

LOOKING RISKY:

BODY IMAGE AND RISK TAKING BEHAVIOURS

"I think women see me on the cover of magazines and think I never have a pimple or bags under my eyes. You have to realise that's after two hours of hair and make-up, plus (photo) retouching. Even I don't wake up looking like Cindy Crawford."

Cindy Crawford cited in K Cooke, *Real Gorgeous: The truth about body and beauty*, Allen & Unwin: Sydney, 1996.

INTRODUCTION

This paper examines body image and risk taking behaviours across the lifecycle of women. The discussion looks at body image as a broad concept and examines the comprehensive range of effects of unhealthy body image on women's physical and mental health. Unhealthy body image can be associated with unhealthy behaviours. Risk taking behaviours such as smoking, drug and alcohol abuse, disordered eating and suicide and self harm are examined to see whether there are commonalities between women with unhealthy body image and women who engage in risk taking behaviours.

The paper looks at factors that influence body image through the lifecycle. These factors include women's age and life events, which intersect with social, cultural and economic environments. The paper looks at recent studies and statistics on levels of body dissatisfaction and the prevalence of risk taking behaviours to identify policy implications and intervention points aimed at improving levels of body image satisfaction and reduce engagement in risk taking behaviours.

Concept of Sense of Wellbeing

The concept of sense of wellbeing used in this paper draws on a framework developed by the State/Territory Working Group on Body Image that reports to the Women's Adviser's Meeting (WAM). The concept is based on an understanding of women's health and wellbeing as the many social, mental and physical factors that impact on women's health status. In line with this concept, unhealthy body image is seen as symptomatic of a broader problem within an individual's mental, physical or social framework. Other symptoms could include depression, anxiety, poor self esteem, disability and poor physical health and alienation. Risk taking behaviours among girls and women can be seen as a symptom of their social, mental and physical environment. For the purposes of this paper, risk taking behaviours include smoking; drug and alcohol abuse; disordered eating; and suicide and self harm.

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I. BODY IMAGE

Definition of Body Image

Common understandings of body image focus on size and shape, rather than on the cognitive, perceptual and affective aspects of body experience. Women's Health Queensland has developed a definition of body image that recognises how body image issues reflects more than a concern about size and shape:

Body image refers to the picture that a person forms of their body in their mind. A person's body image is influenced by their own beliefs and attitudes as well as ideals in society. One's body image does not remain the same but changes in response to lifestyle events (puberty, pregnancy, disability, illness, surgery, menopause and even different stages in the menstrual cycle)¹.

Unhealthy body image is then understood as a negative picture of one's body, often characterised by low self esteem and unhealthy behaviours. This paper will attempt to broaden understandings of body image from a focus on shape and size to include psychological, functional, physical, and sexual aspects of wellbeing throughout the lifecycle. This can best be achieved through promotion of diversity and acceptance, celebration of difference and healthy lifestyles. In doing so, it is highlighted that the factors that influence body image may intersect or combine in different ways for individual women.

The theory of self-objectification is helpful in understanding the processes involved in women's emotional and behavioural responses and their desire to meet cultural ideals, including the importance of physical appearance². 'Self-objectification' is defined as a form of self-consciousness characterised by habitual and constant monitoring of the body's outward appearance. This can lead to certain negative emotional and experiential consequences, for example shame and anxiety about one's body, and a decrease in awareness of internal bodily states at the expense of an obsession with the external body. The accumulation of these experiences is linked to the development of psychological disorders such as depression and eating disorders³.

For some women, their bodies and how they feel about them, can become the context within which they discuss their feelings of being good or bad. Discussing food, diets and their perceived sexual attractiveness can shift women's focus away from multifaceted life issues, such as depression, relationship problems and stress⁴.

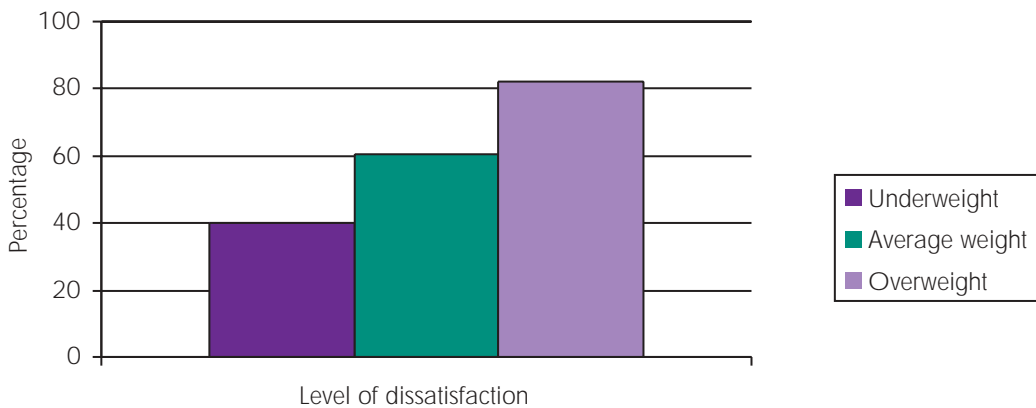
Levels of Body Image Dissatisfaction

Unhealthy body image can be measured by levels of body image dissatisfaction or prevalence of eating disorders. In this context, the term "eating disorders" refers to the psychiatric disorders of anorexia nervosa and bulimia nervosa, while disordered eating is used as a broader term, encompassing unhealthy dieting and overeating.

