Body Image

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Body Dysmorphic Disorder  A clinical preoccupation with a trivial or imagined defect in one's appearance.

Body Image  Self-perception of appearance that includes both perceptual experience and subjective evaluation.

Body Image Distortion  The extent to which individuals inaccurately perceive their body size.

Body Image Satisfaction  The extent to which individuals positively evaluate the shape or size of their bodies.

Restraint Eating  Individuals who frequently or chronically diet and who vacillate between restricting caloric intake and engaging in bouts of disinhibited eating.

Stigma  A mark or feature that brands individuals as being undesirably different or abnormal in some way and makes them susceptible to prejudice and discrimination.

BODY IMAGE is a multifaceted construct composed of the perceptions, thoughts, and feelings that individuals hold about their physical being. This article presents a review of the factors that influence the development and maintenance of body image. It also summarizes the disorders associated with body image deficits.

I. MEASUREMENT ISSUES

Body image refers to perceptions, thoughts, and feelings about one's physical appearance. It involves a self-perception that consists of both perceptual experience and subjective evaluation, based in part on the reactions of others. Despite its long history, the construct of body image is poorly understood, probably because of its multifaceted and complex nature.

The measurement of body image typically focuses on either perceptual estimation or on affective reactions to self-evaluation. Perceptual assessment techniques examine the accuracy of judgments about physical size. For instance, participants might be asked to estimate the width of their waist, hips, and thighs by adjusting the width of light beams onto a dark surface to match their judgment of the relative width of those body parts. Body image is then measured by comparing perceptual estimates with actual body widths, and the resulting difference indicates whether individuals under- or overestimate their bodies.

Whole-body procedures typically present participants with a visual representation (through photographs, silhouette selection, video image, or mirror image) that has been distorted by the researcher to be larger or smaller than the participant's actual image. Participants then modify or adjust the distorted image so that it matches their estimation of their correct physical size. Again, the difference between perceived
and actual body size is used as an indicator of body image. The usefulness of perceptual estimates for assessing body image has yet to be reliably demonstrated. Body image distortions are common and occur with equal frequency across many diverse subject populations, including those with eating disorders, those who are obese, and those who are of average weight. These distortions are also unrelated to body image satisfaction; they do not indicate any pathological condition, and they have little diagnostic utility for identifying disordered eating. Moreover, the various body size assessment techniques tend not to be highly correlated with each other, and there are serious concerns about whether any of them have adequate reliability or validity.

There are a number of conceptual reasons to believe that the accuracy of size estimation is a poor indicator of self-perception of physical appearance. Disparities between estimated and actual body size may be influenced by experience, motivation, subjective evaluation, and context. For example, most people have limited experience with estimating the size of their bodies. Examining video or still pictures of one's body is of little use for estimating size; after all, such images are usually quite a bit smaller than actual size. Similarly, the reflection of physical image depends on the optical properties of the reflective surface, and it is possible that estimations of physical size are based on mirrors that distort the physical image. The physical context in which one experiences or evaluates physical size may also bias body size estimation. One basic psychological principle is known as perceptual contrast—sticking one's hand in a bucket of cold water after having it in a bucket of warm water will make the water feel especially cold. In an analogous way, judgment of one's own physical size will be influenced by the physical characteristics of others in proximity. For example, a person may feel particularly heavy after he or she has been around thinner people, or particularly thin after being around heavier people. It is not clear, therefore, that people should be expected to have a particularly accurate appraisal of their physical size. In short, the use of perceptual estimation techniques cannot be recommended at this time.

The second major method of assessing body image is through subjective evaluation, as measured by affective, cognitive, or behavioral reactions to one's physical appearance. These various measures indicate the extent to which individuals are satisfied or dissatisfied with their bodies. For instance, one widely used technique has subjects view a number of silhouettes that depict a range of body figures from underweight to overweight. Individuals choose the silhouette that best represents their current body size, as well as the silhouette that best represents their ideal body size, and the discrepancy between these two indicates level of body image satisfaction. Note that although this requires some degree of perceptual estimation, it is the subjective discrepancy between current and ideal that is relevant to body image; whether people's estimates of their current size are accurate is usually not of interest to those who use this method. Other common techniques for assessing body image evaluation include self-ratings of physical attractiveness; ratings of specific body part satisfaction (i.e., hips, thighs, nose, and chest); self-ratings of weight, size, or shape satisfaction; and affective reactions (such as anxiety or depression) to thoughts about the body. A wide assortment of rating scales exist that are suitable for evaluating body image.

