

**Maladaptive Perfectionism, Self-Efficacy and Social
Comparison: Predictors for Body Dissatisfaction and
Subsequent Disordered Eating in Females?**

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Abstract

This study aimed to investigate the relationship between maladaptive perfectionism, self-efficacy and social comparison and the extent to which these variables predict body dissatisfaction among females. A sample of females (n = 219) participated in the quantitative study by completing four self-reported questionnaires that examined each variable; The Frost Multidimensional Perfectionism Scale (FMPS), The Generalised Self-Efficacy Scale (GSE), The Social Comparison Scale and The Body Shape Questionnaire 16B (BSQ 16B). Data was analysed using Pearson correlations, multiple linear regressions and t tests. Overall, results conveyed a significant relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction. Maladaptive perfectionism and social comparison were found to be significant predictors of body dissatisfaction. However, self-efficacy was not found to significantly predict body dissatisfaction. In conclusion, the present study replicates previous research findings with regards to the area of body dissatisfaction in females. The main limitation of the current study relates to the inclusion of females only as participants. Findings and recommendations for future research are discussed.

Chapter 1: Introduction

1.1 Overview

The following literature review will aim to provide a concise overview of the theorists and research relevant to the area of body dissatisfaction and disordered eating among females. Females only are of sole interest to the current study as a result of the prevalence of disordered eating in females. Women are much more likely to develop disordered eating behaviours compared to men; only between 5 and 15% of those who develop eating disorders are male (Jeor et al. 2002). The study will investigate the role of key variables, including perfectionism, self-efficacy and social comparison, as possible mediators and casual influences for the onset of body dissatisfaction.

Although the area of disordered eating among females has received much interest and research in recent years, studies have mainly focused on perfectionism, self-efficacy and social comparison as sole variables, or have investigated them with other variables. However, this area of research lacks studies focusing on the combination of these three variables as possible casual factors within the area of body dissatisfaction among females. As a result of this gap in the literature, the current study proposes to provide original insight into the casual role played by afore mentioned variables, in terms of body dissatisfaction.

Body image can be defined as “the internal subjective representations of physical appearance and bodily experiences” (Cash & Pruvinsky, 2004, p. 7).

Considerable research has been conducted in order to understand the consequences of body image dissatisfaction and its effects on disordered eating among females. A large body of research currently supports the psychological and physical distress caused by body dissatisfaction in females (van den Berg, 2004; Thompson, 2004; & Wichstrom, 1999) and its association with excessive dieting behaviours and disordered eating behaviours (van den Berg, 2007). Research indicates that individual traits and attributes coupled with sociocultural pressures such as, exposure to media ideal images, social comparison and family and peer dieting, have been identified as risk factors for increased levels of body dissatisfaction (van den Berg et al. 2007). Body image dissatisfaction has been found to have a strong casual role in the onset of eating disturbances (Cattarin & Thompson, 1994). According to Stice & Shaw (2002), body dissatisfaction is a primary risk factor for the development of disordered eating pathology.

Disordered eating can be conceptualised as irregular patterns of eating behaviours including; self-starvation, self-induced vomiting or laxative abuse (APA, 2000). Harrison & Cantor (1997) found that females with disordered eating are more likely to skip meals, reduce calorie intake and abuse laxatives.

Clinical Eating Disorders

Eating disorders are one of the most detrimental disorders facing women in today's society; physically, emotionally, mentally and psychologically (Latimer-kern, 2009). According to Garner & Myerholtz (1998) eating disorders have been characterised as having main features including “a persistent overconcern with body

size and shape indicated by behaviour such as prolonged fasting, strenuous fasting, and self-induced vomiting aimed at decreasing body weight and fat” (p. 592). The current diagnostic and statistics manual (DSM 5) divides eating disorders into three main categories; anorexia nervosa, bulimia nervosa and binge eating disorder (APA, 2013).

According to the APA (2000) anorexia nervosa is characterised by the refusal to maintain a minimally normal body weight, fear of gaining weight and exhibition of significant disturbance in the perception of the shape or size of one’s body. The onset of anorexia nervosa is often accompanied by a stressful life event (Latimer-Kern, 2009). Bulimia nervosa is characterised by a cycle of binge eating and inappropriate compensatory behaviours to prevent weight gain (Latimer-Kern, 2009). Binge eating disorder was approved for inclusion as its own category of eating disorder within the DSM 5. Binge eating disorder can be defined as “recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control” (APA, 2013). An individual suffering from binge eating disorder may experience feelings of guilt, shame and disgust. The binges may occur on average, at least once a week over three months (APA, 2013).

Prevalence and Incidence Rates of Disordered Eating Behaviours

The incidence rates of disordered eating behaviours have increased markedly over the last fifty years (Polivy & Herman, 2002). Although prevalence rates of eating disorders vary across cultures, it has been estimated that over 6% of all women have

an eating disorder of some kind (APA, 2000). According to Hoek (2003) anorexia nervosa is more prevalent among females aged 15-19, whereas bulimia nervosa was found to be highest in females aged 20-24 years of age (Nunn, 2009). Ackard & Fulkerson (2007) conducted a nationwide study of 4746 students and found that 41.5% conveyed body shape disturbances, 36.4% had a negative influence of body shape/weight on self-esteem, 9.4% engaged in compensatory behaviours, 0.04% met the criteria for anorexia, 0.3% met the criteria for bulimia and 1.9% met the criteria for binge eating disorder. Studies have found that disordered eating tends to be especially prevalent among college aged females; Reinking & Alexander (2005) found that 7.1% of female athletes and 12.9% of female non-athletes were found to be at a high risk for developing disordered eating behaviours (Nunn, 2009).

It is estimated that 95% of those who have eating disorders are between the ages of twelve and twenty-five. The mortality rate associated with anorexia nervosa is twelve times higher than the death rate associated with all other causes of death for females aged between fifteen and twenty-five years of age (Sullivan, 1995). Graber et al (2003) has suggested that 20% of all females will experience some form of eating disturbances during their lives, in the form of bingeing, purging, laxative abuse or unhealthy dieting behaviours. It has been estimated that between 15% and 62% of college aged females will make use of pathogenic weight control behaviours such as, laxatives, self-induced vomiting and excessive or dangerous dieting behaviours at some stage during their college period (Kirk, 2001). According to a study of 185 female college students; 58% felt under pressure to be a certain weight, and of the 83% that dieted in order to achieve weight loss, 44% were of a normal, healthy weight (Malinauskas et al., 2006).

Research focusing on the prevalence of eating disorders across cultures has found that the development of disordered eating is much higher in Western cultures; prevalence rates for anorexia in Western cultures range from 0.1% to 5.7% compared to almost non-existent rates in non-western cultures (Makino 2004, as cited in Latimer-Kern, 2009). The increased incidence of disordered eating in Western cultures may be as a result of the focus on and acceptance of thin female bodies as the only societal ideal. Current Western social standards of beauty overly emphasise the desirability of thinness coupled with the idealisation of a thin body that is impossible for most females to achieve in a healthy manner (Zoletic & Durakovic-Belko, 2009). Heatherton (2000) states that 82% of female students reported that they would like to lose weight, however, only 1.4% of these students were actually overweight. Heatherton's research conveys the female struggle to achieve an impossibly thin ideal body; sacrificing one's health in order to do so (Zoletic & Durakovic-Belko, 2009).

Future Implications of Disordered Eating

Many psychological problems including anxiety, depression, panic disorders and substance abuse have been found to be associated with disordered eating behaviours. According to Woodside and Staab (2006) approximately 75% of individuals with disordered eating pathology will have a lifetime prevalence of comorbid depression. Similarly, the lifetime prevalence for anxiety disorders is also increased; by an estimated 40% for OCD, 11% for panic disorders, 20% with social phobias and 15% with specific phobias. Woodside and Staab (2006) also estimate that the lifetime prevalence for substance use or abuse is 17% in anorexics and 40% in bulimics (Latimer-Kern, 2009).