There is considerable disparity between the prevalence of eating disorders and the prevalence of body dissatisfaction amongst Australian women. The prevalence of eating disorders is substantially lower than the prevalence of body dissatisfaction. This may reflect the nature of eating disorders where many people can live with the disorder for a long time without treatment or a clinical diagnosis. In 1997 it was estimated that eating disorders affect around 2.2 percent of women⁵. The burden of disease of eating disorders was 11,176 DALYs⁶ in 1996. This is comparable to the burden of epilepsy (11,5196 DALYs), kidney cancer (11,412 DALYs) and rheumatoid arthritis (11,989 DALYs).

The prevalence of body dissatisfaction has been found to be much higher than the prevalence of eating disorders by the Australian Longitudinal Study on Women's Health. This study found that between 40 percent and 82 percent of women in the young women cohort (18-23 years in 1996) were dissatisfied with their weight and/or shape⁷. The study's findings of the relationship between body size and body dissatisfaction is shown in the following figure:

Relationship between body size and body dissatisfaction



Source: Fiona Campbell, "Predicting body dissatisfaction amongst women" in *Women's Health Australia Annual Report 2001*, Newcastle, 2001, p. 20

The figure shows that dissatisfaction with weight and shape increases with weight, however, a concerning figure is that 40 percent of women classified as underweight (BMI^B less than 20) were dissatisfied. The study also found that women who considered themselves overweight, women who wanted to weigh less and women who had used dieting methods in the past month were most likely to be dissatisfied. A further supposition taken from the results was a greater likelihood of dissatisfaction associated with poorer mental health scores, rural rather than urban location, and being an ex-smoker rather than a non-smoker⁹.

Studies comparing body dissatisfaction between women and men have found inconsistent results, with some studies reporting no difference in body image between adult men and women¹⁰, and others suggesting that men have much healthier body image than women across all ages from 40-79 years¹¹. However, one gender difference that has been found is the overwhelming majority of dissatisfied women wanting to lose weight, compared to dissatisfied men who were evenly divided between those who wish to lose and those who wish to gain weight¹².

Studies have consistently found that healthy individuals rated their appearance more positively than less healthy individuals, regardless of their age or gender¹³. In addition, low to moderate levels of exercise have been associated with a range of health benefits for women of all ages,¹⁴ including mental wellbeing¹⁵. These results suggest that engaging in physical activity may be a key factor assisting a positive sense of wellbeing across the lifecycle of Australian women.

While considering this conclusion, it is important to note that excessive physical activity can also be a symptom of unhealthy slimming behaviour in some women. Any strategy to increase levels of physical activity needs to ensure that promotion of physical activity takes into account different age groups and health levels.

These research studies suggest a need to balance the high levels of women wanting to lose weight with promotion of healthy eating behaviours and acceptance of diverse body shapes and sizes. Government responses to the high levels of body image dissatisfaction among women need to consider the increasing number of women and men who are overweight or obese. These conditions can carry serious health issues, and losing weight may actually be in the best health interests for some women.

A further issue of interest is the difference between the perceptions among women and men of weight issues. The 2001 ABS *National Health Survey* results suggest that women are better at judging whether their weight fits the healthy weight range, compared to men¹⁶. The survey found that 38 percent of women assessed themselves as being overweight, which was similar to the proportion of women who were classified as overweight. However, 30 percent of men assessed themselves to be overweight, compared to 58 percent who were classified as either overweight or obese¹⁷.

These results highlight that there are significant differences between weight levels and weight perceptions among women and men. The next section looks at factors influencing these differences and body image dissatisfaction.

II. FACTORS THAT INFLUENCE BODY IMAGE

Research has found that factors affecting women's body image include a form of cultural disempowerment of women and the pressure to attain an unrealistic beauty ideal that is thought to be culturally imposed¹⁸. Paxton notes that:

there are many ways in which women view and evaluate themselves but their attitudes towards their own bodies are some of the most intense, salient and often fraught. In Western societies, many women define themselves, not through their personal qualities, relationships or achievements, but in their assessment of, and emotional response to their appearance ie. their body image¹⁹.

The way that women perceive their bodies changes over the lifecycle. Particular events that affect body image include adolescence, pregnancy, menopause and ageing. Lifestyle factors, such as health, nutrition and physical activity also contribute to a person's body image, in addition to cultural factors such as indigenous status, ethnicity, sexual orientation, history of sexual violence, disability and illness.

Additional variables, such as socio-economic status, general health status and education levels can cut across these factors influencing body image. There is conflicting evidence regarding the role of socio-economic status in the development of individual women's body image. While research suggests that women who are socio-economically disadvantaged are more likely to be affected by obesity than women from higher socio-economic groups²⁰, most studies show that socio-economic status is not related to eating disorders, body dissatisfaction, dieting to lose weight or disordered eating among females²¹.