Although the majority of people are relatively satisfied with their bodies, evaluative measures of body image indicate that many individuals, both men and women, from young to old, are dissatisfied with their bodies. Current North American society has been described as being obsessed and preoccupied with the body, and national surveys indicate that at least one third of men and more than one third of women are dissatisfied with certain aspects of their bodies. Moreover, nearly half of all men and the vast majority of women report wanting to lose at least a modest amount of body weight. Perhaps surprisingly, body image dissatisfaction is also relatively common among the elderly and among very young children, some of whom starve themselves to the point of stunted physical growth in order to avoid being fat.

The measurement of body image satisfaction is not without conceptual, definitional, and psychometric problems. For instance, some measures of body image dissatisfaction may reflect general negative affect (such as low self-esteem or depression) rather than specific unhappiness with one's body, and it is unclear whether negative affect is the cause, consequence, or mere correlate of body image dissatisfaction. The precise manner by which physical appearance affects global self-
Esteem has not yet been determined. Some conceptual models of self-esteem treat physical appearance (including the body) as one facet of self-concept that contributes to global self-esteem, whereas other theories treat body image as only tangentially related to global self-esteem, which is based more on self-efficacy and positive regard from significant others.

In addition, the vast assortment of different methods for assessing body image satisfaction has led to some conceptual ambiguity. A desire to lose weight, for example, might indicate body image dissatisfaction or it could indicate a desire to lead a healthier lifestyle. Although more than three quarters of women report wanting to lose at least 10 pounds, the majority of women are generally more positive about their bodies than they are negative. A great deal of evidence indicates that most people (both men and women) are ambivalent about their bodies rather than totally dissatisfied or satisfied. That is, people typically are happy with some of their physical features but are quite unhappy with other features. Although it is generally true that disliking multiple physical features is linked with increased overall body dissatisfaction, the structural properties of the body image construct (i.e., how the various parts contribute to the whole) have yet to be precisely determined.

In summary, there is little consensus about the best methods for measuring body image. Although it is clear that evaluative measures are more useful than perceptual measures, the particular evaluative measure chosen should be based both on the specific goals of the evaluation or research and on the psychometric properties (i.e., reliability and validity) of the specific instrument.

II. PHYSICAL AND PHYSIOLOGICAL INFLUENCES

Almost every physical characteristic plays some role in determining body image (e.g., genetic hair loss, facial acne, pregnancy, wrinkles, pubertal changes). Four characteristics in particular, however, are central to the development and maintenance of body image.

The first of these factors is body weight. Individuals who are objectively or subjectively overweight tend to hold a negative body image. Such dissatisfaction is especially likely to occur among those who were (or are) overweight as adolescents. Note, however, that there are only slight negative correlations between body weight per se and global self-esteem or psychological well-being. That is, body weight is only modestly related to satisfaction with other aspects of the self-concept (such as academic achievement or social skills). However, believing oneself to be overweight, whether one is or not, is closely related to body image dissatisfaction. Thus, body image mediates the relation between body weight and self-esteem. [See SELF-ESTEEM.]

A second factor that influences body image is gender. Across the life span, women tend to have lower body image satisfaction than men. Women are more likely than men to evaluate specific body features negatively, to attempt weight loss, to report anxiety about the evaluation of their physical appearance, and to have cosmetic surgery. Body image dissatisfaction among women is almost invariably related to self-perceptions of overweight, whereas dissatisfaction among men is equally divided between worries about being overweight and worries about being underweight. Being physically large may have benefits for men because of the association between size and power. Men who are physically large are viewed as more powerful than men who are physically slight, and a significant number of men engage in compensatory behaviors to increase physical size or musculature. Thus, very thin men are much more likely than very thin women to experience body image dissatisfaction.