According to Kirk (2001) it is estimated that between 4% and 20% of women diagnosed with an eating disorder will die due to unresolved symptomatology, with anorexia being the most fatal of all psychiatric disorders (APA, 2000). Bulimic patients have been found to experience further complications due to “fluid and electrolyte imbalance, oesophageal tears, gastric rupture, cardiac arrhythmia and rectal prolapse” (APA, 2000, as cited in Latimer-Kern, 2009). Further implications of disordered eating include reductions in peak bone mass, vitamin and mineral deficiencies and gastrointestinal problems (Latimer-kern, 2009). Nicholls and Stanhope (2000) found that prolonged disordered eating also increased the risk for hepatic steatosis.

Body dissatisfaction and subsequent disordered eating is becoming more widespread and prevalent an issue amongst women in the twenty first century. Research has found disordered eating to be directly associated with a number of psychological, physical and developmental problems. According to Polivy and Herman (2002) not all females who experience body dissatisfaction go on to develop disordered eating. No single casual factor is responsible for the development of disordered eating in females; rather a complex interplay of different variables may be to blame. It is important to understand the factors that interact to produce disordered in females; many studies have investigated the effects of perfectionism, self-efficacy and social comparison as individual mediating variables. However, no studies exist at present to examine perfectionism, self-efficacy and social comparison as predictors of body dissatisfaction in women. As a result of this limitation; the current study will attempt to address this gap in the literature.

1.2 Perfectionism

According to Burns (1980), perfectionists can be conceptualised as individuals “who strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment” (as cited in Anthony & Swinson, 2009). In recent years, perfectionism has been identified as a variable associated with many negative psychological outcomes including eating disorder symptomatology (Koch, 2006). Hamachek (1978) distinguished between normal and neurotic perfectionists stating that normal perfectionists are those who set high standards for themselves yet “feel free to be less precise as the situation permits” (p. 27). Hamachek (1978) characterises neurotic perfectionists as those who set high standards but allow little room for making mistakes (Frost et al. 1990). Perfectionism involves “high standards of performance which are accompanied by tendencies for overly critical evaluations of one’s behaviour” (Frost, Martin, Lahart & Rosenblate, 1990, p. 450).

Current research supports a multidimensional view of perfectionism as having both adaptive and maladaptive traits and tendencies (Ashby & Rice, 2002). According to Hewitt & Flett (2002), adaptive perfectionism is characterised by the pursuit of reasonable and realistic standards, in contrast, maladaptive perfectionism is characterised by the pursuit of excessively high standards and is motivated by fears of failure and of disappointing others. Adaptive perfectionists experience encouragement and have good work habits; the individual’s self-worth is not directly associated with perceived success (Ramsey & Ramsey, 2002). According to Frost, Heimberg, Holt, Mattia and Neubauer (1993) adaptive perfectionism reflects the adaptive aspect of

personal motivation (Koch, 2006). In contrast, maladaptive perfectionists strive towards unattainable goals and have an intense fear of making mistakes (Peterson, 2002). The excessive self-criticism unique to maladaptive perfectionism may have a negative impact on one's self-concept and eating behaviours; such as excessive dieting (Koch, 2006). According to Frost, Heimberg, Holt, Mattia & Neubauer (1993), perfectionism can be best assessed in terms of six subscales; Personal Standards, Organisation, Concern Over Mistakes, Doubts About Actions, Parental Concerns and Personal Standards. Frost et. al (1993) have found scores on the Personal Standards and Organisation subscales to be associated with adaptive perfectionism, whereas, scores on Concern over Mistakes, Parental Expectations, Parental Criticisms and Doubt About Actions are associated with maladaptive perfectionism. Similarly, Frost et al (1993) found that maladaptive perfectionism was positively related to depressive symptoms, negative affect and disordered eating.

Maladaptive perfectionism generates an intensely self-critical attitude and is considered to be a major psychological factor in the development of eating disorders (Marsero et al. 2011). According to Costin (2007) typical characteristics of perfectionism include dichotomous thinking, rigid goal-setting and a perfectionistic filter to scrutinise flaws and ignore successes (Marsero et al. 2011). The characteristics of maladaptive perfectionism convey the ease at which these traits can manifest into pathological behaviour (Marsero et al. 2011). Theorists have long held the view that perfectionism plays an important role in the development of body dissatisfaction and disordered eating behaviours (Brouwers & Wiggum, 1993). Vohs et al. (2001) argue that eating disorders, characterised by a rigid desire to achieve unrealistic standards of thinness, embody the nature of perfectionism. Maladaptive

perfectionistic traits, such as doubting one's own actions and concern over mistakes have been found to positively correlate with disordered eating in females (Egan et al. 2011).

According to Egan et al (2011) perfectionism increases and maintains eating disorder pathology and is significantly elevated in anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified (Egan et al. 2013). According to Minarik & Ahrens (1996) Concern over Mistakes and Doubts about Actions were significantly associated with measures of disordered eating patterns in nonclinical women (Vohs et al. 2001). Many theorists suggest that the females in Western cultures who develop an obsessive concern for perfection often equate perfection with thinness (Sheldon, 2010). According to Bordo (1993) society focuses on thinness as equivalent to success and testament to being in control of one's life. Modern society has constructed a thinner, tighter body as the female norm and as a result, "almost all of us who can afford to be eating well are dieting and hungry almost all of the time" (Bordo, 1993). According to Hewitt, Flett & Edinger (1995) some perfectionistic striving in disordered eating seems to be motivated by a strong desire to conform to an ideal model of perfection that is demanded by the self and perceived as being demanded by others (Duffy, 2008).

Studies have repeatedly shown links between maladaptive perfectionism and disordered eating symptoms; Hewitt, Flett and Ediger (1995) found that women who are perfectionists tend to view the achievement and personification of society's ideal body as essential to their sense of self-worth. Similarly, Ashby, Rice and Martin (2008) found that college-aged women with eating disorders exhibit higher levels of

maladaptive perfectionism in comparison to healthy individuals (Koch, 2006). According to Koch's (2006) study, maladaptive perfectionism was found to uniquely predict disordered eating symptoms. Ashby, Kottelman and Schoen (2009) also found support for this link suggesting that women within an eating disorder group had higher levels of maladaptive perfectionism than those within a control group (Koch, 2006). Joiner et al (1997) found that perfectionism predicted bulimic symptoms in women with self-perceptions of being overweight; however, it did not predict symptoms in women who did not perceive themselves as being overweight. Minarik and Ahrens (1996) found that perfectionism, in particular a concern for making mistakes, may be focused by societal influences towards a fear of not meeting sociocultural appearance ideals, resulting in the adoption of disturbed eating patterns (van den Berg, 2002).

Although it is widely agreed that maladaptive perfectionism plays a role in the development of disordered eating, research has failed to identify the exact role of perfectionism. Bardone-Cone et al (2007) argued that although perfectionism has been identified as having a strong role in the onset of eating disorders, few studies have examined the possible mediating factors which may be influential in this relationship (Egan et al. 2013). Factor analyses have consistently found a two factor solution for perfectionism, consisting of adaptive perfectionism (Organisation and Personal Standards) and maladaptive concerns (Concern over Mistakes, Doubts About Actions, Parental Expectations and Parental Criticisms) (Wade & Tiggemann, 2013). Adaptive perfectionism has been found to be associated with healthy functioning while maladaptive concerns have been associated with psychopathology. Elevated levels of maladaptive perfectionism have been identified as a risk factor in the

development of eating disorders (Wade & Tiggemann, 2013). As a result, the current study will focus on maladaptive perfectionism as a predictor for disordered eating in females.

The present study aims to investigate the influence of maladaptive perfectionism, self-efficacy and social comparison as moderating factors in the development of body dissatisfaction and subsequent disordered eating in females.