Community involvement, social and economic equity and support from family and friends have a positive effect on general health and wellbeing²² and may affect women's body image.

Other research suggests that amongst urban, suburban and rural teenagers, there are no differences regarding body image or dieting²³.

The Lifecycle

Girls

Research suggests that the same determinants that predict body dissatisfaction in adolescents and adults exist in young girls²⁴. Body image attitudes develop during childhood and dissatisfaction tends to increase during adolescence and young adulthood, especially in women²⁵. Societal values and views around the association of thinness with attractiveness are being expressed by children as young as seven years of age²⁶. The process of socialisation, which begins at birth²⁷, means that strong messages about body shape, beauty and sexual attractiveness can reach girls well before they reach puberty²⁸.

There is limited data on the development of body image concerns and body dissatisfaction in children, making it difficult to understand the causes and consequences of body image concerns in children²⁹. However, researchers have found that both boys and girls who have a larger body mass index desire to be thinner, and children who report higher levels of body dissatisfaction and body image concerns also report poorer self-esteem and are generally dissatisfied with other aspects of their lives³⁰. Research has also shown that perceived peer likeability and interactions with peers are predictors of body dissatisfaction amongst children and that perceived and actual encouragement from both parents to control weight are also predictors³¹.

There are inconsistent research findings on the relationship between parental modelling of weight loss related activities and healthy body image in children³². However, it is recognised that parents do play a pivotal role in the development of their children's eating attitudes and behaviours in a number of ways. These include the influence over a child's diet, parental modelling of eating attitudes behaviours, parental encouragement to lose weight and parental criticism of their child's weight³³. This suggests that healthy body image in children requires parental awareness about the influence parents can have over the future eating behaviours and attitudes of their children.

Teenagers and Young Women

Sex differences in body image emerge somewhere between the ages of eight and ten years³⁴. Studies have shown that as boys grow older, the discrepancy between their perceived and ideal body size decreases, whilst for girls the discrepancy

increases. Girls are more likely than boys to compare themselves to others and to rate themselves more negatively in comparison to boys³⁵.

This discrepancy is supported by the statistics cited above from the Australian Longitudinal Study on Women's Health that reported levels of body dissatisfaction between 40 percent and 82 percent of women aged 18-23 years.

As already stated, the Australian Institute of Health and Welfare (AIHW) report on the health of young people aged 12-24 years shows that eating disorders and mental health problems are some of the leading causes of burden of disease in young women³⁶. Of all women, teenagers and young women are most likely to develop disordered eating patterns, although as already stated, estimates of the prevalence of eating disorders (2.2 percent³⁷) are far below the prevalence of body dissatisfaction.

Physical activity and nutrition may be important factors for shaping a positive sense of wellbeing throughout the developmental stages. Research has indicated that women who participate in sports and physical activity have a more positive body image than those women who do not participate in any form of physical activity³⁸. This is believed to be due to the approval elicited from peers and family and friends regarding participation in sport. Physical activity also helps women feel that their bodies are capable and competent³⁹.

Considering the research supporting the similarities of determinants predicting body dissatisfaction in girls, adolescents and adults, early dieting and related behaviours can be viewed as risk factors which in the long term may lead to chronic body image problems, weight cycling, obesity, and eating disorders⁴⁰. Adequate nutrition, because of its long-term health benefits, is important during adolescence.

Most programmes on body image are targeted to teenagers and young women. This is likely to be a reflection of the high prevalence of eating disorders in young women compared to children and women over 30. Programmes generally aim to raise awareness through health information and self-esteem workshops targeted to female high school students and resources for teachers to assist in promoting self-esteem and recognising early signs of eating disorders. Often, programmes take the "weight acceptance" approach, with some programmes aiming to educate women about changing unhealthy eating behaviours and promoting physical activity. The burden of disease

for eating disorders, the statistics on body image dissatisfaction and overweight and obesity levels in Australia suggest a need to balance programmes targeted at weight acceptance with promotion of healthy lifestyle. A focus on healthy behaviours, rather than shapes and sizes may assist in aiming for 'wellness' rather than weight control – healthy at any weight rather than thin at any cost⁴¹.

Women in Mid-Later Life

Following childhood, adolescence and child-bearing years, life events may include menopause, medical problems, chronic illness, other physiological changes, loss of partner, restrictions in social and personal activities, and changes in status and relationships with families and friends⁴². These are all factors that contribute to one's idea of self.

Increasingly in Australian society there is a preoccupation with youth and beauty in which "women diminish in status as they age"⁴³. In addition, older women are not commonly viewed as sexual beings⁴⁴. These factors can result in a loss of, or reduction in, self esteem⁴⁵. To add to this, there is a double standard of ageing that exists for men and women in that older men's worth is not judged by their appearance in the same way as women's worth is. Whereas some older men are respected for their power and authority, older women have traditionally had a more difficult time being valued for these qualities⁴⁶.

The preoccupation with youth and beauty may be a Western cultural factor that is very different from many other cultures which value the wisdom and beauty of their elders (American Indian, some Asian, and Polynesian cultures are some examples)⁴⁷.