The link between mass and power in men also illustrates the importance that a third physical factor, body height, has on determining body image, particularly for men. Whereas most women are satisfied with their height, many men have a desire to be taller and tend to overreport their height. This is not surprising, given the well-documented link between men's height and positive social outcomes such as leadership, power, income, and perceptions of attractiveness. Many short men report dissatisfaction with their stature and some evidence suggests that they are more likely to experience decreased self-esteem and more negative body image relative to their taller male counterparts. For women, the importance of height is less clear, although a relatively tall stature appears to be a desirable trait for most women. Height may be an important component of a positive body image only to the extent that it allows women to appear thinner and
leggier. However, women who are particularly tall sometimes report decreased body image satisfaction, in part because their height makes it difficult to satisfy the societal injunction that the male be taller than his female partner.

A fourth factor that contributes to one's body image is physical attractiveness. Physical attractiveness refers to specific facial and body features that are valued by members of a society. The specific attributes that are prized differ depending on gender. For women, facial features that indicate youthfulness (e.g., large eyes, small nose, big lips) and body features that are petite and thin (e.g., long legs, flat stomach) tend to be desirable. For men, facial features that imply maturity (e.g., square jaw, visible cheekbones) and body features that indicate mass and largeness (e.g., height, mesomorph build) tend to be desirable. Some evidence indicates that average rather than unusual features are viewed as most attractive. For instance, some research on this topic uses computer programs to average facial features from many different faces. The composite averages are typically viewed as being more attractive than the individual faces. Of course, it is important to note that it is personal beliefs about attractiveness that influence body image. Most studies have found only a modest association between objectively rated physical attractiveness (i.e., ratings made by independent observers) and body image. However, subjective ratings of physical attractiveness (i.e., personal beliefs) are closely linked to body image satisfaction.

The four components of body image are determined primarily by physiological and genetic factors. Height, gender, and physical appearance are typically immutable, except through surgical modification. Genetic influences also play a prominent role in body weight, although public perception is that body weight is much more mutable than other physical characteristics. Most people grossly underestimate the physiological influences on body weight and perceive it to be a matter of individual control and willpower. Believing that body weight, especially one's own body weight, is controllable contributes to body dissatisfaction.

III. CULTURAL INFLUENCES

Throughout history, cultural influences have played significant roles in determining body image. For instance, the Greeks revered the male body, the Romans prized thinness, and people from the Middle Ages showed a preference for larger, rounder female body types, as later epitomized in Rubenesque art. Modern American society places an emphasis on individuality and self-definition, whereas individuals in previous eras tended to rely less on themselves and more on the structure of society to define aspects of their selves. Thus, the meaning and definition of body image change over time as a function of cultural and societal influences.

Although a limited number of physical attributes deemed to be attractive have remained stable over time and across cultures (e.g., fleshiness rather than flabbiness, cleanliness, and symmetry in one's body), most evaluative aspects of physical appearance are culturally bound—what is beautiful in one culture is not necessarily beautiful in another. For instance, styles of clothing, hair, and makeup vary greatly. Individuals will also go to great lengths in an attempt to conform to cultural standards of physical attractiveness. Extreme examples of this include the Burmese tradition of women affixing brass rings around their necks to stretch their necks to lengths of up to 15 inches; women in Victorian England wearing corsets so tight that the corsets distorted internal organs and damaged the ribcage; the East Indies tradition of filing teeth down to the gums; the South American (Abipone) tradition of inflicting deep wounds on the face, breasts, and arms; the Chinese tradition of binding women's feet to the point of crippling and deforming them; and the recent proliferation of Americans piercing and tattooing various body parts.

Within a single culture, mandates for what is beautiful and desirable also undergo substantial variation across time, particularly for women. For instance, during the 1820s, some women drank vinegar to lose weight and stayed up all night to look pale and fragile; in the mid-nineteenth century, a big, voluptuous figure was in vogue and women often worried about appearing too thin; in the early twentieth century, a more slender but very sturdy physique was desirable. After World War I, flat chests became desirable as did a new trend of applying makeup to one's face. Although the preference for body size has fluctuated over the last century, Americans have been obsessed with thinness for at least the last 30 years. Indeed, the 1990s saw a return to prizing the thin, pale, and fragile appearance of the 1820s (i.e., the waif, Kate Moss or Gwyneth Paltrow).
Even within the same time frame, there can be substantial heterogeneity in what is perceived as ideal. For instance, throughout the 1940s and 1950s, a voluptuous ideal (i.e., Marilyn Monroe) shared center stage with a thin ideal (i.e., Audrey Hepburn). In the 1980s, a muscular, healthy physique (i.e., Jane Fonda) gained prominence at the same time that a softer, more feminine physique (i.e., Dolly Parton) was also thought to be attractive.