1.3 Self-Efficacy

According to Bandura (1994) self-efficacy refers to the belief in one's own capabilities to achieve what one sets out to do. Bandura's theory argued that self-efficacy is not a universal trait, rather "a differentiated set of self beliefs linked to distinct realms of functioning" (Bandura 2006, as cited in Maddux & Gosselin, 2003). Self-efficacy beliefs relate to the ability to coordinate one's actions and skills to attain certain goals in particular circumstances (Maddux & Gosselin, 2003). Bandura argued that an individual's sense of self-efficacy is developed and shaped by social sources, such as, social models, peer persuasion and experiences that influence an individual's strengths and weaknesses (Love Kemp, 2007). Perceived self-efficacy is characterised by looking at one's potential to reach a particular goal based on one's previous competence and actions (Love Kemp, 2007).

Bandura's theory argues that perceived discrepancies between one's personal standard's and attainments are either motivational or discouraging based on the strength of one's self-efficacy (Vohs et al, 2001). According to Bandura, "those

who distrust their capabilities are easily discouraged by failure, whereas those who are highly assured of their efficacy will intensify their efforts and persevere until they succeed (Bandura & Cervone, 1986, p. 93). Individuals high in self-efficacy expect positive outcomes and perceive fewer barriers for performing a behaviour compared to those low in self-efficacy that tend to expect negative outcomes and perceive more obstacles (Davila, 2010). According to Bandura (1997) self-efficacy influences how a person thinks, feels and behaves; a strong sense of one's own competence facilitates performance in a variety of settings. In contrast, individuals low in self-efficacy may experience low self-esteem and negative thoughts in relation to one's own abilities. Similarly, individuals low in self-efficacy have a sense of reduced motivation compared to those high in self-efficacy; low self-efficacy is also associated with depression, anxiety and helplessness (Sassoon, 2005).

Generalised self-efficacy reflects a global confidence in one's coping ability across a range of demanding circumstances (Schwarzer, 2002). Research in the area of disordered eating suggests that disordered eating behaviours may be adopted as an alternative coping mechanism when an individual has a low sense of self-efficacy. Carver and Scheier (1981) suggested that when an individual is faced with an unmet standard, coupled with a reduced possibility of overcoming the discrepancy; negative affect ensues. In terms of disordered eating, when a woman is faced with a weight discrepancy, self-efficacy has been found to determine one's response to this discrepancy (Bardone-Cone et al. 2006). In Western cultures, female self-efficacy is based mainly on the control and mastery of one's own body; thus as a female develops, control of her body is largely conveyed through the embodiment of the culturally constructed ideal of thinness.

An individual's sense of self-efficacy is formed through social sources.

Within the twenty first century, females are applauded and revered for the achievement and maintenance of a thin body shape. In contrast, the failure to achieve this socially constructed thin-ideal is portrayed as an inability to control one's impulses (Bordo, 1993). As a consequence of society's idealisation of the thin female body as a symbol of control; the perception of self-efficacy may be based primarily on one's physical appearance (Valutis et al. 2008). Society's idealised body shape has moved from the curvy Marilyn Monroe body type in the 1950's to the rail thin body type of Kate Moss in the 2000's; what was considered to be perfect in the 1950's is now viewed as unsightly and "full figure" (Bordo, 1993, p. 57). A female's perceived sense of self-efficacy may be based on the control of her physical body. As the societal ideals become more controlled; any softness of the body is regarded as "unsightly" and must be eliminated immediately (Bordo, 1993, p. 57). Valutis et al. (2008) argued that a female's self-efficacy regarding eating, weight and body size can influence whether or not one spends time worrying about discrepancies between current and idealistic body size (Valutis et al. 2009).

Valutis et al (2009) found supporting evidence for low self-efficacy predicting weight related preoccupations. Similar findings came from Toray and Cooley's (1997) research; results showed lower self-efficacy in individuals whose weight fluctuated in comparison to those whose weight remained stable (Valutis et al. 2009). Studies have also supported an association between self-efficacy and disordered eating; Etringer et al (1989) found that women with bulimia had a lower sense of self-efficacy compared to non-bulimic women (Bardone-Cone et al. 2006). Females low in self-efficacy experience less confidence in their own abilities and as a

result, may be more likely to engage in disordered eating behaviours when faced with discrepancies between their actual and ideal body weight. Bardone-Cone et al. (2006) argued that not achieving the culturally created thin ideal body may increase the chances of developing disordered eating behaviours in females high in perfectionism and low in self-efficacy. Females low in self-efficacy and high in perfectionism have been found to have an increased vulnerability to developing disordered eating patterns such as, bulimic symptoms and binge eating symptoms as the result of a perceived inability to achieve the ideal (Carver & Scheier, 1981).

1.4 Social Comparison

According to Mettee and Smith (1977), Festinger's social comparison theory relates to "our quest to know ourselves, about the search for self-relevant information and how people gain self-knowledge and discover reality about themselves" (p. 70). Festinger's social comparison theory argues that individual's establish their own self identity by making comparisons between themselves and others who have certain valued attributes (Festinger, 1954). Social comparison theory posits that individuals have both a conscious and unconscious desire to improve and as a result, engage in social comparison. Similarly, according to Festinger's (1954) theory, people are more likely to compare oneself to an individual similar to oneself.

Festinger's social comparison theory argues that humans need for self-evaluation is often satisfied by comparing oneself to relevant, similar others. Upward social comparisons are comparisons to superior peers and are thought to be utilised when improvements to one's self are intended (Bleichert et al. 2009). Conversely,

downward social comparison refers to comparisons made to those perceived as worse than us; downward social comparisons are believed to occur in an attempt to protect and improve one's self worth (Bletchert et al. 2009). Recent research has found that images of models or females in the media serve as comparison others for many females as the result of the accessibility of media outlets in today's society (Warren, 2006). People who engage in unrealistic upward social comparisons may be more vulnerable to body dissatisfaction if a large discrepancy exists between their actual body size and their ideal body size (Poveromo, 2007). According to Stormer and Thompson (1995) making regular upward social comparisons in order to self evaluate lowers an individual's self-esteem (Duffy, 2008). Research by Tiggemann & McGill (2004) and Tiggemann & Slater (2003) has found that body image dissatisfaction is predicted by an engagement in social comparison with a comparison body that is generally unattainable to the average woman (Poveromo, 2007).

Females are constantly exposed to environments that emphasise the importance of thinness, thus subsequently conveying the self-relevance of thinness. As a result, females engage in body comparisons as the primary means of social comparison, increasing the risk of developing body dissatisfaction (van den Berg et al. 2007). Festinger (1954) proposed that individuals who are uncertain of themselves will be more likely to engage in upward comparisons with superior others. Festinger's theory has been supported by research finding suggesting that individuals who suffer from low self-esteem or depression are more likely to engage in comparisons with others (van den Berg et al. 2007).

Richins (2001) found that 71.3% of female college students think about how they look compared to models when viewing clothing advertisements. This upward social comparison with airbrushed models may expose females to constant negative self-evaluation of their own appearance. Repeated self-evaluation is likely to result in increased body image disturbance which is a main risk factor in the development of disordered eating (Warren, 2006). Similarly, Heinberg and Thompson (1992) conducted a study in which they informed participants that their weight was heavier or lighter than either a similar other person, such as a student in their college, or a global other, such as an average person in the UK. Heinberg and Thompson (1992) found that participants who compared themselves to similar others reported more body dissatisfaction and appearance-related anxiety than those who compared themselves to more global others.

Brytek-Matera and Schiltz (2011) argue for the importance of the domains of the self in relation to body dissatisfaction; actual self, ideal self and ought self. The actual self refers to attributes people actually possess, the ideal self relates to attributes individuals desire to possess and the ought self refers to attributes which people believe they should possess (Dowdy, 2013). Discrepancies between one's actual and ideal self has been found to result in sadness and feelings of dejection and hopelessness; all of which are symptoms associated with the prediction of bulimic symptoms. Discrepancies between the actual and ought self often result in feelings of frustration, anger and tension (Brytek-Matera, 2011). Results have found that the ideal self is more pathological in eating disorder patients compared to those without eating disorders; similarly, individuals suffering from bulimia and anorexia often overestimate their body size (Brytek-Matera, 2011). Researchers have reported that

body shape dissatisfaction, and subsequent disordered eating, often involves the belief that one's physical appearance does not meet some personally relevant standard (Strauman, Vookles, Berenstein, Chaiken & Higgins, 1991). Research has found a link between comparing oneself unfavourably to others (downward social comparison) and disordered eating.