Australian studies have found that as women age, their desire to be thinner does not change. Other body satisfaction factors also do not change, including the importance of weight control, overweight preoccupation, global body image, satisfaction with appearance or satisfaction with body parts⁴⁸. However, while women in mid-later life still desire to be thinner, weight may become a less important source of esteem as women grow into adulthood⁴⁹. Some studies have suggested that the importance of physical appearance (as opposed to physical satisfaction) for women diminishes with age⁵⁰. This raises an interesting question of why older women, although placing less focus on appearance, continue to desire to be thinner.

It has been suggested that for women who do not exercise, age is associated with lower body satisfaction, but for those who do exercise, increasing age was associated with greater body satisfaction⁵¹. Women's Health Australia has found a relationship between physical activity and emotional wellbeing amongst older women⁵². Their longitudinal research established that women who had made a transition from some physical activity to none generally showed more negative changes in emotional wellbeing than those who had always been sedentary. Older women who maintained or adopted physical activity had better emotional wellbeing⁵³. The study has also highlighted the importance of social support from partners and friends to maintain physical activity as women age⁵⁴. These findings suggest that physical activity is linked to emotional health factors that can contribute to a negative or unhealthy sense of wellbeing.

Pregnancy

Women who have children face another transitional point in how they view their bodies due to significant and rapid physical changes that occur to women's bodies during pregnancy.

Although the physical changes in pregnancy are in direct contrast to the Western cultural ideal of thinness of women, in their samples Hausler and Connors found that pregnant women felt "less fat" than women with no children⁵⁵. In addition, the Australian Longitudinal Study on Women's Health has found that women are likely to put on weight around the key life events of finding a long-term partner and childbirth⁵⁶.

Research has also suggested that weight and body shape issues become less of a concern for pregnant and early postnatal women, due to the role of motherhood and responsibility of caring for a baby being a more important focus than weight and body image issues⁵⁷. Evidence suggests that pregnant and postnatal women with a positive view of motherhood are fitter, feel stronger and do not feel significantly less attractive than women with no children⁵⁸.

Disability and Illness

Women with a disability who were interviewed by the Boston Women's Health Book Collective said that they were treated as children and were not permitted normalcy, such as exhibiting sexual urges. This treatment has the potential to damage the body image of any woman, without the added difficulty of dealing with a disability⁵⁹.

From another perspective, women who have experienced a serious illness such as breast cancer may also have particular body image issues relating to their situation. A woman with breast cancer:

...is likely to be faced with multiple concerns that can vary widely and change across time. They include coping with fears over her health and future, undergoing unpleasant treatments and coping with physical symptoms⁶⁰.

Some of these concerns affect a woman's body image directly. The Cancer Council highlights that cancer treatment side effects, scars from surgery, having a breast removed and changes in body weight can all affect a person's sense of wellbeing. While some changes are temporary - hair grows back after chemotherapy - others, such as losing a breast, are permanent⁶¹.

It is promising to note that the National Breast Cancer Centre has developed a resource such as the *Psychosocial Clinical Practice Guidelines*⁶² for women with breast cancer recognising the body image issues these women face. This may be a useful basis for further work in the area of body image, disability and illness.

Indigenous Women

Through the Australian Longitudinal Study on Women's Health Kenardy found that Aboriginal and Torres Strait Islander women generally had higher Body Mass Index (BMI) ratings than non-indigenous Australian women⁶³ and that there are higher rates of dieting amongst Aboriginal women and greater body dissatisfaction. In addition, more dieting and higher prevalence of disordered eating were found amongst Torres Strait Islander women⁶⁴. Disordered eating, including obesity, has negative consequences for overall health and wellbeing and may lead to health issues such as heart disease and diabetes.

These results have policy implications, particularly for many of the National Health Priority Areas, one of which is diabetes mellitus. In 2001, the National Health Survey found that Aboriginal and Torres Strait Islanders were over three times more likely as non-indigenous Australians to report some form of diabetes⁶⁵.

Indigenous women in Australia may face very different lifecycle issues than those of non-

indigenous women. Indigenous women have a low life expectancy, which at 63 years is around 20 years less than the respective life expectancies of all women Australia⁶⁶. In addition, they experience lower socio-economic status, higher rates of unemployment, poorer education levels and lower rates of home ownership, all of which can impact upon health and sense of wellbeing⁶⁷.

There appears a need to determine how Aboriginal and Torres Strait Islander women conceptualise their bodies and whether acculturation might impact on this. This is an important area for further research as it has implications for the mental and physical health of indigenous Australians.

Ethnicity

In the Australian context, despite the diversity in how different ethnic groups view beauty in women, the Australian Longitudinal Study on Women's Health has shown that:

Various ethnic groups residing in Australia experience more pressure to conform to the ideal of slimness than their counterparts living in their home countries. Westernisation has spread the message that 'slim is better' to cultures that once idealised adiposity⁶⁸.