Although beauty is conceived of in many heterogeneous ways, there is a clear message to women in our society that beautiful physical appearance is a must for happiness and success. There are consistent media messages targeted at women that portray the notion that "what is beautiful and thin is good." Severely underweight women are overrepresented in glamour magazines, on television programs, and in the movies. The typical woman presented in the glamour industry is 5 feet 11 inches tall and weighs approximately 110 pounds, which is 7 inches taller and 30 pounds lighter than the average woman in our country. This portrayal of an ideal that is 20% below the average creates and reinforces the stigma of the large body size.

A. Obesity

Possessing a stigma, a strongly undesirable physical or dispositional characteristic, typically has negative repercussions on many aspects of one's life. It has adverse effects on factors such as interactions with nonstigmatized individuals and on many aspects of the self-concept, including body image. The stigma of obesity is particularly detrimental because it involves the perception of a deformation in the body as well as characterological weakness. Thus, obesity evokes immediate negative responses from observers not only because of its displeasing aesthetic qualities but also because obese individuals are held personally responsible for their condition. For instance, people are 40 times more likely to hold obese individuals responsible for their condition than they are to hold blind individuals responsible. Obese individuals who offer some medical reason for their weight problem (e.g., a thyroid condition) or provide evidence that they are on a diet to lose weight are less likely to be stigmatized. However, obese individuals who do not offer such information are typically derogated and held in contempt for their apparent lack of control and insufficient willpower.

Not all members of North American society equally stigmatize the obese. Black individuals appear to stigmatize obesity much less than do White individuals. For instance, Black men are more likely than White men to find bigger and heavier women attractive and desirable. Black women are much less likely to consider themselves obese and are much more satisfied with their weight than are White women, despite the fact that Black women are twice as likely to be obese. Black women also rate large Black body shapes much more positively than do White women rating large White body shapes. The lack of obesity stigma among Black women may, in part, reflect the impressive number of role models who are large Black women (e.g., Oprah Winfrey, Aretha Franklin, Toni Morrison, Jocelyn Elders, and Maya Angelou). In summary, a variety of evidence demonstrates that being overweight is much more stigmatizing for White women than for Black women.

Recent research indicates that the stigma of obesity varies greatly across cultures. For example, Fijians, Kenyans, Samoans, Mexicans, and Israelis stigmatize obesity less than do Americans, Canadians, and the British. These differences may partially reflect cultural ideology, especially in terms of the value placed on self-reliance and self-determination. For instance, American college students tend to believe that obesity is self-determined and therefore are more likely than Mexican college students to believe that the poor treatment of the obese is deserved. Similarly, children in Israel hold relatively positive views of the obese, possibly because they are raised in a society that tends not to view the obese as personally responsible for their large body size.

The stigma of obesity has a number of negative consequences for those who are overweight. In particular, those who are perceived to be obese are subject to public rejection and ridicule. Obese children and adults are less liked than their slimmer peers and are often excluded from clubs, friendships, dates, and marriages. Perhaps surprisingly, research shows that formerly obese individuals continue to be stigmatized for having been obese even after they obtain a normal body weight. This can be taken as further evidence that the stigma of obesity is as much about character as it is about physical appearance.

Obesity takes its toll not only on psychological well-being, but also on socioeconomic status, possibly through overt discrimination. For instance, colleges
admit proportionately fewer obese individuals, and especially obese women, than average-weight individuals, despite similar interests in attending college and similar high school ranks, IQ scores, and PSAT and SAT test scores. This discrimination is especially likely to occur among prestigious colleges that interview applicants. Indeed, although at least 20% of young American adults are obese, the percentage of obese students in the Ivy League is less than 2%. An additional limiting factor that interferes with obese women attaining higher education is that their parents are significantly less likely to assist them financially in their education than are parents of nonobese daughters (even after controlling for the parents’ socioeconomic status).