According to Striegel-Moore (1995) girls are socialised to view their self-concept in terms of the relational self; thus conveying the importance of defining oneself in relation to others and to consider the thoughts, opinions and ideas of others (Latimer-Kern, 2009). Striegel-Moore (1995) argues that the relational self places females at increased vulnerability to the thoughts and opinions of others, thus resulting in a higher risk for developing body dissatisfaction and eating pathology. Champion & Furnham (1999) found that 54% of the women in their study reported that their ideal body was thinner than their perception of their current body. Champion & Furnham (1999) also found that 54% of these females desired to have a body size that was thinner than the societal norm at that time (Poveromo, 2007).

Muir et al. (1999) found that comparison with others' appearance or one's own self-ideal was cited by adolescent girls as the most frequent trigger for first time diets (Muir, Wertheim, & Paxton, 1999). Similarly, van den Berg's (2002) research found that social comparison was the most dominant predictor of body dissatisfactions and eating disturbances (Pokrajac-Bulian et al. 2008). Pokrajac-Bulian et al. (2008) found that girls with a higher level of internalisation of societal appearance standards, coupled with a higher tendency to compare their own appearance to those of others, are more susceptible to developing dieting behaviour, a

desire to be thinner and fear of weight gain. This behaviour may result in the possible development of eating disturbances (Pokrajac-Bulian et al. 2008).

According to Bandura's social cognitive theory (1989), social comparison is a significant means of developing one's sense of self-efficacy. A favourable comparison to others results in an increase in self-efficacy; however, unfavourable comparisons with others can result in decreases in self-efficacy. Self-efficacy is viewed as the basis of behavioural control.

Summary

The goal of the present study is to examine body dissatisfaction among females and its relationship to maladaptive perfectionism, self-efficacy and social comparison. The present study will attempt to understand the relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction. Body dissatisfaction is assessed as a means of diagnosing the possible prevalence of disordered eating behaviours. Maladaptive perfectionists are characterised by self defeatist thinking; magnifying any unmet standards while downplaying any achievements (Wong Kwok Leung, 2009). When faced with an unrealistic thin ideal body shape, maladaptive perfectionists may be more likely to magnify the beauty standard and as a result, become more distressed by it. It is reasonable to speculate that as perfectionists engage in upward social comparison; they feel more negative effects than those low in perfectionism. As a result of the negative feelings, maladaptive perfectionists may experience higher body dissatisfaction and may be more susceptible to disordered eating behaviours (Wong Kwok Leung, 2009).

Similarly, females low in self-efficacy will be more susceptible to high levels of body dissatisfaction resulting from a lack of confidence in one's ability to achieve the societal ideal body shape. According to previous research, maladaptive perfectionism, self-efficacy and social comparison may act as moderating variables in the development of disordered eating among females.

1.3 Hypotheses

The current study aims to investigate how maladaptive perfectionism, self-efficacy and social comparison interact to influence body dissatisfaction among women. The combination of high maladaptive perfectionism, low self-efficacy and social comparison to those with more desirable body shapes has been found to be a predisposition to the development of body dissatisfaction among females (Bardone & Cervone, 1986).

H1. It is hypothesised that there will be a significant relationship between maladaptive perfectionism, self-efficacy and social comparison.

H2. It is hypothesised that maladaptive perfectionism, self-efficacy and social comparison will significantly predict body dissatisfaction in females.

H3. It is hypothesised that those who score high in maladaptive perfectionism will have higher levels of body dissatisfaction.

H4. It is hypothesised that those who score low in social comparison will have higher levels of body dissatisfaction.

H5. It is hypothesised that those individuals who have low self-efficacy will score higher in body dissatisfaction

Chapter 2: Methodology

2.1 Participants

A self-report questionnaire was formulated including measures to test for body dissatisfaction, maladaptive perfectionism, self-efficacy and social comparison. The online questionnaire was created using Google docs' online survey hosting site. Two hundred and nineteen individuals participated in the study, all of which were female as per requirements. The population sample was targeted through online social media sites such as Facebook, in order to receive maximum participation from the general population. Participation was entirely voluntary and individuals were required to be female and 18 years or older in order to participate in the survey. Data was collected over a period of approximately two weeks.

2.2 Design

This study utilised a quantitative research design. Self-reported questionnaires were administered including; The Eating Disorder Inventory- 16B subscale, the Frost Multidimensional Perfectionism Scale (FMPS), The Generalised Self-Efficacy Scale (GSE) and the Social Comparison Scale. The study was also correlational in nature; containing both criterion and predictor variables. The criterion variable refers to body dissatisfaction, whereas predictor variables include maladaptive perfectionism, self-efficacy and social comparison.

2.3 Materials

The Frost Multidimensional Perfectionism Scale (Frost et al. 1990)

The Frost Multidimensional Perfectionism Scale (FMPS) is a 35 item questionnaire that was utilised to measure levels of perfectionism amongst respondents. This measure uses a series of subscales designed to measure one's concern over mistakes (CM), (9 items e.g. "If I fail partly it is as bad as being a complete failure"), Personal Standards (PS), (7 items e.g. "I have extremely high goals"), Parental Expectations (PE), (5 items e.g. "My parents set very high standards for me") Parental Criticism (PC), (4 items e.g. "My parents never try to understand my mistakes") Doubts About Actions (D) (4 items e.g. "I usually have doubts about the simple everyday things I do") and Organisation (O) (6 items e.g. "Organisation is very important to me") (Frost et al. 1990). Responses are scored on a 5 point Likert scale ranging from (1) "strongly disagree" to (5) "strongly agree". Higher scores on concern over mistakes, parental expectations, parental criticism and doubts over actions are positively correlated with maladaptive perfectionism. Conversely, high scores within the personal standards and organisation subscales correlate with adaptive perfectionism (Frost et al. 1990). Internal consistency for the subscales is ($\alpha = .73$ to $.93$) and ($\alpha = .90$) for the overall scale (Frost et al. 1993).

Generalised Self-efficacy Scale (Schwarzer & Jerusalem, 1995).

The Generalised Self-efficacy Scale is a 10 item psychometric scale used to measure an individual's perceived self-efficacy. This scale was utilised to measure

respondent's ability to cope with daily hassles as well as one's adaption after experiencing various kinds of stressful life events (Schwarzer & Jerusalem, 1995). Responses are scored on a four point Likert scale ranging from (1) "not at all true" to (4) "exactly true". Responses to all ten items are summed to yield a final score ranging from 10 to 40. Cronbach's alphas ranged from .76 to .90 (Schwarzer & Jerusalem, 1995).

The Body Shape Questionnaire 16B subscale (Evans & Dolan, 1993).

The BSQ-16 is a 16 item subscale of the body shape questionnaire. This self-report measure was designed to measure the body shape preoccupations typical of bulimia nervosa and anorexia nervosa (Evans & Dolan, 1993). This measure assesses negative feelings about one's body size and shape by evaluating the fear of putting on weight, feelings of low self-esteem because of one's appearance, the desire to lose weight, and body dissatisfaction (Evans & Dolan, 1993). The BSQ-16 utilises a 6-point Likert scale with responses ranging from (1) "never" to (6) "always" with possible scores ranging from 16 to 96. A score greater than 20 reflects body image concerns (Evans & Dolan, 1993).

Social Comparison Scale (Allan & Gilbert, 1995).

The social comparison scale is designed to measure self-perceptions of social rank and relative social standing. Participants are required to make a global comparison of themselves in relation to others and rate themselves along a ten point scale (Allen & Gilbert, 1995). The 11 items relate to rank, attractiveness and how well

the person thinks they fit in within society. Low scores relate to feelings of inferiority and low rank perceptions of oneself. Cronbach's alphas were found to be .88 and .96 within clinical populations and .90 and .91 with student populations (Allen & Gilbert, 1995).