Immigrant women's rates of dieting and disordered eating, Body Mass Index (BMI) ratings, and shape and weight dissatisfaction, become closer to Australian-born women the longer they have lived in Australia⁶⁹. This finding lends support to the above hypothesis that migrant women experience a type of acculturation when it comes to body image whereby they internalise the beauty norms of the dominant Western culture.

Body image is shaped differently for women who, in addition to their gender, are marginalised by their ethnicity. The effects of a dominant beauty myth based on a mono-cultural standard has serious mental and physical health implications. The addition of issues such as age, disability and sexuality will further complicate body image issues for these women.

In a 1995 and follow up 1998 study, Becker found a shift in eating habits among Fijian girls following the introduction of television in Fiji in 1995.

In 1995 three percent of girls, aged 17 on average, reported that they had vomited to control weight. In 1998 this figure had risen to 15 percent of the

girls questioned in the sample. Becker concluded that the shift in eating habits was related to "modernity and the arrival of television and Western ideals of beauty"⁷⁰.

American research on a similar issue found that African American and Asian women generally had a more positive body-image than Caucasian women, depending on the degree to which they have accepted the beauty standards of the dominant culture⁷¹. Additionally, a study of Mexican immigrants to the USA, found that the extent to which they were affected by the prevailing super-thin ideal was related to how old they were when they immigrated – those above the age of 17 were less affected than those below⁷². This further supports the acculturation principle of body image.

In the age of abundance and consumerism, personal control over one's life, including diet, is an important social value. This is juxtaposed against the material poverty in developing countries where access to wealth and its symbolism is of great value. The above studies provide evidence for the notion that the overall wealth of a country, region or ethnic group affects ratings of attractiveness.

The preoccupation with weight and shape as major defining characteristics of body image for women appears to be a Western society phenomenon. Uptake of a Western diet may contribute to weight and body image issues. Research into the qualities that make up body image for other ethnicities and how these could positively influence Western ideals could be a valuable exercise.

Sexual Orientation

There is some evidence to suggest that lesbians are more likely to be satisfied with their bodies than heterosexual women⁷³. The challenge remains to explore why this might be the case for women considered a marginalised group, and may provide insights into the characteristics women require to develop a healthy body image. Exploration of similarities and differences between heterosexual and gay men may also provide insights into how sexual orientation influences body image.

Experience of Violence

A large amount of research exists exploring possible links between experiences of sexual violence (whether as a child or an adult) and a negative body image. However, some of this research is contradictory, indicating more work needs to be done in this area.

Numerous psychological disturbances and adverse behaviours are noted after experiencing sexual violence, including depression, anxiety, poor mental health, sleeping disorder, self-injury/self-harm and eating disorders⁷⁴.

Research has found different associations between sexual violence for different age groups, suggesting that the timing of sexual abuse and the age of the woman are important mediating factors in relation to body image⁷⁵. For young women, past sexual abuse has predicted weight dissatisfaction, but not dieting or disordered eating behaviours. However, current experience of sexual violence for young women has been predictive of disordering eating. For middle-aged women, past sexual violence was predictive of disordered eating, but not dieting or weight dissatisfaction.

Discussing the association between body image and experience of sexual violence, Taylor, Manning and North suggest that survivors of sexual violence have altered perceptions of their bodies. These perceptions make survivors more likely to self-harm and/or develop eating disorders in an effort to cleanse and control their bodies⁷⁶.

Other research suggests that women who have experienced a violent relationship with a partner or spouse may also have a high level of body consciousness (but not necessarily an unhealthy body image)⁷⁷. One study found that a quarter of all women who had been in a violent relationship with a partner/spouse also reported having cosmetic surgery. The study found that these women may seek cosmetic surgery in an attempt to appease a critical partner, to boost their own self-esteem, use cosmetic surgery as a form of self control over their appearance, or to remove physical effects (such as scars) of domestic violence⁷⁸.

Research continues to be conducted in this area and may inform further public policy development, both in the areas of body image and sexual and domestic violence.

Media Portrayal of Women

The ubiquitous nature of the mass media makes it a particularly powerful medium sending messages about the “ideal” female body as thin, tall and long-legged⁷⁹. Research into the representation of women in magazines and on television shows a shift towards women who are underweight⁸⁰. Durkin suggests that this shift is evidence of a thinner ideal developed over the last 40 years⁸¹, where women become invisible to themselves by trying to meet unrealistic standards⁸². It is also proposed that the mass media appraise women against unrealistic standards promoted by the advertising and beauty industries and grounded in fantasies about how a woman should look and behave⁸³.

There is on going discussion regarding the influence of the media and the fashion/beauty industries on women, and their body image. It has now been established that the media’s portrayal of the ‘ideal’ female form as skinny is a pathological influence among women who already have some of the setting conditions for an eating disorder⁸⁴. The influence on women’s body satisfaction and sense of wellbeing is less certain with studies producing conflicting results⁸⁵. It has been established that certain groups of women may be more vulnerable to media images than others, and it is unlikely that media images have the same impact for all women. At most risk are women with eating disorders and teenage women (particularly older teenagers and overweight teenagers)⁸⁶.

It is important to recognise the influence of advertising on the media’s portrayal of women. Advertising provides the primary source of revenue for media, and economic concerns play a central role in determining content and presentation⁸⁷.