There is considerable evidence for widespread discrimination against those who are obese. Many employers are reluctant to hire obese individuals and some occupations openly discriminate against overweight workers, despite a lack of evidence documenting any relation between body weight and occupational ability. Although some occupations require high levels of physical fitness among its workers (e.g., firefighters, police officers), exclusions are sometimes made on the basis of appearance rather than on the basis of tests of physical ability or fitness (e.g., flight attendants, retail sales clerks). It is unclear why a flight attendant who weighs 175 pounds is any less capable than one who weighs 115 pounds.

Obese women tend to achieve a lower socioeconomic status than average-weight and underweight women. Unlike their slimmer peers, heavy women are less likely to achieve a higher status than that held by their parents. The weights of female (but not male) adolescents have been found to influence future earnings such that women who were obese at 11 and 16 years of age earned significantly less at age 23 (regardless of whether they maintained their obesity) when compared with women who were not obese at 11 and 16. Multiple explanations exist for why there is a strong negative correlation between women’s body weight and socioeconomic status (SES), but serious consideration must be given to the possibility that the stigma of obesity is responsible for this pattern. It is interesting to note that although low SES is associated with obesity in developed countries, high SES is associated with obesity in developing countries.

In summary, body image is influenced by current cultural fads, fashions, and preferences, all of which are subject to change. Those who possess physical characteristics that are valued within a culture will likely have a positive body image, whereas those who possess culturally devalued characteristics are often stigmatized and will most likely experience poor body image. [See Obesity.]

B. Disability and Body Image

Physical disability or disfigurement may have a profound impact on body image, depending on the type and severity of the disabling condition. For instance, permanent damage to major portions of the body (i.e., paraplegia, quadriplegia, major limb amputation) are more predictive of body image dissatisfaction than are less severe physical disabilities.

The degree to which physical disability influences body image is also determined by factors such as onset timing, visibility of the condition, and the cause of the disability. First, disabilities that originate early in life (e.g., congenital blindness) have less impact than do disabilities that arise after childhood. When disabilities occur after childhood, individuals have to deal not only with their physical disability, but they must also cope with the loss of their former nonstigmatized identity. Second, if the disability can be hidden (e.g., a prosthetic device), body image is less likely to be disrupted than if the disability cannot be hidden (e.g., wheelchair). Third, believing that the disability was caused by factors under personal control may preclude full acceptance of the disability, especially if the person dwells on their former nonstigmatized self and continually engages in counterfactual thinking (e.g., “if I hadn’t been injured, I would be happier”).

Physically disabled individuals’ body images are also threatened by the reactions that they receive from nonstigmatized others. Specifically, attitudinal research reveals that individuals often hold negative attitudes toward physical disability and disfigurement. These attitudes may be displayed overtly or covertly. Research examining social exchanges between physically disabled and nondisabled individuals reveals that nondisabled individuals exhibit a number of nervous and avoidant behaviors (e.g., they are more physiologically aroused, terminate the interaction sooner, stand at greater speaking distances, and show more behavioral inhibition) when interacting with a physically disabled person than a nondisabled person. Such verbal and nonverbal gestures likely have a negative influence on body image.

The self-perception that one is being stigmatized
may have a negative impact on body image even if the supposed stigmatizer is unaware of the target’s stigmatizing condition. In a series of clever studies, a fake scar was applied to a subject’s face and the subject then interacted with another person. Unbeknownst to the subject, the experimenter had actually removed the scar before the social interaction. In this situation, those who believed that they had a scar (even though they did not) believed that they were the targets of stigmatization. This self-fulfilling prophecy shows that the self-perception of being the target of discrimination is an important component of body image.

