expressiveness and control, were related to a greater incidence of disordered eating.
These studies emphasize the importance of familial influences on women’s eating behaviors from adolescence into early adulthood.

**Peer predictors of disordered eating.** Many studies have also examined relationships within female adolescent and young adult peer groups, and their influence on eating and weight-related behaviors. Gilbert and Meyer (2005) found that adolescent females’ scores on the Drive for Thinness and Body Dissatisfaction subscales were related to their fear of being evaluated negatively by the general public and by their friends. Schutz and Paxton (2007) reported that perceived concerns of weight among friends, and perceived advantages of being thin in relationships, were positively associated with higher body dissatisfaction, and more disordered eating behaviors. Researchers have also found that before being part of a sorority, college women showed no differences in terms of eating behaviors, but that after they became a part of the sorority, women displayed higher scores on the Drive for Thinness subscale (Allison & Park, 2004). Others have found that women involved in sorority peer groups, and those wishing to become part of such peer groups, show higher rates of disordered eating behaviors and attitudes than women from the general college population (Basow, Foran & Bookwala, 2007; Rolnik, Engeln-Maddox & Miller, 2010). Whereas family factors and peers play a role in disordered eating, romantic relationships may be the most intriguing and important influence on disordered eating behaviors.

**Romantic relationship predictors of disordered eating.** Romantic relationships become increasingly emotionally important as adolescents grow into young adults (Fuhrman & Buhrmester, 1992). Relationships are characterized by two or more people who have some influence over their partner’s behaviors, attitudes, and emotions; intimacy, or an affectionate and emotional closeness (VandenBos, 2007), is a defining feature of romantic relationships. The
development of these relationships typically coincides with the onset of eating disturbances in females (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). Romantic relationships may lead to increased concern about weight and dieting behaviors because thinness has been associated with dating (Gralen et al., 1990). Due to this fact, researchers have examined if and how partners influence the eating behaviors of women.

Many researchers have found links between specific aspects of relationships and disordered eating in the female partners. The aspects of relationships that influence eating behaviors include quality of and satisfaction within the relationship. Markey, Markey and Birch (2001) found that marital quality of the participants was the best predictor of unhealthy dieting techniques in women, such that those with poorer marital quality were more likely to experience unhealthy dieting techniques. Intrapersonal influences, poor understanding from, or of, their spouses, and low levels of marital love and harmony also predicted unhealthy eating behaviors in women. Others have examined how relationship satisfaction relates to disordered eating in women, but the findings are somewhat mixed. For instance, higher satisfaction with one’s own relationship has been found to be negatively correlated to weight in women (Sheets & Ajmere, 2005). This study may emphasize the fact that relationships, even when satisfactory, may not buffer disordered eating. However, it has also been reported that women are more satisfied with their bodies when they have male partners who are satisfied with their relationship (Boyes et al., 2007). In examining the male partner’s satisfaction with his female partner’s body, Markey and Markey (2006) found that women thought their male partners were less satisfied with their female bodies than was actually the case. Additionally, other researchers have demonstrated that changes in eating, weight, and shape concerns (which included disordered eating as well as other weight-related attitudes and behaviors) of women were predicted by men’s actual satisfaction.
with their partner’s bodies, rather than the women’s perception of the partner’s satisfaction with their bodies (Morrison et al., 2009). Although the direction of the relation to disordered eating in women is not entirely clear, relationship satisfaction, male’s dissatisfaction with his female partner’s body, and poor quality of the relationship seem to increase disordered eating behaviors in women.

Variables concerning the individual partners in the relationship, rather than the romantic relationship itself, have also been examined with respect to disordered eating behaviors in women. Boyes et al. (2007) reported that women were less satisfied with their bodies and displayed unhealthy dieting techniques when their partners were depressed and had low self-esteem. Social support from each partner has also been assessed. Weller and Dziegielewski (2004) demonstrated that perceptions of low social support from women’s partners predicted lower body image disturbance, although this was not related to the development of eating disturbances. It was also reported that esteem support, such as complimenting one’s partner, was most beneficial in reducing their partner’s stress and anxiety about body image. Low psychological well-being and social support within the context of romantic relationships have demonstrated links to eating disturbances and body dissatisfaction in young women and girls.

Although the influence of romantic partners on eating behaviors has clearly been researched, two interesting findings are in need of further examination to gain a better understanding of disordered eating in romantic relationships. The evidence that romantic partners may be more influential than women themselves in determining their disordered eating behaviors is somewhat limited and needs to be more extensively investigated (Boyes et al., 2007; Morrison et al., 2009). Similarly, it is interesting that partner variables, such as the partner’s personal well-being (Boyes et al., 2007), demonstrate a link to disordered eating behaviors in
women and yet, have not been extensively studied. Benevolent sexism is a variable that may help explain both of the previous findings, as well as shed new light on the influence of romantic partners on eating behaviors.