2.4 Procedure

Ethical approval was granted by the ethics board of the Psychology Department within Dublin Business School. Participants were required to be female and above eighteen years of age to be involved in the study. Participants were assured of the complete confidentiality of their answers. Consenting individuals were required to complete the Frost Multidimensional Perfectionism Scale consisting of 35 items, The Generalised Self-Efficacy Scale consisting of 10 items, the Social Comparison Scale consisting of 11 items, and the Eating Disorders Inventory- 16B subscale containing 16 items. Questionnaires required 15 to 20 minutes to complete and no participants withdrew from the study. Following the completion of the questionnaires participants were directed to the debriefing sheet; this sheet informed participants of the true nature of the study and also explained the necessity of debriefing for researchers in certain cases. Contact information was provided for helplines such as Aware and Bodywise in the eventuality that completion of the survey caused any distress for participants. Copies of the questionnaire and the debriefing sheet are included in the appendices.

2.5 Data Analysis

The data analysis was conducted using IBM SPSS Statistics Version 21. Descriptive and inferential statistics were conducted and the results are reported below. Pearson's correlations were utilised to examine that relationship between the predictor variables; maladaptive perfectionism, self-efficacy, social comparison and the criterion variable; body dissatisfaction. A multiple linear regression was conducted to examine the influence of maladaptive perfectionism, self-efficacy, social comparison as predictors of body dissatisfaction. Finally, independent samples t tests were conducted to examine the differences between participants who scored high and low on The Body Shape Questionnaire. Similarly, independent samples t tests were used to examine differences between high and low levels of each of the independent variables and the corresponding levels of the dependent variable.

Chapter 3: Results

3.1 Descriptive Statistics

The sample consisted of 219 female participants (n=219). Before running any tests to check for significant relationships, a number of descriptive statistics were calculated to discover any trends in the scoring of the variables. A report of the means (*M*) and standard deviations (*SD*) of the predictor and criterion variables are conveyed in the table below.

Table 1: *Means and Standard Deviations for Predictor and Criterion variables*

Variable	N	Mean	Standard Deviation
Maladaptive Perfectionism	219	57.62	14.45
Self-efficacy	219	30.39	4.34
Social Comparison	219	58.39	15.72
Disordered Eating	219	52.40	19.13

The mean score for maladaptive perfectionism as measured by the maladaptive subscales within the Frost Multidimensional Perfectionism Scale, is 57.62 (SD = 14.45). The possible scores for the Maladaptive Perfectionism subscale range from 22 to 110 (Frost et al. 1990).

The mean score for self-efficacy in the current study is 30.39 ($SD = 4.34$) with the possible scores for the Generalised Self-Efficacy Scale ranging from 10 to 40 (Schwarzer & Jerusalem, 1995). Therefore, participant's mean scores indicate a high level of self-efficacy. The mean score for social comparison is 58.39 ($SD = 15.72$), conveying a moderate level of social comparison. With regard to body dissatisfaction which was measured on a 6 point Likert scale ranging from 1 to 6, the sample had a mean of 52.40 ($SD = 19.13$). According to Evans & Dolan (1993) and Taylor's (1987) research using the BSQ within a UK sample a mean score of 52 or above suggests a moderate concern with shape. Participants in the present study therefore convey a moderate level of body dissatisfaction as identified by the Body Shape Questionnaire 16B.

Body dissatisfaction was examined using the Body Shape Questionnaire 16B. Using this scale, participant's possible answers ranged from 16 to 96. For analysis purposes, participants were divided into three groups based on their total scores; those with a total score ranging from 16 to 35 were placed in the "low" category, those respondents scoring between 36 and 55 were placed in the "moderate" category and finally, those who scored between 56 and 96 were placed into the "high" category. According to the Body Shape Questionnaire 16B, scores below 36 indicate no concern with shape, scores between 36 and 66 indicate a mild to moderate concern with body shape, and however a score above 66 indicates a marked concern with body shape. The respondent's total scores on The Body Shape Questionnaire are represented in the pie chart below.

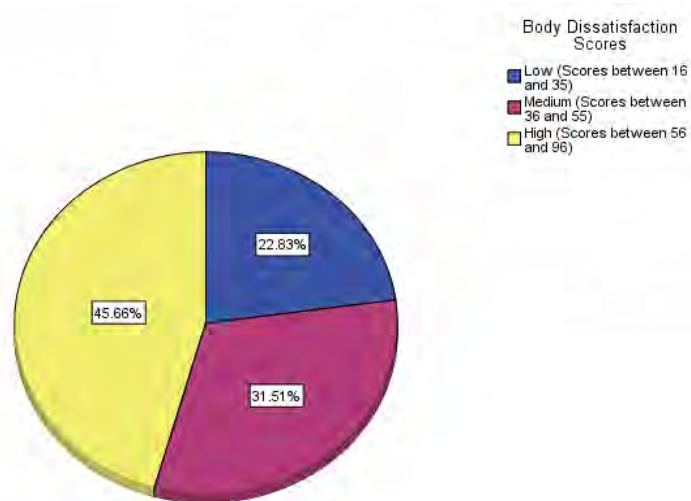


Figure 1: *Pie Chart conveying Respondents scores on Body Dissatisfaction*

The above pie chart conveys that 45.6% of female respondents showed high levels of body dissatisfaction compared to only 22.8% of females in the present study displaying no marked body dissatisfaction. Almost half of all participants displayed very high levels of body dissatisfaction compared to less than a quarter of respondents with low to no existing body dissatisfaction.

3.2 Inferential Statistics

Hypothesis 1: It is hypothesised that there will be a significant relationship between maladaptive perfectionism, self-efficacy and social comparison.

Tests for normality indicated that all the variables met the assumptions. A Pearson's Correlation Coefficient was conducted in order to investigate whether a relationship existed between maladaptive perfectionism, self-efficacy and social

comparison in terms of disordered eating. The mean scores for social comparison was 58.38 ($SD = 15.71$), and for disordered eating was 52.40 ($SD = 19.13$). A Pearson correlation found that there was a moderate negative significant relationship between social comparison and disordered eating ($r(217) = -.46, p < .01$). Similarly, a Pearson correlation coefficient found that there was a moderate positive significant relationship between maladaptive perfectionism ($M = 57.62, SD = 14.45$) and disordered eating ($r(217) = .41, p < .01$). A Pearson correlation coefficient was also conducted to test the relationship between self-efficacy and disordered eating. Results found a weak negative significant relationship between self-efficacy ($M = 30.39, SD = 4.34$) and disordered eating ($r(217) = -.26, p < .01$). Therefore, the null hypotheses are rejected for these variables. Table 2 below illustrates the significant relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction.

Table 2: *Pearson's Correlations illustrating the significant relationship between Maladaptive perfectionism, Self-Efficacy, Social Comparison and Body Dissatisfaction*

Scale		Body Dissat	Self- Efficacy	Social Comparison	Maladaptive Perfectionism
Body Dissatisfaction	Pearson	1	-.265**	-.460**	.407**
	Correlation				
	Sig. (2-tailed)	.	.000	.000	.000
	N	219	219	219	219
Self-Efficacy	Pearson	-.265**	1	.412**	-.229**

	Correlation				
	Sig. (2-tailed)	.000	.	.000	.000
	N	219	219	219	219
Social Comparison	Pearson	-.460**	.412**	1	-.269**
	Correlation				
	Sig. (2-tailed)	.000	.000	.	.000
	N	219	219	219	219
Maladaptive Perfectionism	Pearson	.407**	-.229**	-.269**	1
	Correlation				
	Sig. (2-tailed)	.000	.000	.000	.
	N	219	219	219	219

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

H.2: It is hypothesised that maladaptive perfectionism, self-efficacy and social comparison will significantly predict body dissatisfaction in females

Preliminary analysis found no violations to normality, homoscedasticity, linearity and multicollinearity existed, hence a regression analysis could be conducted.

