

Gender role, eating disorder symptoms, and body image concern in ballet dancers

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Abstract

Objective: Our objective was to evaluate the relationships between gender role, eating behavior, and body image in nonprofessional female ballet dancers. **Methods:** One hundred ten female ballet dancers and 59 controls were administered the Bem Sex Role Inventory, the Eating Disorder Examination (EDE), the Body Uneasiness Test (BUT), and the Beck Depression Inventory. **Results:** Ballet dancers scored higher than controls in most of the items evaluating body image and eating behaviors; a high number of ballet dancers with undifferentiated gender role were also observed. In the

dancers group, male-typified subjects showed higher median scores of EDE and BUT scales, while in the control group, the highest median scores of EDE and BUT scales were found in undifferentiated subjects. **Conclusion:** Ballet schools' cultural pressure towards an ideal of leanness could interfere with the process of gender role acquisition. Ballet dancers appear to be overconcerned with performance; this could reinforce the internalization of several constructs that are generally considered as typically male.

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Introduction

Many studies have focused on a higher prevalence of eating disorders (EDs) in female adolescents, especially when they are involved in a sport that is considered particularly high-risk. Recent studies showed that EDs in female athletes are significantly more prevalent in white than in black ones [1,2]. Ethnic differences in EDs and body image dissatisfaction are well known even in nonathlete female samples [3–6], probably due to cultural differences.

Recent research studies suggest the mediating role of culture in promoting and/or enhancing drive for thinness and body image dissatisfaction [7,8], whereas little is known

about the influence of gender role on the internalization of culturally bounded ideal of body image, weight, and other constructs related to EDs, such as perfectionism and self-esteem [9].

Gender role could be defined as a construct that represents all behaviors that are sex-dimorphic in a given culture. Unlike biological gender, gender role is a social construct that is based on the cultural stereotype of what attitudes, behaviors, and characteristics are considered typically masculine or typically feminine [10]. It is widely assumed that gender identity and gender role are almost totally learned with minimal biological determination [11]. A prototypic feminine gender role is characterized as affectionate, yielding, emotional, and dependent, whereas a masculine gender role is typically identified as analytic, assertive, competitive, and dominant. Androgyny is defined as high levels of both masculine and feminine traits, whereas cross-gender refers to a mismatch between actual gender and gender role [12].

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Gender plays an important role in the development and maintenance of EDs: eating and weight-related problems, body image disturbance, and low self-esteem affect more females than males [13–15].

Two theoretical frameworks are commonly referred to when explaining the differing prevalence of EDs between females and males:

1. the presence of substantial biological differences between genders
2. the role of culturally bounded differences in gender role and body image ideal internalization.

Biological differences between genders comprise a series of factors that could enhance the risk of EDs, such as body fat composition, endocrine and hormonal variability [16], and proneness to mood disorders [17,18].

With regard to culturally bounded differences between genders, studies on female and male body image idealization confirm that, at least in western countries, drive for thinness and weight dissatisfaction start in childhood in females, whereas males are more prone to increase their muscle mass [19]. In addition, during the last 40 years, the female ideal body image has become thinner and thinner in all western countries [13,20].

Some data have shown that gender role orientation is important in modeling intrapersonal development and interpersonal relationships, influencing both self-esteem and body satisfaction [10]. Studies on college students highlighted that self-esteem is generally lower in females than in males: females build their self-esteem on constructs that are different from those in males, among them perfectionism and body image [21,22].

Body image dissatisfaction and EDs are also known to occur more frequently in athletes, dancers, and skaters: athlete groups seems to be at risk for EDs, presenting more ED symptoms than controls [23–26] and showing weight and body image concerns (BICs) similar to those of ED patients [27]. ED symptoms are common both in professional and nonprofessional athletes [24,25], in whom drive for thinness, leanness, and weight control are widely represented. ED symptoms in athletes and ballet dancers have been reported to be sustained by a complex interaction between sociocultural pressure for thinness, athletic performance anxiety, and negative self-appraisal of athletic achievement [28,29]. These factors can lead to overconcern with the size and the shape of the body, which are considered to play a notable role in developing and maintaining EDs [28]. Brownell and Wadden [30] also suggested that certain types of sports participation could be harmful for certain types of people: young women characterized as competitive, concerned with performance, and perfectionist are at increased risk for developing an ED when performing intense athletic activities. The same activity, especially at nonelite level, may be safe for other women who are devoid of these personality characteristics [30,31].

A protective role of exercise against EDs has nevertheless been proposed, hypothesizing that success in athletic performance could be a defending factor against body dissatisfaction, drive for thinness, and low self-esteem. In fact, in several studies, gymnasts and nonelite high school athletes were shown to have a reduced risk of disordered eating behaviors compared to controls [26,31,32]. Nevertheless, in the largest study conducted to date, which enrolled the entire population of Norwegian male and female elite athletes ($n=1620$) and 1696 controls, the prevalence of EDs was higher in athletes than in controls, was higher in female athletes than in male athletes, and was more common among those competing in leanness-dependent and weight-dependent sports than in those competing in other sports [26]. It should also be noted that studies on sports and EDs are quite heterogeneous, making it difficult to evaluate a single sport as a risk factor per se without considering individual characteristics that could interfere with the choice of a particular sport, such as personality [31].

Different studies suggested that white female athletes appear to be overconcerned with the current cultural idealization of thinness. In particular, self-esteem seems to be significantly influenced by cultural pressure, body dissatisfaction, and athletic success [32]. Moreover, white female athletes show a lower self-esteem compared with both black females and white/black male athletes; white female athletes report also a significantly higher drive for thinness, higher body dissatisfaction, and more disturbed eating behaviors than black female and white/black male athletes. A higher self-esteem, along with greater body satisfaction, among black females may depend on less cultural idealization of thinness for both black males and females [2,33].

Finally, several studies have investigated the possible relationships between gender role and EDs [10,34–36], but little is known about such relationships in nonclinical samples and nonprofessional athletes. In particular, no study to date has evaluated the impact of gender role on body image satisfaction and eating behavior in female adolescent ballet dancers.

The aim of the present study was to evaluate the relationships between eating attitudes and behavior, body image self-perception, and gender role in nonprofessional female ballet dancers and nonphysically active female students.

Methods

Subjects

Two different Caucasian female groups were studied: a ballet-dancers group and a control group of nonphysically active students. Female dancers were randomly selected from the seven largest nonprofessional ballet schools of a common geographical area (Florence county) using the alphabetical lists supplied by school teachers. The inclusion

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