**Benevolent Sexism**

Benevolent sexism, a type of sexism that rewards women for remaining traditional (Glick & Fiske, 1996), may help explain disordered eating in women in romantic relationships. According to Glick and Fiske (1996), sexism is ambivalent because it can be demonstrated in a well-known hostile way and also in a less recognized benevolent manner. Although hostile and benevolent sexism may be experienced differently, both types demonstrate an underlying belief that women should “inhabit restricted domestic roles and are the ‘weaker’ sex” (Glick & Fiske, 1996). Hostile sexism involves discriminating against women who are nontraditional for not adhering to conventional feminine roles. Alternatively, benevolent sexism is a set of attitudes that also emphasize women in traditional roles, but it involves positive feelings towards those who fit feminine stereotypes. It usually involves behaviors that are perceived to be prosocial in nature, by rewarding women who remain in traditionally feminine roles, such as being a housewife and stay-at-home mother (Glick & Fiske, 1996). Since benevolent sexism entails holding protective attitudes toward women because they are wives and mothers who take care of men, women have been found to endorse benevolently sexist attitudes (Glick & Fiske, 2001). Women are idealized and romanticized as love objects that complement traditional male attributes. Many women may remain more traditionally feminine, such as by maintaining a petite, feminine appearance, because benevolent sexism provides rewards to women who adhere to conventional gender roles.
In examining the effects of benevolent sexism, it is essential to investigate the situations in which benevolent sexism appears to be highly influential. Some researchers report that women tolerate benevolent sexism so that they do not have to deal with the harmful repercussions of hostile sexism. Glick et al. (2000) found that women in countries in which men’s hostile sexism is particularly high report very high levels of benevolent sexism. Others report an increase in women's benevolent sexist attitudes when they believe men hold negative attitudes toward women (Fischer, 2006). Alternatively, other researchers emphasize the influence of men’s benevolent sexist attitudes on those held by women. Sibley et al. (2009) found that perceptions of normative benevolent sexism in men produced changes in female participants’ own levels of benevolent sexism. Specifically, the more a woman perceived most men to be benevolently sexist, the more she endorsed benevolent sexism attitudes. These studies demonstrate a link between situations in which women are aware of men’s sexist attitudes and women’s own sexist attitudes, emphasizing the importance of examining male views.

Benevolent sexism appears to be important to the formation of heterosexual relationships by producing preferences in characteristics of potential partners. Chen, Fiske and Lee (2009) reported that, while the significance of the findings in American men were only marginal, Chinese and American men who reported higher levels of benevolent sexism were looking more for mates who were docile and traditional than men lower on benevolent sexism. Ambivalent sexist attitudes (the combination of benevolent and hostile sexism) were also found to predict preferences for potential mates in men and women (Travaglia, Overall & Sibley, 2009). Other researchers have found that women think of benevolent sexist men as more attractive than other men. Female German undergraduates rated a profile of a benevolent sexist man as the most likeable and sexiest, when compared to a hostile sexist man, a nonsexist man, and a man
demonstrating both hostile and benevolent sexism (Bohner, Ahlborn, & Steiner, 2010). This relationship was moderated by women’s own levels of benevolent sexism. Therefore, benevolent sexism appears to be influential for women in finding potential romantic partners.

Benevolent sexism negatively affects many aspects of women’s lives. Benevolent sexism has been shown to be detrimental to the way female employees, pregnant women, and rape victims are perceived (Durán, Moya, Megías, & Viki, 2010; Hebl, King, Glick, Singletary & Kazama, 2007; Viki, Abrams & Masser, 2004). Similarly, the sexual activity of women is affected by benevolent sexism, such that women who appear chaste receive benevolently sexist treatment, especially from other women (Fowers & Fowers, 2010). The most dangerous impact of benevolent sexism, however, may be the effect on women’s self-perceptions. Being exposed to benevolent sexism has been found to lead women to remember instances in which they felt incompetent, to have more intrusive thoughts during a task, and to derive more self-worth from relational characteristics rather than task-oriented attributes (Barreto, Ellemers, Piebinga & Moya, 2010; Dumont, Sarlet & Dardenne, 2010). Not only does benevolent sexism appear to influence women’s beliefs about their cognitive abilities, but it also has been linked to their thoughts about female appearance.

Another consequence of benevolent sexist attitudes and beliefs are detrimental appearance-related behaviors in women. Although one group of researchers found a relationship between healthy appearance-related attitudes and benevolent sexism (Forbes et al., 2005), many researchers have suggested that benevolent sexism is closely related to more unhealthy forms of appearance management. Forbes, Collinsworth, Jobe, Braun, and Wise (2007) found that the current ideals of women in Western countries, such as the importance of beauty and thinness, were related to benevolent sexism. However, these Western beauty ideals were more closely
associated with hostile sexism than benevolent sexism. One similar study reported a relationship between benevolent sexism and the use of cosmetics. Those who held many benevolently sexist beliefs reported using more cosmetics for a romantic date than those who were low in benevolent sexism (Franzoi, 2001). In a more recent replication, Forbes, Jung and Haas (2006) also demonstrated the association between benevolent sexism and dating cosmetic use, enhancing the link between benevolent sexism and somewhat negative appearance management strategies. Finally, benevolent sexism and other-objectification, or the extent to which the individual objectifies others, have been found to be related to individual differences in the endorsement of the thinness ideal (Swami et al., 2010). For instance, women who reported high benevolent sexism and other-objectification also reported high levels of body dissatisfaction. Benevolent sexism demonstrates a clear relationship with unhealthy appearance attitudes; however, the question of whether it is related to eating behaviors remains.

The strong correlation with self-objectification, defined as treating one’s body as if it were an object, may help to explain how benevolent sexism might influence disordered eating behaviors in women. State, or situational, benevolent sexism has been reported to be directly related to self-objectification, such that women who were exposed to an incident involving a benevolently sexist action reported higher levels of self-objectification, body surveillance, and body shame (Shepherd et al., 2011). Calogero and Jost (2011) similarly found that exposure of women to benevolent sexism increased self-objectification, body shame, and self-surveillance. Although there appears to be no current study that directly relates benevolent sexism to disordered eating, it is possible that because self-objectification is related to disordered eating behaviors, benevolent sexism is a predictor of disordered eating as well. Therefore, it is
important to examine how self-objectification relates to disordered eating, especially in the context of romantic relationships.

**Self-objectification**

According to Objectification Theory, sexual objectification, defined as the process of being treated as if one is an object, is commonly experienced by women and girls, and can lead women to view themselves from the perspective of an outsider (Fredrickson & Roberts, 1997). Due to prevalent and persistent sexual objectification, girls and women may internalize the way outsiders see them, and objectify themselves in order to receive opportunities awarded to attractive females. It is experienced in both interpersonal relationships and through media images, but may be especially common in romantic relationships because women want to attract their mate (Fredrickson & Roberts, 1997). Self-objectification varies from individual to individual and moment to moment, with adolescent and young adult females being more susceptible to self-objectification than older women due to pubertal changes and an increasing differentiation of the genders (Fredrickson & Roberts, 1997). Because romantic relationships and adolescence both increase the likelihood of self-objectification, young women in romantic relationships are very likely to experience self-objectification.