A multiple linear regression was performed with body dissatisfaction as the dependent variable and maladaptive perfectionism, self-efficacy and social comparison as the predictor variables. The regression was found to be a good fit ($R^2 =$

30%) and the overall relationship was significant ($F(3, 215) = 30.757, p < .005$). Significant predictors are listed in table 3. Social comparison and maladaptive perfectionism displayed significant positive and negative associations respectively with body dissatisfaction. However, multiple regression found that self-efficacy displayed no significant associations. The regression coefficient for maladaptive perfectionism was .397 (95% CI = .241 - .553), and for social comparison was -.438 (95% CI = -.591 - -.284). The standardised regression coefficients show that, of the significant predictors of disordered eating, social comparison is a slightly better predictor of disordered eating (beta = -.359) compared to maladaptive perfectionism (beta = .300). However, the multiple linear regression found that self-efficacy did not significantly predict body dissatisfaction.

Table 3: *Showing Significant Predictors of Body Dissatisfaction*

Predictor	Beta	T	P
Social Comparison	-.359	-5.630	< 0.01
Maladaptive Perfectionism	.300	5.015	< 0.01

H.3: *It is hypothesised that those who score higher in Maladaptive Perfectionism will have higher levels of Body Dissatisfaction.*

An independent samples t test was conducted to examine whether individuals with high maladaptive perfectionism would have higher body dissatisfaction compared to those low in maladaptive perfectionism. Females with

high body dissatisfaction ($M = 62.53$, $SD = 15.48$) were found to have higher levels of maladaptive perfectionism than those females with low body dissatisfaction ($M = 51.92$, $SD = 12.23$). The 95% confidence limits show that the population mean difference of the variables lies somewhere between -15.206 and -6.104; ($t(120.62) = -4.57$, $p = .000$). Therefore the null hypothesis can be rejected.

H4. It is hypothesised that those who score lower in social comparison will have higher levels of body dissatisfaction

An independent samples t test was conducted to investigate whether individuals with lower scores on the social comparison questionnaire would have higher levels of body dissatisfaction compared to those individuals who scored high on the social comparison questionnaire. Females high in body dissatisfaction ($M = 52.32$, $SD = 14.20$) were found to have significantly lower levels of social comparison compared to those with low body dissatisfaction ($M = 66.46$, $SD = 13.07$). The 95% confidence limits show that the population mean difference of the variables lies somewhere between 9.519 and 18.761; ($t(105.74) = 6.067$, $p = .000$). As females score lower in terms of comparing oneself unfavourably with others; levels of body dissatisfaction increase. Therefore, the null hypothesis can be rejected.

H5. It is hypothesised that females with low levels of self-efficacy will have higher body dissatisfaction.

An independent samples t test was utilised to examine the differences between levels of self-efficacy among females with both high and low levels of body

dissatisfaction. Females with low levels of body dissatisfaction ($M = 32.16$, $SD = 3.81$) were found to have higher self-efficacy than those females with high levels of body dissatisfaction ($M = 29.56$, $SD = 4.38$). The 95% confidence limits convey that the population mean difference of the variables lies somewhere between 1.245 and 3.954; ($t(113.82) = 3.802$, $p = .000$). Therefore, the null hypothesis can be rejected.

3.3 Additional Findings:

Independent t-test comparing Body Dissatisfaction levels

Respondent answers on the Eating Disorders Inventory 16B questionnaire were divided into three categories; low, moderate and high. The “low” category contained total scores ranging from 16 to 35, the “moderate” category contained total scores ranging from 36 to 55, and the “high” category contained total scores ranging from 56 to 96. The “high” category ($M = 70.14$, $SD = 10.21$) were found to have much higher levels of disordered eating than the “low category” ($M = 27.74$, $SD = 4.64$). The 95% confidence limits show that the population mean difference of the variables lies somewhere between -44.799 and -40.000; ($t(148) = -34.920$, $p = .000$).

Chapter 4: Discussion

4.1 Aims of the Study

The main aims of this study include establishing whether maladaptive perfectionism, self-efficacy and social comparison predict body dissatisfaction in females. It is necessary to investigate whether a significant relationship exists between the three independent variables; maladaptive perfectionism, self-efficacy and social comparison, and the dependent variable; body dissatisfaction.

Results showed the existence of a significant relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction. Results found that maladaptive perfectionism and social comparison were significant predictors of body dissatisfaction. However, self-efficacy was not found to be a significant predictor of body dissatisfaction. This study also found very high levels of body dissatisfaction among the 219 female participants in the study.

4.2 Analysis by Hypothesis

H1: That there will be a significant relationship between maladaptive perfectionism, self-efficacy, social comparison and body image dissatisfaction.

In previous research, the link between maladaptive perfectionism and body image dissatisfaction has been supported (Egan et al. 2007). Similarly, previous studies have supported a link between social comparison and body image

dissatisfaction (Tiggemann & Slater, 2003). Research has also supported the link between self-efficacy and body dissatisfaction, especially in relation to bulimic symptoms (Bardone-Cone et al., 2006). Results showed a significant relationship between all four variables and as a result, the null hypothesis was rejected.

The results of the current study are supported by previous researchers such as, Bardone-Cone et al. (2006); Poveromo (2007), and Valutis et al. (2008). According to Koch (2006) maladaptive perfectionist traits such as, excessive self-criticism has been found to significantly correlate with body dissatisfaction and subsequent disordered eating behaviours. Valutis et al (2008) found that an individual's self-efficacy regarding their own weight is positively associated with weight-related preoccupations. According to van den Berg (2002) social comparison was found to be the leading predictor of body dissatisfaction amongst females.

Cain et al. (2008) argued that the combination of high maladaptive perfectionism and low self-efficacy has been proposed as a vulnerability stress model for bulimic and binge eating symptoms. Studies have repeatedly shown links between maladaptive perfectionism and disordered eating symptoms; Hewitt et al. (1995) found that women who are perfectionists tend to view the achievement and personification of society's ideal body as essential to their sense of self-worth. Females high in maladaptive perfectionist traits are more likely to experience body dissatisfaction and negative affect as a result of any discrepancy between their actual body shape and ideal body shape.

Social comparison has also been identified as a strong predictor of body dissatisfaction amongst females; researchers have reported that body dissatisfaction often involves the belief that one's physical appearance does not meet some personally and socially relevant standard (Strauman et al. 1991). Pokrajac-Bulian et al. (2008) found that females with an internalisation of societal appearance standards coupled with a tendency to engage in social comparison were more susceptible to dieting behaviour, a desire to lose weight and fear of weight gain.

Similarly, when a woman is faced with a weight discrepancy, self-efficacy has been found to determine one's response to this discrepancy (Bardone-Cone et al. 2006). Females low in self-efficacy experience less confidence in their own abilities and as a result, may be more likely to engage in disordered eating behaviours when faced with discrepancies between their own body shape and the body size of their comparison other (Bardone-Cone et al. 2006).

H2: It is hypothesised that maladaptive perfectionism, self-efficacy and social comparison will significantly predict body dissatisfaction

The results from the current study found maladaptive perfectionism and social comparison to be predictors of body image dissatisfaction. However, self-efficacy was not found to significantly predict body image dissatisfaction within the sample population (n=219). Consequently, the null hypothesis was partially rejected.

According to Koch's (2006) study maladaptive perfectionism was found to predict disordered eating. Similarly, Ashby, Kotteman and Schoen (2009) found

higher levels of maladaptive perfectionism among females suffering from anorexia nervosa compared with controls. Pokrajac-Bulian et al. (2008) found females with a high internalisation of societal standards who compare themselves to ‘superior’ others, are more likely to engage in dieting behaviours and have lower feelings of self-worth. Self-efficacy was not found to predict body dissatisfaction in the current research. However, previous research has identified low self efficacy as being correlated with disordered eating behaviours such as bulimia (Etringer et al. 1989). It is possible that self efficacy is associated with body dissatisfaction but does not predict it.