By selecting models and using image-making strategies such as retouching photos, the advertising industry has elevated images of beauty to go beyond the reality of the natural female body⁸⁸. Images combine with messages presented in magazine articles and advertising which link thinness with sex, love, money and happiness.

In response to sexist and stereotypical exploitation of women in the media, the Victorian Government is developing Gender Portrayal Guidelines for government advertising which will be promoted to the advertising industry with the aim of improving the portrayal of women in advertising.

III. THE ASSOCIATION BETWEEN BODY IMAGE AND RISK TAKING BEHAVIOURS

Considering body image as an indicator of women's sense of wellbeing raises the question whether unhealthy body image can be associated with risk taking behaviours. There appear to be some similarities between women with body dissatisfaction and women who engage in risk taking behaviours. Like body image, risk taking behaviours such as smoking, substance use and suicide and self harm may be viewed as a symptom of a broader problem with women's wellbeing.

Risk taking behaviours such as smoking and disordered eating have been identified as major burden of disease in young women and girls⁸⁹. A paper produced by the NSW Department for Women, *Young women's health: depression and risk taking behaviour*, identifies substance abuse (smoking, alcohol and drug use) and eating disorders as having a significant impact on young women's health⁹⁰.

Information on risk taking behaviours focuses on young women, however smoking rates, alcohol use, and misuse of prescription drugs by mid age and older women suggests that risk taking behaviours exist in different forms across the lifecycle⁹¹. Generally though, these behaviours decrease as women age.

A. Disordered Eating

Obesity and eating disorders continue to be a major social concern, and can be seen as the effect that unhealthy body image has on a woman's health. These disorders have both economic and social implications that will impact on health policy. Disordered eating can impact on the National Health Priority Areas of:

- mental health;
- cancer control;
- diabetes mellitus;
- cardiovascular disease and stroke;
- injury prevention and control; and
- arthritis and musculoskeletal conditions.

While research outlines the intersection of an unhealthy body image and disordered eating, it is necessary to point out that the two do not always coincide. It is possible for women to be afflicted

by unhealthy body image, but not necessarily an eating disorder.

Excessive dieting and overeating are associated with poor physical and mental health, including depression⁹². Information available on the risk taking behaviours of young women suggest a link between mental health and eating habits, with a report showing that in 1996 almost 20 percent of young women (18-23 years) eating (more or less) as a method of coping with stress⁹³. The same study found that young women who reported unhealthy eating practices and high stress also had poor mental health⁹⁴. Recent studies into mental health and depression have found a higher prevalence of depression in women than men in each category from 18-65+ years⁹⁵. Further exploratory work on any links between depression and unhealthy body image and disordered eating is required before conclusions can be made in this area.

Eating disorders tend to have a chronic, fluctuating course and can persist for years. The most common disorders in Australia are anorexia nervosa and bulimia nervosa, which affect around 1.8 percent and 0.4 percent of women respectively. Young women are most likely to be affected⁹⁶.

Eating disorder prevention programmes have focused on school-based self-esteem promotion programmes and have been shown to improve body satisfaction and eating behaviours. However, while short-term attitude changes have been noted, there is little evidence of the long-term impact of prevention programmes in this area⁹⁷. This lack of success with long-term attitudinal change suggests that a broader approach to body image may be warranted.

Impact of unhealthy body image, eating disorders and obesity

The impact of unhealthy body image must be considered as more than simply the prevalence of eating disorders, illness or injury.

Considering unhealthy body image as related to sense of wellbeing recognises the value to individuals of having a positive body image through a focus on wellness rather than weight control⁹⁸. However, there is little research on the costs and burdens of unhealthy body image that goes beyond the costs of eating disorders.

The complexity posed by the high levels of Australians who are overweight and obese suggests

that strategies to address body image dissatisfaction also need to consider increasing the focus on increasing physical activity and nutrition rather than achieving ideal shapes and sizes.

Unhealthy Body Image

Unhealthy body image impacts on a woman's physical and emotional/mental health, often in ways that produce a cyclical effect whereby factors influencing body image can combine and in some, lead to the development of disordered eating. However, it has been shown that many more Australian women experience body dissatisfaction than those who develop an eating disorder. Women's Health Australia has found that ongoing physical health problems (such as general health, bodily pain, often experiencing common symptoms and history of low iron levels) are associated with frequent dieting⁹⁹. Kenardy et al have shown that frequency of dieting may have mental health implications, with a 45 percent increase in the likelihood of depression reported in women who dieted five or more times in a year. In addition, associations between dieting and other health risk behaviours such as smoking and physical inactivity have been found¹⁰⁰. While these associations do not necessarily amount to a causal relationship between dieting and mental health, smoking or physical inactivity, the findings are concerning and warrant further investigation.

Eating Disorders

Between 1992 and 1997 there were eight deaths among 12-24 year olds due to eating disorders¹⁰¹. The burden of disease from anorexia nervosa and bulimia nervosa is an ongoing cost..