Women may self-objectify in interpersonal relationships as a strategy for keeping those relationships. Specifically, women may place a great amount of importance on maintaining romantic relationships and, as a result, on self-objectification to maintain their appearance (Sanchez & Kwang, 2007). Sanchez and Kwang (2007) found that, regardless of relationship status, women who were exposed to highlighted statements describing self-worth as being derived from relationships reported more body shame (an aspect of self-objectification) than women who were not shown statements describing self-worth as a result of relationships. This
finding supports the idea that women self-objectify in relationships to maintain their relationships. Also, women who are currently single and primed to think of relationships report higher levels of self-objectification than women who are romantically involved and also primed to think of relationships (Sanchez & Broccoli, 2008), suggesting that women objectify to appeal to potential partners. These studies emphasize the fact that self-objectification is a strategy for obtaining and maintaining romantic relationships.

Unfortunately, many women may experience a lower quality of life as a result of self-objectifying in romantic relationships. Self-objectification negatively affects women’s feelings of safety, awareness of physiological cues, and sexual experiences (Calogero & Thompson, 2009; Fredrickson & Roberts, 1997; Steer & Tiggemann, 2008). Self-objectification in women is also related to depressed mood (Grabe, Hyde, & Lindberg, 2007; Grabe & Jackson, 2009; Miner-Rubino, Twenge, & Fredrickson, 2002; Szymanski & Henning, 2007; Tiggemann & Kuring, 2004). Another often reported consequence of the consistent monitoring of one’s body involved in self-objectification is disordered eating. Self-objectification has been shown to be related to disordered eating through body shame, self-surveillance, and other related variables. Body shame has been found to fully mediate the relationship between self-objectification and disordered eating in women, such that objectifying one’s body predicts body shame, which then predicts disordered eating behaviors in women (Calogero, 2009; Greenleaf, 2005; Greenleaf & McGreer, 2006; Slater & Tiggeman, 2002; Tiggemann & Slater, 2001). Others have also found a small direct relationship between self-objectification and disordered eating (Moradi, Dirks & Matteson, 2005; Noll & Fredrickson, 1998). Tiggemann and Kuring (2004) found that self-objectification and self-surveillance predicted disordered eating symptoms in women. Finally, other variables related to the association between self-objectification and disordered eating are poor awareness
of internal states, the enjoyment of being sexualized, and appearance anxiety (Greenleaf & McGreer, 2006; Liss, Erchull & Ramsey, 2011; Myers & Crowther, 2008; Tylka & Hill, 2004). Whatever the specific self-objectifying variables that influence disordered eating may be, self-objectification and disordered eating are clearly related.

The Current Study

Because both self-objectification and benevolent sexism appear to be important in romantic relationships and have a connection to appearance-related behaviors in women, it is reasonable to expect that benevolent sexism of a male partner, female benevolent sexism and female self-objectification play a role in the disordered eating behaviors of the female partner. Evidence suggests that the male partner’s level of benevolent sexism is important because variables relating to the male partner have demonstrated significance in predicting disordered eating behaviors in female partners. Specifically, relationship satisfaction, relationship quality, satisfaction with partner’s body, and mental well-being of partners, have predicted disordered eating behaviors in women (Boyes et al., 2007; Markey & Markey, 2006; Markey et al., 2001; Morrison et al., 2009). Following the findings of Sibley et al. (2009), benevolent sexism of the male partner is likely a better predictor of the female partner’s disordered eating behaviors than are her own levels of benevolent sexism. Sibley et al. (2009) found that perceptions of normative benevolent sexist attitudes of men produced change in the female participant’s level of benevolent sexism. In extending this finding, male and female benevolent sexism may have an influence on disordered eating above that of female self-objectification in women. This may be especially true coming from an important male, such as a romantic partner.
The model for the current study is as follows:

![Diagram of the model of social predictors of female disordered eating]

*Figure 1.* The model of social predictors of female disordered eating.

Therefore, the hypotheses of the current study are:

- **Hypothesis 1a:** Self-objectification and female benevolent sexism will be positively correlated.
- **Hypothesis 1b:** Self-objectification and male benevolent sexism will be positively correlated.
- **Hypothesis 2:** Male benevolent sexism and female benevolent sexism will be positively correlated.
- **Hypothesis 3:** Self-objectification will be a significant predictor of disordered eating in women.
- **Hypothesis 4:** Benevolent sexism will be a significant predictor of disordered eating in women.
- **Hypothesis 5:** Benevolent sexism will add predictive value to disordered eating above that of self-objectification.
- **Hypothesis 6:** Male benevolent sexism will be a better predictor of disordered eating in women than female benevolent sexism.
Methods

Participants

The participants in the study were 84 college women, over the age of 18, who were in a monogamous heterosexual relationship of at least one month’s duration. Participants were recruited through the university’s Human Participant Pool (HPP). The listing on the HPP website was titled “Attitudes and Romantic Relationships” and provided the list of criteria that participants needed to meet. Participants were required to have never been diagnosed with an eating disorder prior to participation in the study. A total of 32 women were eliminated from the sample because of the possibility of undiagnosed Anorexia Nervosa (AN) or Bulimia Nervosa (BN) based on their responses to items from the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I; First, Gibbon, Spitzer & Williams, 2002). By eliminating those who met the current study’s criteria of an eating disorder, we were able to focus on disordered eating behaviors in a nonclinical population. Data from the male partners of the female participants were also collected.

