LESBIAN WOMEN AND EATING DISORDER SYMPTOMATOLOGY: A TEST AND EXTENSION OF OBJECTIFICATION THEORY

By

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by

Tiffany L. Graham
This thesis is dedicated to my best friend and mother, Donna Graham.
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Abstract of Thesis Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Master of Science

LESBIAN WOMEN AND EATING DISORDER SYMPTOMATOLOGY: A TEST AND EXTENSION OF OBJECTIFICATION THEORY

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Objectification theory posits that women in Western society experience sexually objectifying events that lead to the adoption of an outsider’s perspective upon one’s own body. Such self-objectification produces increased body shame in response to perceived failure to live up to cultural beauty standards. Body shame, in turn, results in eating disorder symptomatology. Although empirical support for the tenets of objectification theory is accumulating, to date, little research exists that addresses the applicability of objectification theory to lesbian women. In addition, two factors, connection with the lesbian community and feminist ideology, have emerged from the literature as variables that may play a role in the development of eating disorder-related attitudes and behaviors among lesbian persons. The current study tested the objectification theory framework as it applies to eating disorder symptomatology in a sample of 531 lesbian women, and additionally explored the roles of connection with the lesbian community and feminist ideology. A theoretically based path analysis was conducted to investigate relationships
among all variables in the model. Results indicated that the objectification theory framework was applicable for lesbian women, and disconnection from the lesbian community was a stronger predictor of eating disorder related attitudes and behaviors than feminist ideology. Implications of findings and directions for future research are discussed.
CHAPTER 1
INTRODUCTION

The prevalence of eating disorder-related attitudes and behaviors among women in Western society is astounding. Nearly two percent of women develop anorexia nervosa (Walters & Kendler, 1995), and approximately three percent battle with bulimia nervosa (Romano & Quinn, 2001). In addition, the rates of eating disorders have doubled since the 1960’s, and disordered eating behavior can manifest as early as elementary school (Steiner & Lock, 1998). Even among women who are not diagnosed with eating disorders, concern with physical appearance and body weight is so pervasive that it has been deemed “normative discontent” (Rodin, Silberstein, & Striegel-Moore, 1984), and scholars have advocated the conceptualization of eating problems as a continuum instead of discrete diagnostic categories (Scarano & Kalodner-Martin, 1994).

Fredrickson and Roberts (1997) proposed objectification theory as a framework for understanding the development of eating disorder-related attitudes and behaviors along with other health concerns among women. Objectification theory posits that women within American culture are exposed to sexually objectifying events that include staring, sexual ogling, catcalls, and blatant sexual harassment and degradation. Often, emphasis is placed on women’s individual body parts, instead of the whole person, and strong importance is placed on a woman’s body and not her mind, skills, or abilities. Girls and women are taught at an early age that physical appearance is important, as they are frequently objectified through various media images including magazines, television shows, commercials, movies, and pornographic materials. Through such experiences of
sexual objectification, women are socialized to become “objects to be looked at and evaluated by others” (Fredrickson & Roberts, 1997, p. 177) and they learn to treat other women in the same way.

According to objectification theory, cultural experiences of sexual objectification promote self-objectification, or taking on the perspective of an observer upon one’s own body. More specifically, as a result of pervasive experiences of sexual objectification, girls and women come to internalize an observer’s perspective upon their bodies and “view themselves as objects or sights to be appreciated by others” (Fredrickson & Roberts, 1997, p. 180). Objectification theory posits that chronic self-objectification, in turn, increases body shame, promotes anxiety, reduces experiences of peak motivational states or flow experiences (i.e., periods of intense concentration on a challenging and rewarding task), and decreases awareness of internal bodily states (e.g., heart rate, sexual arousal). These experiences in turn result in depression, sexual dysfunction, and eating disorders among women.

Within this larger framework of objectification theory (Fredrickson & Roberts, 1997), the links among sexual objectification experiences, self-objectification, and body shame have been posited as the most critical to understanding eating disorder symptomatology and empirical evidence has supported these proposed links.