The present study found social comparison to be a slightly stronger predictor of body dissatisfaction than maladaptive perfectionism. There is a negative significant relationship between social comparison and body dissatisfaction; as an individual engages in negative social comparison, thus scoring lower on the social comparison scale; her levels of body dissatisfaction increase. The present study found a positive significant relationship between maladaptive perfectionism; as a female’s level of maladaptive perfectionism increases, so too does her body dissatisfaction.

H3: It is hypothesised that those who score higher in maladaptive perfectionism will have higher levels of body dissatisfaction

Results of the current study found that participants who had higher levels of maladaptive perfectionism had higher levels of body dissatisfaction. These results are supported by previous literature within the area of disordered eating in females (Cain et al. 2008).

According to Egan et al. (2011) maladaptive perfectionism increases and maintains disordered eating behaviours. Individuals suffering from eating disorders such as, anorexia nervosa and bulimia nervosa were found to have significantly higher levels of maladaptive perfectionism compared to controls (Egan et al. 2011).

According to Marsero et al. (2011) the characteristics of maladaptive perfectionism; including scrutinising one's flaws, ignoring successes and a compulsive focus on rigid goals, conveys the ease at which maladaptive perfectionism traits can manifest into pathological behaviours. The current study supports previous findings of maladaptive perfectionism as correlated with body dissatisfaction and disordered eating amongst females (Ashby, Kotteman & Schoen, 2009; Vohs et al. 2001; Minarik & Ahrens, 1996). Higher levels of maladaptive perfectionism were associated with high levels of body dissatisfaction.

H4: It is hypothesised that those who score lower in the social comparison scale will have higher levels of body dissatisfaction

This study found that lower levels of social comparison were significantly associated with body dissatisfaction. Low scores on the social comparison scale indicate upward social comparison; comparing oneself unfavourably to superior others thus resulting in lower body dissatisfaction (Allan & Gilbert, 1995).

The findings of the present study are supported by previous research within the area of disordered eating and body dissatisfaction. According to Warren (2006) repeated social comparison is likely to result in increased body image disturbance and

dissatisfaction which is a main risk factor for the development of disordered eating behaviours. Several studies have found support for social comparison as a mediator between sociocultural pressures to be thin and body dissatisfaction in female samples (van den Berg et al. 2002; Keery et al. 2004). Muir et al. (1999) found that unfavourable comparisons with others or one's own self-ideal was cited as the most frequent trigger for diets. Similarly, van den Berg et al. (2002) found social comparison to be the most dominant predictor of body dissatisfaction and eating disturbances. The findings of this study support the association between social comparison and body dissatisfaction.

H5: It is hypothesised that females with low levels of self-efficacy will have high levels of body dissatisfaction

Results found that within the current sample (n=219) females with higher levels of body dissatisfaction had lower feelings of self-efficacy compared to those females with low body dissatisfaction who had high levels of self-efficacy.

This finding is supported by Toray and Cooley's (1997) research which found lower levels of self-efficacy among females whose weight fluctuated compared to those whose weight remained stable. According to Cain et al. (2008) the stress of feeling overweight compared to society's idealised standard of thinness coupled with low self-efficacy may lead to disordered eating behaviours such as, binge eating or bulimia. Females with low self-efficacy may feel they are unable to reach certain goals, such as a lower weight; as a result may be more likely to experience body dissatisfaction and disordered eating behaviours (Cain et al. 2008). According to

Valutis et al. (2008) an individual's self-efficacy determines one's reaction to discrepancies between actual body size and ideal body size; those low in self-efficacy were found to utilise disengaged coping strategies such as disordered eating. Research has found individuals low in self-efficacy to be less motivated than those high in self efficacy, low self efficacy has also been associated with depression and anxiety (Sassoon, 2005).

Additional Findings:

Initially, respondents were separated into "high" "medium" and "low" groups based on their total score in the Body Shape Questionnaire. Those who scored under 35 were placed into the "low" body dissatisfaction group, scores between 36 and 55 were included in the "moderate" category while those respondents scoring between 56 and 96 were placed into the "high" body dissatisfaction category. Interestingly, the study found a large proportion of respondents fell into the "high" body dissatisfaction category. The total participation in the questionnaire was (n = 219) with 69 respondents scoring between 36 and 55 and falling into the "medium" category, 100 participants scored above 56 in the Body Shape Questionnaire thus entering the "high" category. These results convey the high levels of body dissatisfaction among the female participants within the present study. Such high levels of body dissatisfaction among females in a non-clinical sample convey the growing problem among females in the 21st century. A substantial body of research supports the negative distress caused by body dissatisfaction as well as its association with the development of unhealthy dieting and disordered eating behaviours (van den Berg, 2007). The results of the present study convey the necessity of identifying

casual factors in the development of body dissatisfaction in the attempt to construct means of alleviating the problem. The examination of maladaptive perfectionism, self-efficacy and social comparison as predictor variables in the development of body dissatisfaction has provided further insight into the area on which future research can build.

4.3 Strengths and Weaknesses

There were both strengths and weaknesses associated with the current study. To the researcher's knowledge no previous study has investigated the influence of maladaptive perfectionism, self-efficacy and social comparison as predictors of body image dissatisfaction. The present study found two of the three variables examined to be significant predictors of body dissatisfaction. As a result, the findings from this study fill a gap in the literature while also providing further insight into the timely issue of female body dissatisfaction.

A further strength refers to all questionnaires used in this study were reliable and all measures have been used previously as successful measures to examine the area of body image dissatisfaction.

However, a number of limitations within the study must be acknowledged. Firstly, the researcher focused on females only as the sole participants of the study. This decision was based on the prevalence of body image dissatisfaction and disordered eating among females predominantly. The body of literature regarding male and female body dissatisfaction was too large to be accurately reviewed within

the word count stipulation. As a result, the researcher decided to focus on females only. The result of this decision meant that comparisons could not be made between males and females regarding the influence of maladaptive perfectionism, self-efficacy and social comparison on body dissatisfaction. A comparison between males and females in terms of body dissatisfaction may have yielded different results in terms of the variables being investigated.

A second limitation to the study is the use of self-reported questionnaires as tools to measure variables. The results of the study were based on the assumption that participants responded honestly and accurately while completing the questionnaires. However, the areas of body dissatisfaction and disordered eating behaviours are quite difficult and emotional issues and as a result, it is possible that participants responded in a more socially acceptable manner. This may have resulted in bias affecting participant responses.

A third limitation of the present study relates to sample size. The sample was not entirely representative; numbering 219 female participants. A larger sample would have allowed for a more generalised representation. A larger sample size may also have affected the results; which possibly may have resulted in higher levels of significance.

Finally, participants were not required to identify their age or location when completing the survey. As a result, possible age related correlations were not noted. Similarly, failure to examine participant location resulted in an inability to compare

responses across cultures and societies. Future research should include demographic information.

4.4 Future Research

Overall this study has contributed significantly to the existing research in the area of body image dissatisfaction and disordered eating. The present study has extended existing research by examining the influence of maladaptive perfectionism, self-efficacy and social comparison as predictors of body dissatisfaction. Although these variables have been separately investigated in previous studies; few studies have examined all three variables as interacting moderators predicting body dissatisfaction.

However, future research could gain more insight into the causes of body image dissatisfaction by eliminating self-efficacy as a predictor variable. Although self-efficacy was found to have a significant relationship with body dissatisfaction, multiple regression conveyed that self-efficacy did not predict body image dissatisfaction in the current study. Future research could investigate the predictive influence of weight related self-efficacy rather than generalised self-efficacy.

Further research should also examine body dissatisfaction across a range of ages. A wide age range could be used to compare patterns of body dissatisfaction across age groups. Future research studies should also examine respondent locations in order to investigate possible cultural and societal correlations or differences. Similarly, further studies could examine the effects of maladaptive perfectionism,

self-efficacy and social comparison as predictors for body dissatisfaction among males.