**IV. DEVELOPMENT OF BODY IMAGE**

Physical appearance is an omnipresent feature of self that has important implications for body image throughout the life span. As early as infancy, attractive babies are responded to with more positive attention (e.g., increased smiling, eye contact, greater expectations for intelligence) than are unattractive babies. In addition, mothers of attractive babies are more affectionate and play with their babies more than mothers of unattractive babies. This differential treatment of attractive and unattractive individuals continues into preschool and school-age years. Adults rate attractive children as possessing more positive personality traits, having greater academic ability, being more intelligent, and being more likely to be successful than unattractive children, and such ratings are made solely on the basis of appearance. These differential evaluative reactions may have a strong and detrimental impact on the self-esteem and body image of unattractive or overweight children.

Adolescence is a critical period during which maturational changes in body size and shape influence body image. During puberty, most girls gain approximately 25 pounds. This weight gain is not evenly distributed across the body, but rather the added weight predominantly settles in the breast, hip, and thigh regions. This pattern of weight gain is particularly displeasing to many adolescent girls because it conflicts with the cultural ideal of a thin, tall, and fat-free female figure. Adolescence is also a time of increased self-reflection and self-attention, such that many girls become obsessed with body image issues.

Heightened concern with body weight is probably responsible for the initiation of chronic dieting and its commonly related disordered eating. By the ninth grade, nearly all female adolescents report having at some point dieted in an attempt to lose weight. The societal emphasis on female thinness may explain why women are more concerned with eating, weight, and appearance across the life span than men, and why they feel stigmatized in ways that men do not as a result of being slightly (as little as 5 to 10 pounds) over their ideal body weight.

White girls who come from upper or upper-middle class families are the most likely to worry about their weight, show the greatest decreases in self-esteem during adolescence, and are at the greatest risk for developing eating disorders. One possible explanation is that cultural expectations for these girls are more rigid and demanding than for girls of other ethnic and socioeconomic backgrounds, which may lead to feelings of perfectionism and inadequacy. These girls are expected to be thin, beautiful, and smart, and to marry well.

In addition to cultural pressures, body image is also influenced by parents and peers. Family dysfunction and parental conflict relate to a variety of psychological problems, including body image dissatisfaction and disordered eating. Research has demonstrated that eating disorders and poor body image may be especially likely among girls whose parents are perfectionistic, critical, or overcontrolling, and who make comments about their daughter’s weight or physical appearance. Similarly, the children of parents who themselves are preoccupied with body weight issues and dieting, or who have symptoms of disordered eating are at a greater risk for developing body image dissatisfaction.

Negative comments from peers, particularly in the form of teasing, are important predictors of body image dissatisfaction. Unattractive and obese individuals are liked less, are excluded from clubs and social events, and are viewed by their peers as possessing more negative traits (e.g., lazy, sloppy) than their slimmer and more attractive peers. This social exclusion may promote a self-fulfilling prophecy, in that ostracized individuals have fewer opportunities to acquire social skills (because of their limited social opportunities) and, in turn, their diminished social skills reinforce people’s avoidance of them.

Body image dissatisfaction tends to remain fairly stable during adulthood. As individuals mature into adulthood and begin to focus on family and career issues, some individuals may even show increased body image satisfaction. This is especially likely to occur
when individuals enter long-term committed relationships with supportive and nurturing partners. Individuals who gain large amounts of weight during adulthood may experience some body image dissatisfaction as a result of their increased corpulence. Excessive weight gain in adulthood is common in the United States and carries a number of potentially serious health consequences. Preventive health care workers and physicians emphasize body image issues in order to promote weight loss among those whose health is at risk. Thus, body image dissatisfaction may motivate efforts to have a healthful life style. Conversely, body image dissatisfaction may, and often does, lead to dangerous dieting practices and unhealthful weight cycling.

Finally, changes in appearance and physical stamina that accompany old age may have a negative influence on body image. The adage that men view body as a tool and women view body as decoration may explain why many elderly individuals experience some degree of body image dissatisfaction. Older men may feel a decline in their body satisfaction because of their declining physical abilities. Women, however, may be more concerned about excess weight as well as their wrinkling skin and hair loss. Both men and women may also be concerned about being too thin, as being frail may serve as a constant reminder of the inevitability of death. Although there are insufficient data to examine such issues, it seems plausible that individuals who have the greatest degree of body image dissatisfaction during early adulthood will continue to have the greatest body image dissatisfaction during old age, even if the precise factors influencing body image change.