**Empirical Support for Objectification Theory Applied to Eating Disorder Symptomatology**

To date, the relationships among self-objectification, body shame, and eating disorder symptomatology have received much empirical support. One such example exists in an experiment conducted by Fredrickson, Roberts, Noll, Quinn, and Twenge (1998). According to objectification theory, self-objectification is likely to occur when a
woman is made more aware of her body’s appearance. Fredrickson et al. (1998) elicited such a situation by manipulating the type of clothing worn by participants. In this study, 114 women were assigned randomly to a swimsuit or sweater condition. After trying on the designated clothing, participants were asked to look in a full-length mirror to evaluate the clothing, and then sample a cookie for a mock taste test. Results indicated that women who were wearing a swimsuit reported significantly higher levels of self-objectification and body shame, and ate fewer cookies (i.e., restrained eating) than did women in the sweater condition. Thus, a situation that heightened self-objectification resulted in restrained eating and higher levels of reported self-objectification and body shame.

Contributing further support for the theory, Noll and Fredrickson (1998) and Moradi, Dirks, and Matteson (2005) also found that self-objectification was related positively to eating disorder symptomatology. Furthermore, both studies found evidence that this link was mediated, partially, by body shame. In other words, in addition to the direct positive link between self-objectification and eating disorder symptoms, self-objectification was related to greater levels of body shame, which in turn were related to higher levels of eating disorder symptomatology. These findings were consistent with objectification theory’s proposition that body shame is a key mechanism through which self-objectification is translated into eating disorder symptoms.

In contrast to the numerous studies that have examined and found support for the proposed roles of self-objectification and body shame in eating disorder-related attitudes and behaviors, sexual objectification experiences are only recently beginning to receive empirical attention in the literature on objectification theory. Hill (2002) began to address this gap by examining the relationship between sexual objectification experiences and
self-objectification with a sample of 502, mostly White women (307 heterosexual, 33 bisexual, 155 lesbian, and 7 who did not report sexual orientation). Hill assessed sexual objectification experiences using a combination of existing measures that assess sexual harassment, other degrading experiences, and the extent that women are treated as sexual objects.

Results indicated that reports of sexual objectification experiences were related positively to self-objectification. However, this relationship was moderated by age, such that the magnitude of the relationship between sexual objectification experiences and self-objectification was strong and positive for women between the ages of 50 and 79, but non-significant for those between the ages of 18 and 49 years old. This interaction effect might be explained by the potential larger accumulation of objectification experiences for older women than for younger women.

Additional evidence suggests that internalization of sociocultural standards of beauty, a construct not explicitly included in the objectification theory framework or Hill’s (2002) study, might be an important mechanism that translates sexual objectification experiences into self-objectification and other eating disorder-related variables. For example, Morry and Staska (2001) found that exposure to beauty magazines, a specific type of sexual objectification experience, was related to higher levels of disordered eating and body shape dissatisfaction, but these links were mediated by internalization of sociocultural standards of beauty. That is, exposure to beauty magazines was related to greater acceptance of society’s beauty mandates, and such internalization in turn was related to higher levels of self-objectification, body shape dissatisfaction, and eating disorder symptomatology.
Moradi et al. (2005) conducted the most comprehensive assessment of the objectification theory framework as applied to eating disorder symptoms to date by including the proposed links among sexual objectification experiences, self-objectification, body shame, and eating disorder symptoms. Based on literature highlighting the importance of internalization of sociocultural standards of beauty and Morry and Staska’s (2001) findings indicating the importance of including this variable in tests of objectification theory, Moradi et al. also included internalization in the model. Moradi et al.’s path analytic findings with over 200 undergraduate women demonstrated that reported experiences of sexual objectification were significantly related to higher levels of internalization, which in turn was significantly linked with greater body surveillance (an indicator of self-objectification), body shame, and eating disorder symptoms. In addition, body surveillance was linked significantly with body shame, which was correlated significantly with disordered eating.

Moradi et al. (2005) examined the significance of mediator effects and found that internalization of sociocultural standards of beauty emerged as a mediator of the link of reported experiences of sexual objectification to body surveillance, body shame, and eating disorder symptoms. Furthermore, as described in objectification theory, body surveillance also mediated the link of reported sexual objectification experiences to body shame. Finally, consistent with previous research (e.g., Noll & Fredrickson, 1998), body shame partially mediated the link of body surveillance to eating disorder symptomatology. The overall model provided a very good fit to the data and accounted for 50% of the variance in eating disorder symptomatology.
Taken together, the studies conducted by Hill (2002), Morry and Staska (2001), and Moradi et al. (2005) supported the role of sexual objectification experiences in the objectification theory framework. In addition, they demonstrated the importance of attending to the role of internalization of sociocultural standards of beauty in the objectification theory framework.