The health implications of anorexia nervosa specifically include malnutrition, osteoporosis or bone wastage, constipation, insomnia, hallucinations, and ultimately, in some cases, death. Bulimia nervosa can cause swollen salivary glands, damage to teeth, mouth, throat and gullet from forced vomiting and stomach acids, gastrointestinal damage, diarrhoea, constipation, malnutrition, fatal stomach rupture, and heart attack¹⁰². Emotional and psychological effects of eating disorders include difficulties with activities associated with food, loneliness due to self-imposed isolation, deceptive behaviours relating to food, fear of the disapproval of others, and mood swings, changes in personality, emotional outbursts or depression¹⁰³.

Treatment for eating disorders includes hospitalised care to restore weight lost, treat psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts and achieve long-term remission and rehabilitation, or full recovery. In Australia the cost for treating eating disorders in 1993-94 was \$22 million¹⁰⁴. This figure does not include ongoing treatment costs for chronic conditions which eating disorder sufferers may develop in later life, such as osteoporosis and heart problems.

Obesity

World Health Organisation statistics show that obesity is a global pandemic and is an accelerating social problem in industrialised countries¹⁰⁵. There are enormous human and social costs associated with obesity, including the related health indications such as heart disease and stroke. It is estimated that treating obesity, because of these associations with cardiovascular disease, non-insulin dependent diabetes mellitus and other disorders, costs \$810 million per year in Australia¹⁰⁶.

Obesity poses a complex problem for women's body image due to both high levels of body image dissatisfaction and high levels of women and men who are overweight or obese. Obesity affects up to 17 percent of women in Australia¹⁰⁷. A study on maintenance of healthy weight among young women has key events in women's lives such as marriage and childbirth are often associated with weight gain¹⁰⁸. The study suggests that strategies for preventing obesity should target women in this life stage.

There are strong correlations between socio-economic status and obesity¹⁰⁹. Women in lower socio-economic groups are more likely to be affected by obesity, with deficient nutritional habits and negative body image. Research demonstrates that people in lower socio-economic groups have less time for physical activity work commitments and lack inexpensive recreational facilities such as gymnasiums and swimming pools. This inability to participate in regular exercise will inevitably affect the health and body image as women can be caught in a cycle of unhealthy eating habits, limited exercise and poverty¹¹⁰.

B. Substance Use

Smoking

Current research indicates that smoking will become more common among women than men, as men quit at a higher rate than women¹¹¹. Smoking rates generally peak between ages of 20 to 24, remain high among women 25-29 and then decline¹¹². The 2001 National Health Survey found that 21 percent of women were current smokers, compared with 28 percent of men. Twenty eight percent of women and 36 percent of men aged 18-34 years smoked¹¹³. The health consequences of smoking are well recognised, causing the greatest number of drug related deaths in Australia¹¹⁴. For women, smoking is also related to difficulties becoming pregnant, risk of miscarriage, menstrual symptoms and early menopause¹¹⁵.

Young women report using tobacco as a method of weight control and using tobacco to portray a particular image¹¹⁶. It is likely that this is influenced by the portrayal of smoking on television and film. Escamilla et al argue that women are often displayed in films using tobacco products to convey sex appeal, emotional control, power, body-image control and comfort, while men smoke to portray masculinity, power, prestige, authority, male bonding and their role as protector¹¹⁷. In addition, evidence suggests that teenagers whose favourite stars smoke on screen are more likely to smoke than those whose favourite stars don't¹¹⁸.

The use of smoking for weight control may not be limited to younger women¹¹⁹, with significantly more women (58 percent) than men (26 percent) expressing concerns about weight gain as a barrier to ceasing smoking¹²⁰. In addition to these associations between smoking and body image, studies have found that dieting behaviour is most prevalent among former smokers, and least prevalent among current smokers¹²¹.

Stress, depression and anxiety and weight control are all reasons cited by women as barriers to quitting cigarette smoking¹²². Women's Health Australia reports that becoming pregnant was a major factor in giving up smoking for young women (18-23 years)¹²³. This suggests that as young women's social roles shift, their reasons for smoking change. However, for pregnant women the concern about weight gain remains a barrier to quitting smoking during pregnancy¹²⁴.

Drug and Alcohol Use

Research indicates that smoking and alcohol consumption often occur together¹²⁵, with positive associations found between binge drinking and smoking among young women by Women's Health Australia¹²⁶. Drug and alcohol use by Australian women on average is lower than for men and women are less likely to consume high risk levels of drugs and alcohol¹²⁷. However, high levels of problem drinking and substance misuse are reported in women aged 18-24¹²⁸.

One study has suggested that the frequency of alcohol use is significantly related to body dissatisfaction and drive for thinness among American women engaged in tertiary education¹²⁹. While there is a general lack of research on links between alcohol and other drug use and body image, this study indicates that young women's consumption of alcohol may be linked to body image. The Australian Longitudinal Study on Women's Health has found that young women who regularly binge drink are more likely than "low risk" drinkers to have used unhealthy weight-control practices. They are also more likely to be current smokers or ex-smokers¹³⁰. These results hint that levels of substance use may be linked to a women's sense of wellbeing and body image.