V. BODY IMAGE DISORDERS

Severe body image problems motivate a number of potentially unhealthy behaviors, including chronic dieting, disordered eating, compulsive exercise, or excessive use of cosmetic surgery. Beginning in early adolescence, and continuing thereafter into adulthood, individuals compare their body shape and weight with a perceived cultural ideal. Those who perceive minimal discrepancy between cultural ideals and personal standing are likely to show body image satisfaction. A discrepancy between self-evaluation of current shape and ideal body shape often motivates people to undertake dieting in order to achieve a more attractive body size. Unfortunately, dieting is rarely successful, with fewer than 1% of individuals who lose weight being able to maintain weight loss over 5 years. One of the primary causes of diet failure is occasional bouts of overeating. Such overeating is often precipitated by emotional distress. That is, those who chronically diet (restrained eaters) become disinhibited by emotional distress, eating much more when they are upset than when they are happy and calm. Difficulties coping with emotional upset may be one of the primary reasons that most diets are doomed to fail. [See DIETING.]

When dieters fail to achieve weight loss, they commonly blame their failure on a lack of willpower, vowing to try harder on the next diet. Continued dietary failures may have harmful and permanent physiological and psychological implications. Physiologically, weight loss and weight gain cycles ("yo-yo-ing") alter metabolism and may make future weight loss more difficult. Psychologically, repeated failures are likely to diminish body image satisfaction and may damage self-esteem. Over time, repeated dietary failures may induce a particularly negative view of self that includes feelings of helplessness, hopelessness, and anxiety. In essence, a downward spiral occurs in which dietary failure increases the perceived need for additional dieting but reduces the likelihood of future success. That is, negative affect interferes with successful dietary self-regulation, and yet each failure also increases negative affect. Over time, many dieters eventually engage in more extreme behaviors to lose weight, such as fasting, excessive exercise, or purging. For individuals who are vulnerable, chronic dieting may promote the development of a clinical eating disorder.

The two most common eating disorders are anorexia nervosa and bulimia nervosa. Individuals with anorexia nervosa typically have an excessive fear of becoming fat and as a result, they refuse to eat. Their self-imposed starvation initially draws favorable comments from friends and relatives, although the anorexic is still quite displeased with her body size. As the anorexic approaches her emaciated ideal, family and friends may become quite concerned and medical attention may be required to prevent death from starvation. [See ANOREXIA NERVOSA AND BULIMIA NERVOSA.]
Individuals with bulimia nervosa tend to alternate between fasting and binge eating. Bulimics tend to be average weight, or even slightly overweight women who regularly binge eat, feel that their eating is out of control, have excessive worries about body weight issues, and most often engage in one or more compensatory behaviors, such as self-induced vomiting, vigorous exercise, or the use of laxatives. Unlike anorexia nervosa, many cases of bulimia go undetected by family or friends. Bulimic individuals typically are quite secretive when it comes to eating, particularly with respect to binging and purging.

It is commonly believed that individuals with anorexia or bulimia have unusually distorted body images. However, the evidence collected using perceptual techniques indicate that although some individuals with eating disorders overestimate their body size, they apparently do not do so to a greater extent than normal-weight control subjects. That is, body size estimation appears to be as inaccurate among those with eating disorders as it is in the general population. However, those with eating disorders do consistently report greater body image dissatisfaction than those without eating disorders. They report low physical appearance self-esteem, report wanting to lose weight, they describe discrepancies between current size and ideal size, and in general are quite unhappy with their self-perceived physical appearance. Thus, body image disturbance for those with eating disorders refers to dissatisfaction rather than distorted perception.

Body image dissatisfaction may promote an unhealthy obsession with attempts to change physical appearance through cosmetic surgery. Cosmetic surgery is performed not only to change a specific feature of physical appearance, but also to enhance psychological well-being and improve body image. Approximately 700,000 cosmetic surgeries are performed yearly by plastic surgeons, with more than three quarters performed on women. The most common types of surgeries involve liposuction, breast augmentation, eyelid surgery, nose surgery, and facelifts.