The mean female age was 21.51 years and ranged from 18.00 to 53.00 years ($SD = 5.03$). The mean male age was 20.92 years, ranging from 17.00 to 54.00 years ($SD = 8.86$; see Table 1). All of the female participants were currently enrolled in college. Of 84 male partners, 69.0% reported a high school diploma as the highest degree received, 22.6% reported an Associate degree, 6.0% reported a Bachelor’s degree, and 1.2% had received a Master’s degree. In terms of ethnicity, 7.1% of women were of Asian/ Pacific Islander background, 28.6% were Hispanic/Latina, 56.0% were White, 6.0% considered themselves Multiethnic, and 2.4% chose the Other category. The Hispanic participant percentage is very similar to the ethnic breakdown of the university (29%), as are the Asian (10%) and Native Hawaiian or Other Pacific Islander
(1%) percentages. However, there are more White participants than expected (56.0% compared to 44% at the University), more Multiethnic participants than expected (6.0% compared to 3% at the University), and fewer African American/Black participants than expected (0% compared to 3% at the University). There were also no American Indian/Alaskan Native participants in the study, though there are 1% reported at the University. Of the male partners, 3.6% reported being African American/Black, 3.6% were Asian, 33.3% were Hispanic/Latino, 1.2% reported being Native Hawaiian or Other Pacific Islander, 47.6% were White, 8.3% reported being Multiethnic, and 2.4% choose the Other category.

Female participants stated a mean of 2.54 years in the current relationship ($SD = 2.32$), ranging from 0.08 to 18.00 years, whereas male partners reported a mean of 2.48 years in the current romantic relationship ($SD = 2.25$), ranging from 0.00 to 18.00 years. The reported years in the current relationship by male and female partners were highly correlated, $r = .98$, $p < .001$.

Table 1

<table>
<thead>
<tr>
<th>Demographics of the Sample</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Hispanic/Latino/Latina</td>
<td>33.3%</td>
<td>28.6%</td>
</tr>
<tr>
<td>White</td>
<td>47.6%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Multietnic</td>
<td>8.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Mean Age</strong></td>
<td>20.92</td>
<td>21.51</td>
</tr>
<tr>
<td><strong>Mean Length of Relationship</strong></td>
<td>2.48</td>
<td>2.54</td>
</tr>
</tbody>
</table>
Measures

The female participants completed seven measures: demographic information, two distractor measures, 4 questions from the SCID-I, a measure of benevolent sexism, self-objectifying behaviors scales, and a measure of eating attitudes and behaviors. Female participants were also asked to provide their height and have their weight measured to determine their Body Mass Index (BMI). The male partners of the participants only completed the demographics questionnaire and the Ambivalent Sexism Inventory (ASI), along with the two distractor questionnaires.

Demographics questionnaire. All participants were given a demographics questionnaire that assessed their racial/ethnic background, length of time in the current relationship, age, and level of education.

Distractor measures. In an attempt to avoid demand characteristics, female participants and male partners completed two distractor measures. The first measure was a health scale, which asked respondents to answer general health-related questions. The second scale consisted of questions assessing the frequency with which partners utilized various modes of contact (i.e., text messaging) to interact with their significant others.

Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I). All female participants completed 4 questions on the SCID-I that assessed some eating disorder symptoms (First et al., 2002). Two questions assessed BN symptoms and 2 assessed AN symptoms. The AN questions were, “Have you ever had a time when you weighed much less than other people thought you ought to weigh?” and “If yes, at that time, were you very afraid that you could become fat?” The BN questions were, “Have you often had times when your eating was out of control?” and “If yes, did you do anything to counteract the effects of eating that much? This could include making
yourself vomit, taking laxatives, enemas, or water pills, strict dieting or fast, or exercising a lot.” If participants answered yes to both of either the BN or AN questions they were eliminated from the study as they were believed to be more likely to have an eating disorder than those who responded no to at least one question in each group.

**Benevolent sexism.** All participants were given the Benevolent Sexism subscale of the Ambivalent Sexism Inventory (ASI) to identify level of benevolent sexism (Glick & Fiske, 1996). The Hostile Sexism subscale of the ASI was administered, but was not examined as it is not of interest to the current study. The items on the Benevolent Sexism subscale assess Protective Paternalism, Complementary Gender Differentiation, and Heterosexual Intimacy. The Benevolent Sexism subscale consists of a total of 11 items. All items are rated on a 6-point Likert scale (0 = strongly disagree; 5 = strongly agree). An example of the items in the complementary gender differentiation category is, “Women have a quality of purity few men possess.” An example of the items created for the protective paternalism category is, “Women should be cherished and protected by men.” Finally, the heterosexual intimacy category includes items such as: “Every man ought to have a woman he adores.” The higher the average score on the total subscale, the more benevolent sexist attitudes the participant endorses. The mean for the female participants in the current study was 2.74 $(SD = .76)$, whereas the mean for male participants in the current study was 2.95 $(SD = .72)$. The female benevolent sexism scores ranged from 0.82 to 4.36, and the male benevolent sexism scores ranged from 1.09 to 4.55. The mean scores in the current study are similar to those found in the literature. For instance, the benevolent sexism scores reported in this study were slightly higher than those reported in Glick and Fiske (1996), which ranged from 2.31 to 2.87 for male benevolent sexism and 1.90 to 2.43 for female benevolent sexism. However, the current study found lower levels of benevolent sexism than did de Lemus, Moya and Glick (2010),
which reported male benevolent sexism ranges from 3.76 to 3.97 and female benevolent sexism ranges from 3.67 to 3.97. It should be noted that de Lemus et al. (2010) examined benevolent sexism in adolescents. The alpha reliability coefficients that were found across six different samples, including undergraduate and non-student samples, ranged from .73 to .85 (Glick & Fiske, 1996). For this study’s samples, the benevolent sexism alpha coefficients were .74 for females and .71 for males. With the exception of undergraduate men, Glick and Fiske (1996) found that men’s benevolent sexism scores were positively correlated to positive attitudes toward women. Although the fact that this relationship was not found in undergraduate men is a concern, more recent studies have demonstrated that benevolent sexism scores in undergraduate men were also found to be positively correlated to positive attitudes toward women (Glick et al., 2000).