4.4 Conclusion

This study explored the influences of maladaptive perfectionism, self-efficacy and social comparison as predictors for body dissatisfaction in females. The main findings of this study include a significant relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction. Similarly, the present study found that maladaptive perfectionism and social comparison can be viewed as significant predictors of body dissatisfaction in females. Self-efficacy was not found to significantly predict body dissatisfaction within the current sample.

In conclusion, the current research supports the findings of previous studies in demonstrating a relationship between maladaptive perfectionism, self-efficacy, social comparison and body dissatisfaction. Furthermore, this study has identified maladaptive perfectionism and social comparison as predictor variables in the development of body dissatisfaction among females.

Although the present study has identified predictors and relationships in the development of body dissatisfaction in females, the only way to gather a more comprehensive and reliable insight and understanding into the area of body dissatisfaction and disordered eating is through continued and extensive research within this area. The identification of maladaptive perfectionism and social

comparison as influential predictors of the development of body dissatisfaction provides a basis on which future studies can build.

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Appendices

Appendix A: Cover Letter

My name is Jessica O' Sullivan and I am conducting research in the Department of Psychology in Dublin Business School, that investigates eating patterns in females. This research has been granted ethical approval from Dublin Business School and is being conducted as part of my studies within the Psychology Higher Diploma and will be submitted for examination.

You are invited to take part in this study and participation involves completing and returning the attached anonymous survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included on the final page.

IT IS REQUIRED THAT FEMALES ONLY PARTICIPATE IN THIS SURVEY

Participation is completely voluntary and so you are not obliged to take part.

Participation is anonymous and confidential. Thus responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been collected.

The questionnaires will be securely stored and data from the questionnaires will be transferred from the paper record to electronic format and stored on a password protected computer.

It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

Should you require any further information about the research, please contact myself, Jessica O' Sullivan at , or my thesis supervisor Dr. Katriona O' Sullivan at

Thank you for taking the time to complete this survey.

Please read the sentences below and select an answer for each statement which indicates how much the statement applies to yourself.

1= Not at all True	2= Hardly True	3=Moderately True	4= Exactly True
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1. I can always manage to solve difficult problems if I try hard enough.
2. If someone opposes me, I can find the means to get what I want.
3. It is easy for me to stick to my aims and accomplish my goals.
4. I am confident that I can deal efficiently with unexpected events.
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.
6. I can solve most problems if I invest the necessary effort.
7. I can remain calm when facing difficulties because I can rely on my coping abilities.
8. When I am confronted with a problem, I can usually find several solutions.
9. If I am in trouble, I can usually think of a solution.
10. I can usually handle whatever comes my way.

Please read the following statements and select an answer based on how much each statement applies to yourself.

1=Strongly Disagree	2=Disagree	3=Neutral	4=Agree	5=Strongly Agree
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1. My parents set very high standards for me.
2. Organisation is very important to me.
3. As a child, I was punished for doing things less than perfectly.
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person.
5. My parents never try to understand my mistakes.
6. It is important to me to be thoroughly competent in what I do.
7. I am a neat person.
8. I try to be an organised person.
9. If I fail at school, I am a failure as a person.
10. I should be upset if I make a mistake.
11. My parents want me to be the best at everything.
12. I set higher goals than most people.
13. If someone does a task better at school better than I do, then I feel as if I failed the whole task.

14. If I fail partly, it is as bad as being a complete failure.
15. Only outstanding performance is good enough in my family.
16. I am very good at focusing my efforts on attaining a goal.
17. Even when I do something very carefully, I often feel that it is not quite right.
18. I hate being less than the best at things.
19. I have extremely high goals.
20. My parents expect excellence from me.
21. People will probably think less of me if I make a mistake.
22. I never feel I can meet my parents' expectations.
23. If I do not do as well as other people it means I am an inferior being.
24. Other people seem to accept lower standards from themselves than I do.
25. If I do not do well all the time, people will not respect me.
26. My parents have always had higher expectations for my future than I have.
27. I try to be a neat person.
28. I usually have doubts about the simple everyday things that I do.
29. Neatness is very important to me.
30. I expect higher performance in my daily tasks than most people.
31. I am an organised person.
32. I tend to get behind in my work because I repeat things over and over.
33. It takes me a long time to get something "right".
34. The fewer mistakes I make, the more people will like me.

35. I never feel that I can meet my parents' standards.

Please circle a number at a point which best describes the way in which you see yourself in comparison to others.

In relationship to others I feel:

Inferior	1	2	3	4	5	6	7	8	9	10	Superior
Incompetent	1	2	3	4	5	6	7	8	9	10	More competent
Unlikeable	1	2	3	4	5	6	7	8	9	10	More likeable
Left out	1	2	3	4	5	6	7	8	9	10	Accepted
Different	1	2	3	4	5	6	7	8	9	10	Same
Untalented	1	2	3	4	5	6	7	8	9	10	More talented
Weaker	1	2	3	4	5	6	7	8	9	10	Stronger
Unconfident	1	2	3	4	5	6	7	8	9	10	More confident
Undesirable	1	2	3	4	5	6	7	8	9	10	More desirable
Unattractive	1	2	3	4	5	6	7	8	9	10	More attractive
An outsider	1	2	3	4	5	6	7	8	9	10	An insider

We should like to know how you have been feeling about your appearance over the last four weeks. Please read each question and circle the appropriate response. Please answer all the questions.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often	6=Always
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OVER THE PAST FOUR WEEKS:

1. Have you been so worried about your shape that you have been feeling you ought to diet?
2. Have you been afraid that you might become fat (or fatter)?
3. Has feeling full (e.g. after eating a large meal) made you feel fat?
4. Have you noticed the shape of other women and felt that your own shape compared unfavourably?
5. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching television, reading, listening to conversations)?
6. Has being naked, such as when taking a bath, made you feel fat?
7. Have you imagined cutting off fleshy areas of your body?

8. Have you not gone out to social occasions (e.g. parties) because you have felt bad about your shape?
9. Have you felt excessively large and rounded?
10. Have you thought that you are in the shape you are because you lack self-control?
11. Have you worried about other people seeing rolls of fat around your waist or stomach?
12. When in company have you worried about taking up too much room (e.g. sitting on a sofa, or a bus seat)?
13. Has seeing your reflection (e.g. in a mirror or shop window) made you feel bad about your shape?
14. Have you pinched areas of your body to see how much fat there is?
15. Have you avoided situations where people could see your body (e.g. communal changing rooms or swimming baths)?
16. Have you been particularly self-conscious about your shape when in the company of other people?

Appendix F: Debriefing Letter

Perfectionism, self-efficacy and social comparison: Predictors of disordered eating in females?

PURPOSE

This purpose of this study is to investigate the influence of maladaptive perfectionism, self-efficacy and social comparison as predictors of disordered eating in females. No title was listed within this study; sometimes when investigating human behaviour, it is necessary to withhold the true nature of the research in order to ensure natural and unbiased responses from all participants.

BACKGROUND

Previous research has identified perfectionism, self-efficacy and social comparison as moderating variables in the development of disordered eating patterns in females. Many studies have found support for these variables, however, few studies have researched the influence of these variables together, further conveying the importance of this study.

CONFIDENTIALITY

Please be ensured that any data collected in this study is strictly confidential and anonymous and that all data will be published as group data.

If participating in this study has caused you any distress and you wish to speak to a counselor please be advised of the following helplines;

Bodywhys:

<http://www.bodywhys.ie/>

1890 200 444

Aware:

<http://www.aware.ie/>

1890 303 302.

If you are interested in obtaining a copy of the final report of this study, or

If you have any questions regarding this study, its purpose or procedures, please feel free to contact the primary investigator Jessica O' Sullivan at 1738752@mydbs.ie or the thesis supervisor Dr. Katriona O' Sullivan at katriona.osullivan@dbs.ie. Thank you!

FOR FURTHER READING

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