There exist a wide array of motivations for seeking cosmetic surgery, from correcting some genuine cosmetic deformity (e.g., cleft palate) to an unwarranted preoccupation with and desire to change some physical feature that is judged as deficient only by the possessor or that is viewed as falling short of some aesthetic ideal (e.g., an imperfect nose or modestly sized breasts). The cosmetic surgeon is in a unique position to observe and facilitate body image change. Such changes typically involve perceptual, affective, and cognitive components. Many individuals who undergo cosmetic surgery report being temporarily disturbed by the change in physical appearance (e.g., sleeplessness, reduced body sensation), although the majority of these individuals adjust well to the change with the passage of time.

Although many individuals who undergo cosmetic surgery are satisfied with the outcome, a significant number report moderate to extreme dissatisfaction. Often surgical patients feel satisfied with their altered features but become dissatisfied and preoccupied with other perceived physical deficiencies. They may subsequently have frequent surgeries to correct or improve multiple physical features. Some of these individuals have a clinical preoccupation with trivial or imagined defects in their appearance. Such a preoccupation is called body dysmorphic disorder, which is a pathological disturbance in body image in which individuals feel extreme distress about minor flaws in some part of the body, such as the size or shape of the ears, eyebrows, mouth, hands, feet, fingers, or buttocks. Individuals with this disorder describe their preoccupations as tormenting, extremely painful, and devastating, and thoughts about their "defect" dominate their lives. In some cases, disturbed thoughts are so intrusive that individuals avoid work and public places, going out only at night when they cannot be seen. Those who have body dysmorphic disorder often undergo cosmetic surgery, but unfortunately for some, the surgery fails to alleviate body image dissatisfaction. Indeed, in some cases it increases their concerns as a doctor's willingness to provide surgery validates their views of abnormality, which may give rise to intensified or new preoccupations.

For the majority of those undergoing cosmetic surgery (i.e., correcting an obvious disfigurement or perceived aberration), physical changes enhance body image. However, surgery will likely be insufficient for improving body image among those with clinical preoccupations of self-perceived physical inadequacies.

VI. IMPROVING BODY IMAGE

Anecdotal and clinical evidence suggest that the key to reducing body image dissatisfaction is through in-
creasing self-acceptance. Although this goal is itself difficult to attain, progress toward self-acceptance can be accomplished in a number of ways. For instance, those who believe they are overweight should be encouraged to exercise and to eat a nutritionally balanced diet rather than go on a strict calorie reducing diet. The goal is therefore one of health rather than one of improved physical appearance. Individuals need to learn to accept and perhaps even value their physical appearance with techniques such as positive self-statements and careful self-examination in front of mirrors, as well as questioning the basis for their desire to lose weight (i.e., the reasons that they want to lose weight or why they believe they are overweight). Sometimes people benefit from education about the determinants of physical characteristics, such as genetic influences on body weight and anatomical discussions of bone structure. Moreover, it is often useful for people to be told that a certain degree of body image dissatisfaction is common, even among those who are objectively highly attractive (and who possess all of the physical attributes that most people desire).

Because body image dissatisfaction arises in part out of fear of social evaluation, increasing social skills and assertiveness may be especially useful for alleviating body image dissatisfaction. Stigmatized individuals may have limited opportunities to develop and refine social interaction skills, and therefore interventions that focus on increasing conversational skills, controlling nonverbal behaviors, and increasing assertiveness might increase positive social interactions, which in turn might diminish some aspects of body image dissatisfaction.

Particularly intense body image dissatisfaction might require some form of counseling or therapy. Treatment is indicated when body image dissatisfaction interferes with normal activities, becomes an obsession that involves unwanted or disturbing thoughts, or when it prevents people from coming into social contact with others. A therapeutic environment might assist individuals in coping with family conflict, social anxiety, or disordered cognitions. Group sessions in which individuals are allowed to decry the social importance placed on the superficial and simplistic criteria of body weight and shape, and to meet others in similar situations, work toward increasing self-satisfaction and providing a social support context for positive body image change. Cognitive–behavioral approaches to improving body image have shown some success in diminishing body image dissatisfaction. Programs that emphasize coping strategies and social skills may be the most beneficial for moderate body image dissatisfaction. Appropriately treating individuals for depression, whether through psychotherapy or medication, may also be an effective strategy for increasing body image satisfaction.

**BIBLIOGRAPHY**