**Self-objectification.** The female participants completed the Body Shame and Surveillance subscales of the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996). The OBCS Surveillance subscale consists of 8 items. An example of an item from the Surveillance subscale is, “During the day, I think about how I look many times.” The items are rated on a 6-point Likert scale, from strongly disagree to strongly agree. Higher average scores on the subscales mean that participants show higher surveillance. The mean for the surveillance scale in the current study was 4.31 and the obtained ranged was 2.00-6.25 ($SD = 1.01$). The mean found in the current study is similar to previous studies, which report ranges of surveillance from 3.97 to 4.67 (Calogero & Jost, 2011; Greenleaf, 2005; Shepherd et al., 2011). The subscale has demonstrated a test-retest reliability of .79. Cronbach’s alphas for Surveillance have ranged from .84 to .89 (Hurt et al., 2007; McKinley & Hyde, 1996). In the current study the Cronbach’s alpha for Surveillance was .77. The Surveillance subscale is correlated to body esteem, $r = -.39,$
demonstrating convergent validity (McKinley & Hyde, 1996). Surveillance is also correlated to public self-consciousness, \( r = .73 \) (McKinley & Hyde, 1996).

The OBCS Body Shame subscale also consists of 8 items, which are rated on a 6-point Likert scale. The higher the average score on the subscale the more body shame a participant embodies. An example of an item from the Body Shame subscale is, “When I can’t control my weight, I feel like something must be wrong with me.” The mean for the body shame scale in the current study was 2.86 and the obtained range was 1.00-4.88 (\( SD = .89 \)). The body shame mean in the current study is similar to the body shame means reported throughout the literature, which ranges from 2.77 to 3.93 (Calogero & Jost, 2011; Greenleaf, 2005; Shepherd et al., 2011). The body shame subscale has demonstrated a test-retest reliability of .79. Body Shame Cronbach’s alphas have ranged from .75 to .83 (Hurt et al., 2007; McKinley & Hyde, 1996). The Cronbach’s alpha for Body Shame in the current study was .67. The Body Shame subscale shows convergent validity to body esteem, with a correlation of \( r = -.51 \) (McKinley & Hyde, 1996).

Disordered eating. The female participants completed the Eating Attitudes Test (EAT-26) (Garner, Olmstead, Bohr & Garfinkel, 1982). The questionnaire includes the assessment of three factors: Dieting, Bulimia and Food Preoccupation, and Oral Control. The EAT-26 uses 26 items to measure disordered eating symptoms. Sample items include “I am aware of the calorie contents of the food I eat” and “I feel that food controls my life.” The scores are measured on a 6-point Likert scale (0 = strongly disagree to 6 = strongly agree). Higher scores indicate more eating disturbances in non-clinical populations. Cronbach’s alphas have been reported to range between .83 and .88 (Hurt et al., 2007). The Cronbach’s alpha for the total scale was .76 in the current study. The literature provides considerable evidence of validity for the scale. Mintz and O’Halloran (2000) found that the EAT-26, when utilized as a continuous measure, demonstrated
significantly different scores for women already known to belong to one of four groups: full syndrome eating disorders, EDNOS, symptomatic, and asymptomatic (or those with no symptoms), demonstrating predictive validity. Also, the EAT-26 demonstrates good concurrent validity with the long version of the scale, the EAT-40, $r = .90$, the Eating Disorders Inventory subscales, such as Thinness, $r = .77$, Bulimia, $r = .37$, Body Dissatisfaction, $r = .37$, and the Cognitive Restraint, $r = .67$, Perceived Hunger, $r = .27$, and Disinhibition, $r = .29$, subscales of the Restrained Eating Inventory (Berland, Thompson, & Linton, 1986).

The EAT-26 is traditionally scored by providing the 3 most extreme responses with weights. For all questions, except one question that is reverse-scored, this means the label of “always” receives the weight of a 3, the label “very often” is given a weight of 2, “often” is provided a weight of 1, and the rest of the labels all receive a weight of 0 (Chana, 2006; Wilder, 2007). This is due to a theoretical belief that the measure can only be continuous for the most extreme values, as non-symptomatic attitudes should not contribute to a diagnosis (Chana, 2006; Wilder, 2007). However, others have provided all labels with distinct weights using the EAT-26 and the ChEAT (children’s form of the Eating Attitudes Test) in order to provide more variability in the measure when using it with nonclinical populations, and to make the data more normally distributed (Greenleaf & McGreer, 2006; Kozee & Tylka, 2006; Prenovost, 2000; Slater & Tiggemann, 2002; Tiggemann & Slater, 2001; Wolf-Bloom, 1998). The current study utilized the latter method of scoring. Participants who met all other criteria but had missing values on the EAT-26 were eliminated from analyses ($N = 5$).

The mean score on disordered eating ($M = 28.27, SD = 11.16$) was lower than those reported in previous research that utilized the same scoring strategy as the current study, which report ranges from 31.38 to 66.53 (Greenleaf & McGreer, 2006; Kozee & Tylka, 2006; Slater &
Tiggemann, 2002; Tiggemann & Slater, 2001). The range of disordered eating scores for the current study was 9.00-56.00. This large difference between the score for disordered eating in the current study and the scores reported in previous studies is likely because other studies did not eliminate women suspected to have undiagnosed eating disorders as in the current study. Although the current study used the EAT-26 as a continuous measure, it is interesting to note that, using the traditional method of scoring, a total of 4 women met the original EAT-26 cutoff for demonstrating eating disorders (a score of greater than 20), even after eliminating 32 women from the study based on their responses to the SCID-I for eating disorders (Mintz & O’Halloran, 2000). This is an interesting finding, as it provides some insight into the prevalence of undiagnosed eating disorders. However, more recently, others have suggested using less strict criteria (greater than 10 or 11; see Rivas, Bersabé, Jiménez & Berrocal, 2010 for a brief discussion).