The use of illicit drugs in Australia is higher in men for all illicit drug types except ecstasy, where use is similar among men and women¹³¹. There is little research investigating any associations between body image satisfaction and illicit drug users. However, it has been reported that illicit drug users are more likely to regularly drink alcohol, be smokers and are at an increased risk of sexual risk-taking behaviours. Polydrug use is also common among illicit drug users¹³², and there is anecdotal evidence that the appetite suppressant qualities of some illicit drugs are considered a benefit of illicit drug use for some women.

The Impact of Substance Use

Approximately one in five deaths in Australia is drug related, with 22,724 people dying and 256,991 hospitalised from drug related causes in 1997¹³³. In 1999, tobacco accounted for over 80 percent of drug related deaths and 60 percent of drug related hospitalisations, alcohol 16 percent of drug related deaths and 37 percent of drug related hospitalisations and illicit drugs responsible for four percent of drug related deaths and drug related

hospitalisations¹³⁴. In 1993-94 the cost of substance abuse disorders was \$348 million¹³⁵. This does not include the social costs, such as impact on the road toll, crime and safety, or the impact on family, relationships and communities. These figures are not gender disaggregated, and it should be recalled that women have a lower substance use level than men, with one in 10 women 18-24 years found to have a substance use disorder in 1998 compared with one in five men¹³⁶.

C. Suicide and Self Harm

The statistics highlight the importance at looking at suicide and self-harming behaviour, either as separate from suicidal behaviour, or as part of a continuum of suicidal behaviour¹³⁷. In 1998 suicide was the seventh leading cause of death for men, at 23 per 100,000. Women's suicide rate is much lower at 5 per 100,000¹³⁸. This difference is reflected in other variables. Men who suicide tend to experience severe mental illness such as depression, and use violent means (eg firearms and hanging). Women who suicide have often experienced situational problems such as breakdown of a relationship, and use a pharmacological substance in an overdose¹³⁹.

There is evidence to suggest that women, particularly those under 25, attempt suicide and self harm at a higher rate than men, although male suicide rates remain considerably higher than female suicide rates¹⁴⁰. Estimates of self harm rates suggest there are between 150 and 300 acts of self harm for every female suicide¹⁴¹. This evidence highlights that the incidence of self harm amongst women may be hidden behind high male suicide rates, and that intervention points for self harming behaviour are required.

Risk factors for suicide and self harming behaviours are complex, cumulative and interacting. Indicators of heightened suicide risk can include depressive symptoms, hopelessness, recent loss, a previous attempt and active contemplation of suicide¹⁴². While depression is a common risk factor for engaging in risk taking behaviours and body image dissatisfaction,¹⁴³ it is unclear whether a relationship exists between suicide and self harming behaviours and body image dissatisfaction.

The Impact of Suicide and Self Harm

The burden of disease for suicide and self-inflicted injuries reflects the higher rate of suicide for men compared to women. Suicide was responsible for 2,363 deaths (1,860 males, 503 females) in 2000¹⁴⁴, however women are hospitalised at higher rates than men in all age groups for self-harm not resulting in death¹⁴⁵. In addition to the costs associated with hospital stays, approximately one third of people who die from suicide and 40 percent of those who attempt suicide have previously received psychiatric treatment¹⁴⁶. In addition the social and emotional costs of self harm and suicide are immeasurable.

CONCLUSION

The discussion in this paper has highlighted that body image dissatisfaction is high among Australian women, with figures ranging between 40 and 82 percent for young women. This dissatisfaction appears to be related to weight levels, with more overweight women dissatisfied than women who are underweight¹⁴⁷. However, research shows that this issue is not as simple as weight/body image correlation. Women's body image is affected by a multitude of factors which vary over the lifecycle, and is also affected by disability, illness, indigenous status, ethnicity, sexual orientation and experience of violence.

The levels of body image dissatisfaction the complexity of its causes pose a challenge for researchers and policy makers to find a safe balance between promotion of healthy body image and healthy weight range, without the implication that there is an "ideal body".

Unhealthy body image is one aspect of women's health and wellbeing which can be associated with risk taking behaviours. This association appears to be quite strong between smoking and body image, with weight control a barrier to quitting smoking¹⁴⁸. Further exploration of the influence of weight control and body image considerations (particularly the desire to portray a particular image) on the uptake of smoking in young women appears warranted.

A difficult issue remaining at the conclusion of this paper is the impact of sexual violence on body image. Research suggests that there are a number of variables affecting associations between sexual violence and eating disorders for women¹⁴⁹. Awareness of the impact of sexual violence on a woman's sense of wellbeing is a critical factor and challenge for body image promotion strategies.

Intervention points for future work have been raised and highlight that integrated policy development is required to address these issues. It is important that body image promotion activities recognise the different factors that influence body image and to highlight that women do not constitute one single group, but rather many groups distinguished by diversity. While this makes body image promotion more difficult, recognising difference may actually improve the capacity of promotional activities to move beyond a thin ideal to focus on healthy behaviours (such as good nutrition, regular exercise, moderate exercise and no drug use) rather than ideal shapes and weight.

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