**BMI.** Female participants provided their height, which was entered into a scale that also measured their weight. This scale then calculated the BMI of each participant to be used as a covariate in data analysis ($M = 23.18$, $SD = 4.21$, range = 16.70-40.10).

**Procedure**

The female participants were recruited through the Human Participant Pool (HPP). Participants signed up aware of the condition that their partners must also be available at roughly the same time to complete their respective questionnaires via email. Administering the questionnaires to participants in the lab and to their partners via email made it less likely for partners to be present during completion of the questionnaires. Also, participants and their partners were reminded that their responses were supposed to be independent. Upon signing up to participate, women and their male partners were provided with corresponding numbers to ensure
anonymity. When participants entered the lab they were directed to a computer on which they were informed about the study and were asked to provide informed consent. On this same computer, the female participants received the questionnaire scales in randomized order, with the exception of the demographics questions, which were always presented first. Following the survey, participants reported their height and had their weight measured. These numbers were entered into a scale to provide each individual’s BMI. Female participants were offered sheets with information about the University’s Counseling and Psychological Services upon completion of the BMI measurements.

Partners of participants were contacted via email during the time the participant was in the lab. However, they were given a window of 24 hours to complete the questionnaires. This time window allowed for enough time to make it likely that the partner responded, while also reducing the probability of communication about the study between partners. The email sent to male partners included a link to SurveyMonkey, the online survey software that was used to administer the questionnaires. As part of the emailed survey, male partners were also provided information about the study and gave informed consent. Male participants only received the demographics questions, the ASI, and two distractor questionnaires and completed the questionnaires in a location of their choice. Male participants were to be emailed information regarding the University counseling services, if they felt anxiety or distress. However, no one emailed requesting counseling services information due to increased anxiety or stress.

After at least 24 hours from the participation of the female, each person was debriefed through email with a broad summary of the research. Finally, the specific hypotheses and research questions of the study were provided to all participants through email once 85 couples who met all the criteria completed the study. In order to ensure a sample size of 85 participants and their male
partner’s data, data were collected until there were 85 full sets of data. If male partners did not complete the survey they were considered non-responders. One couple was removed from the final sample as the female participant was pregnant at the time of the study. Therefore, the final sample consisted of 84 romantic couples.

**Results**

Prior to conducting the bivariate analyses, statistical assumptions were tested. The Kolmogorov-Smirnov (K-S) test reported that surveillance, body shame, female benevolent sexism, and male benevolent sexism, were normally distributed, $p > .05$. Therefore, the normality assumption was met. All scatterplots demonstrated fairly linear and homoscedastic relationships, meeting the two assumptions. The independence of observations assumption was met because none of the participants’ scores should have influenced another’s.

To determine the relationship between self-objectification and female benevolent sexism (Hypothesis 1a) two correlations were calculated. Female surveillance was positively correlated with female benevolent sexism ($r = .27, p = .012$). In other words, those females who spend more time monitoring the way they look were more likely to exhibit beliefs in women’s traditional roles. The second subscale of the OBCS used in this study, body shame, was not significantly correlated with female benevolent sexism ($r = -.06, p = .58$). Therefore, Hypothesis 1a was only partially supported.

To examine the relationships between females’ self-objectification and males’ beliefs in benevolent sexism (Hypothesis 1b) two correlations were run. Results indicated that neither females’ surveillance of their looks ($r = .16, p = .15$) nor body shame ($r = .08, p = .50$) were significantly correlated with male benevolent sexism. Hypothesis 1b was not supported.
A bivariate correlation was run to determine the relationship between females’ benevolent sexism and the benevolent sexism of their male partners (Hypothesis 2). Female benevolent sexism was significantly positively correlated with male benevolent sexism ($r = .27, p = .013$), supporting Hypothesis 2. Women and their male romantic partners tend to have similar attitudes toward women in traditional roles.

Regression analyses were used to assess the variance explained in women’s disordered eating attitudes by self-objectification, female benevolent sexism, and male benevolent sexism. Before the regression analyses were conducted, the statistical assumptions of multiple regression were tested. The histograms of the residuals from the female benevolent sexism and male benevolent sexism regression equations showed that they had a mean of zero. The scatterplots and histograms demonstrated that the residuals from both equations were also fairly normally distributed. The tolerance levels in the final models of both regression models (the female benevolent sexism model and the male benevolent sexism model) ranged from .81 to .97, demonstrating that there was no concern about multicollinearity. The scatterplots of the residuals from both regression models demonstrated that the residuals appear to be fairly homoscedastic. Examination of the scatterplot of the relationship between female benevolent sexism and eating attitudes was fairly linear, as were the relationships between body shame and surveillance with eating attitudes. The relationship between BMI and eating attitudes was also fairly linear. The relationship between male benevolent sexism and eating attitudes appeared to be linear, though the relationship did not appear very strong. Finally, the independence of observations assumption was likely met since data was collected from partners at separate times and they were reminded not to discuss the details of the study during the 24 hour window that each male partner was given to respond.
To determine how much variance self-objectification and female benevolent sexism explain in eating attitudes of women, while holding BMI constant, a hierarchical multiple regression analysis was conducted. BMI was entered onto the first step, followed by surveillance and body shame entered on the second step, and female benevolent sexism entered on step 3. The final regression equation for predicting eating attitudes was significant, when controlling for BMI, $F(4, 79) = 10.26, p < .001, R^2 = .34$. The strongest predictor of eating attitudes in the final model was body shame ($\beta = .37, SE = 1.27, t(79) = 3.66, p < .001$). Surveillance was the next strongest predictor of eating attitudes, ($\beta = .25, SE = 1.10, t(79) = 2.51, p = .014$), whereas female benevolent sexism was not a significant predictor of eating attitudes (see Table 2). Therefore, while self-objectification significantly predicted eating attitudes (Hypothesis 3), females’ benevolent sexism did not (Hypothesis 4 and 5).

A second hierarchical multiple linear regression was conducted to examine the amount of variance self-objectification and male benevolent sexism explain in eating attitudes in women, while holding BMI constant (Hypothesis 4). The final regression equation for predicting eating attitudes in women was significant, $F(4, 79) = 9.65, p < .001, R^2 = .33$. The strongest predictor of eating attitudes, while controlling for BMI, was body shame ($\beta = .36, SE = 1.28, t(79) = 3.52, p = .001$). Surveillance was the next strongest predictor of eating attitudes in women ($\beta = .29, SE = 1.07, t(79) = 3.00, p = .004$), whereas male benevolent sexism was not a significant predictor of eating attitudes in women (see Table 3). Similar to the regression model including female benevolent sexism, self-objectification predicted disordered eating (Hypothesis 3), though males’ benevolent sexism did not (Hypotheses 4 and 5).

Finally, to determine whether female benevolent sexism or male benevolent sexism is a better predictor of eating attitudes the $\beta$ coefficients of each benevolent sexism predictor were to
be compared. However, because neither of the variables was a significant predictor of eating
attitudes no statistical analyses were necessary to demonstrate that Hypothesis 6 was not
supported.

Table 2

_Multiple Hierarchical Regression Analysis Predicting Disordered Eating with Female
Benevolent Sexism_

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE</td>
<td>β</td>
<td>b</td>
<td>SE</td>
<td>β</td>
<td>b</td>
<td>SE</td>
</tr>
<tr>
<td>BMI</td>
<td>.73</td>
<td>.28</td>
<td>.28*</td>
<td>.45</td>
<td>.26</td>
<td>.17</td>
<td>.49</td>
<td>.26</td>
</tr>
<tr>
<td>Surveillance</td>
<td>3.16</td>
<td>1.06</td>
<td>.29**</td>
<td>2.75</td>
<td>1.10</td>
<td>.25*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Shame</td>
<td>4.49</td>
<td>1.27</td>
<td>.36***</td>
<td>4.65</td>
<td>1.27</td>
<td>.37***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FBS</td>
<td></td>
<td></td>
<td></td>
<td>1.87</td>
<td>1.40</td>
<td>.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.08</td>
<td></td>
<td>.33</td>
<td>.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>6.78*</td>
<td>12.96***</td>
<td>10.26***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Note._ FBS = Female Benevolent Sexism
* _p < .05. ** _p < .01. *** _p < .001.

Table 3

_Multiple Hierarchical Regression Analysis Predicting Disordered Eating with Male Benevolent
Sexism_

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE</td>
<td>β</td>
<td>b</td>
<td>SE</td>
<td>β</td>
<td>b</td>
<td>SE</td>
</tr>
<tr>
<td>BMI</td>
<td>.73</td>
<td>.28</td>
<td>.28*</td>
<td>.45</td>
<td>.26</td>
<td>.17</td>
<td>.46</td>
<td>.26</td>
</tr>
<tr>
<td>Surveillance</td>
<td>3.16</td>
<td>1.06</td>
<td>.29**</td>
<td>3.22</td>
<td>1.07</td>
<td>.29**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Shame</td>
<td>4.49</td>
<td>1.27</td>
<td>.36***</td>
<td>4.50</td>
<td>1.28</td>
<td>.36***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBS</td>
<td></td>
<td>-.54</td>
<td>.33</td>
<td>1.45</td>
<td>-.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.08</td>
<td></td>
<td>.33</td>
<td>.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>6.78*</td>
<td>12.96***</td>
<td>9.65***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Note._ MBS = Male Benevolent Sexism
* _p < .05. ** _p < .01. *** _p < .001.

Discussion

The current study examined disordered eating in the context of romantic relationships to
determine the impact of the male partner’s level of benevolent sexism on female eating behaviors
and attitudes. The female partner’s level of benevolent sexism and self-objectification
(surveillance and body shame) were also examined to determine the influence these variables
have on each woman's own eating attitudes. The results demonstrated that males and females who were romantically involved had similar views on benevolent sexism. Also, females who felt more shame about their bodies were not more likely to have higher levels of benevolent sexism or have partners with higher levels of benevolent sexism, as these variables were not related. However, females who monitored their bodies were more likely to demonstrate benevolent sexist attitudes. Finally, women with greater levels of self-objectification were more likely to exhibit disordered eating, whereas benevolent sexism did not play a role in disordered eating.

One of the significant findings of the study demonstrates that female levels of benevolent sexism and their male partner’s levels of benevolent sexism are related. This is likely because people become romantically involved with similar others. Chen, Fiske, and Lee (2009) found that men who had higher levels of benevolent sexism were looking for mates who were more traditional, supporting the interpretation that people become romantically involved because they have similar attitudes. Additionally, romantic partners may become more alike in their attitudes as a result of spending more time together and becoming more familiar with one another’s beliefs. As benevolent sexism is based on relationships between men and women, the benevolent sexism of each romantic partner may become very apparent within the context of a romantic relationship, both explicitly and through the actions of each partner. Future research should attempt to analyze the development of these attitudes in romantic relationships. This finding supports previous literature, which suggests that women are more likely to hold benevolent sexist attitudes when men also do (Sibley et al., 2009). This study also contributed to our understanding of the benevolent sexist attitudes held by males and females who are romantically involved.

Whereas male and female romantic partners were found to have similar views on benevolent sexism, the relationship between benevolent sexism and self-objectification was
different. For females, one aspect of self-objectification was related to benevolent sexism; however, for males, there was not a relationship between benevolent sexism and self-objectification in women. Women who reported more surveillance were more likely to report more benevolent sexism, although there was no relationship between female body shame and benevolent sexism. It is possible that this is because body shame is a more universally experienced feeling due to incessant media portrayals of thin women and the idea that thinness is associated with dating (Frederickson & Roberts, 1997; Gralen et al., 1990). However, only those women who are high in benevolent sexism demonstrate high surveillance, as they may decide to monitor their bodies in order to maintain traditionally feminine characteristics, such as having a mate. Conversely, women with low levels of benevolent sexism may not demonstrate high surveillance as a method to manage their body shame, as they are not as actively seeking more conventional female roles, including obtaining a mate. Therefore, greater surveillance is experienced by women high in benevolent sexism, whereas women high and low in benevolent sexism tend to experience similar levels of body shame.

Another possible explanation for the lack of a significant relationship between body shame and female benevolent sexism, and the lack of a significant relationship between both self-objectification variables and male benevolent sexism, could be due to the fact that the two types of benevolent sexism (state and trait) may display different relationships with self-objectification. Previous studies have experimentally induced benevolent sexism. By inducing benevolent sexism, researchers likely produced what could be considered a state level of benevolent sexism (Calogero & Jost, 2011; Shepherd et al., 2011). The current study examined more trait-like levels of benevolent sexism by measuring current levels for each participant. It is possible that only surveillance is related to female trait benevolent sexism, whereas both
surveillance and body shame are related to female and male state benevolent sexism. This may also explain why male and female benevolent sexism were not found to be significant predictors of eating attitudes in women. Male and female state benevolent sexism may predict variance in disordered eating in women, whereas male and female trait benevolent sexism may not. Future research should experimentally induce benevolent sexism and examine the relationship to disordered eating and self-objectification variables.

The current study did demonstrate that self-objectification is a significant predictor of disordered eating attitudes in women. Both surveillance and body shame were the strongest predictors of disordered eating in both the females’ and males’ models. This replicates previous findings that self-objectification, specifically in terms of self-surveillance and body shame, is related to eating behaviors and attitudes in women (Moradi et al., 2005; Noll & Frederickson, 1998; Tiggemann & Kuring, 2004). This was true even when a woman’s BMI was held constant, which is often utilized as a covariate in studies examining eating attitudes and behaviors (e.g., Daubenmier, 2005). Therefore, regardless of how thin a woman actually is, if she objectifies herself she is likely to demonstrate disordered eating attitudes and behaviors. Collectively, these and the findings of previous studies provide additional reasons to attempt to eliminate self-objectification behaviors in women, as they may contribute to unhealthy eating behaviors in women. This study supports this interpretation in terms of college-aged women in romantic relationships.

**Limitations and Strengths of the Study**

It is important to consider the limitations and strengths of this study. One limitation was the procedure used to collect data from the male partners. In order to facilitate the data collection process and ensure the appropriate sample size was achieved, male partners were sent
a link to the questionnaire in an email. This process may have allowed for communication between partners, though a time limit of 24 hours to provide a response was given to male participants to limit this occurrence. However, it is still possible that partners were able to communicate in this window, possibly providing the male partners with more information than desired. Future research should include follow up surveys to determine whether the partners communicated about the study.

Another limitation was the way in which the male partner’s email was obtained and the validity of the couple’s romantic status. The male partner’s email address was provided by the female participant through email, or if the participant did not receive the email, in the lab during participation. This infrequently resulted in sending the survey to an invalid email address or the female participants not knowing their partner’s email address and providing their own or a joint account. Future researchers should require the male partners to enter the lab and complete the questionnaire while the female participant is doing the same. Additionally, it was impossible to determine whether each pair of respondents was actually a romantic couple. Although unlikely, if pairs were not romantic couples, this could have influenced the results of the study as the attitudes of male romantic partners are likely to have more influence on the female participants eating attitudes than are the attitudes others. Future research should attempt to ensure that each pair of respondents is romantically linked.

The current study also has several strengths. This study is also the first known study to examine disordered eating as a possible consequence of benevolent sexism. Though benevolent sexism was not a significant predictor of disordered eating, this study provided a new direction for benevolent sexism research. Future research examining benevolent sexism should investigate possible eating-related outcomes of benevolent sexism, whether state or trait, as this study did.
In order to examine the variables within romantic relationships, this current study utilized information from both male and female partners in a romantic relationship. The 24 hour time window provided a reasonable amount of time for males to complete the questionnaires, but not enough time to give partners a large opportunity to discuss the details of the study. Finally, by not only requiring participants to never have been diagnosed with an eating disorder, but also attempting to eliminate those participants with possible undiagnosed eating disorders, the current study was able to examine a sample that likely only demonstrated eating behaviors that could not be diagnosed as a clinical eating disorder. However, the last strength is also a limitation of the study. The SCID-I items used in the current study were not diagnostic measures of eating disorders; a small subset of items from the total SCID-I were used, and answers to the items are not meant to be self-reported. Thus, there may have been a number of false positives; that is, participants who did not actually have clinical eating disorders may have been eliminated from the study.

**Conclusion**

The findings of the current study can inform practices designed to decrease disordered eating in women. Specifically, it may be possible to influence disordered eating attitudes by changing surveillance or body shame behaviors in women. The findings also identify a relationship between benevolently sexist attitudes of male and female romantic partners, emphasizing the importance of romantic partners in altering or reaffirming the attitudes of an individual. This information can be put to practice in therapy, and demonstrates how beneficial it is to involve family members and loved ones in the therapeutic process. It also supports previous findings about the importance of male sexist attitudes on female sexist attitudes. This is important to understanding how to decrease and eliminate sexist attitudes in both sexes. This
study is a first step to examining the consequences of self-objectification and benevolent sexism within heterosexual romantic relationships.
References


Wilder, E. (2007). *The relationship between school pressure and disordered eating in students completing the final two years of entry-level physical therapy curricula: A pilot study of*
Missouri programs (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3324234)