**Application of Objectification Theory with Lesbian Individuals**

The tenets of objectification theory have been examined with college women and men (Fredrickson et al., 1998; Huebner & Fredrickson, 1999; Morry & Staska, 2001; Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Tiggemann, & Slater, 2001), adolescent dancers and non-dancers (Slater & Tiggemann, 2002), and women who exercise (Strelan, Mchaffey, & Tiggemann, 2003). However, to date, only one study has examined the aspects of the theory as applied to lesbian persons (Hill 2002).

In Hill’s (2002) previously described study of objectification theory, sexual orientation and age were examined as potential moderators of the relationship between sexual objectification experiences and self-objectification. Consistent with objectification theory, in the entire sample (i.e., heterosexual and lesbian women), experiences of sexual objectification were related positively to self-objectification. Furthermore, sexual orientation did not moderate the link between sexual objectification and self-objectification, suggesting that the relationship was similar for both the heterosexual and lesbian women samples. Although this study began to address the gap in data on the applicability of objectification theory to lesbian persons, it represented only a partial investigation of objectification theory because it did not examine key constructs such as internalization, body shame, and eating disorder symptomatology. In addition, the sample
only consisted of White heterosexual women and White lesbian women, thereby limiting the generalizability of findings.

Thus, the generalizability of the propositions of objectification theory to understanding eating disorder symptomatology among lesbian women is not known and research is needed to examine the applicability of objectification theory to understanding eating disorder symptoms among lesbian persons. Such research must attend to the scholarship on eating disorder-related attitudes and behaviors among lesbian women and include any unique factors, not included in objectification theory, that might shape lesbian women’s experiences of eating disorder-related attitudes and behaviors.

**Eating Disorder Symptomatology among Lesbian Women**

Findings are mixed as to whether or not lesbian women experience different levels of eating disorder symptomatology and body satisfaction when compared with heterosexual women (Beren, Hayden, Wilfley, & Striegel-Moore, 1997). Some studies have revealed no significant differences between lesbian and heterosexual women (Beren, Hayden, Wilfley, & Grilo, 1996; Brand, Rothblum, & Solomon, 1992; Striegel-Moore, Tucker, & Hsu, 1990), whereas other studies indicate that lesbian women experience higher levels of body satisfaction and lower levels of eating disorder symptoms than do heterosexual women. For example, Striegel-Moore and colleagues (1990) found no significant differences in eating behavior and body dissatisfaction in a sample of 52 heterosexual and 30 lesbian undergraduate students. Other studies, however, have shown that lesbian women report lower levels of concern with body weight and physical appearance, internalization of sociocultural standards of beauty, and disordered eating symptomatology, but higher levels of ideal body weights and body satisfaction...
than do heterosexual women (Herzog, Newman, Yeh, & Warshaw, 1992; Share & Mintz, 2002; Siever, 1994).

Myers, Taub, Morris, and Rothblum (1998) used a qualitative research design to search for an explanation of findings of difference versus no difference between lesbian and heterosexual women’s eating disorder-related attitudes and behaviors. In their telephone interviews of 18 lesbian and 2 bisexual women, respondents reported either “feeling freedom from society’s norms after coming out” or still “feeling the pressure to be thin.” This finding highlights the importance of attending to individual differences among lesbian women that shape their experiences of sexual objectification and eating disorder-related attitudes and behaviors. Extant literature on eating disorder-related attitudes and behaviors among lesbian women points to connection with the lesbian community and feminist ideology as two critical individual difference variables that should be examined.

The Role of Connection with the Lesbian Community in Eating Disorder Symptomatology

Extant findings suggest that despite experiencing similar cultural messages as heterosexual women, lesbian women might be less likely to internalize sociocultural beauty standards, which subsequently contributes to higher body esteem and lower levels of disordered eating behavior (Bergeron & Senn, 1998; Share & Mintz, 2002). Lesbian women’s lower level of internalization of sociocultural standards of beauty may be due to multiple causes. For example, the lesbian subculture may be more accepting of a variety of body types and shapes (Siever, 1994). Indeed, one participant from the telephone interviews conducted by Myers et al. (1998) reported that the lesbian community is generally more accepting of larger women. Consistent with this participant’s
observation, empirical findings suggest that lesbian women who interact with other lesbian women are likely to experience positive health effects.

For example, in their study of 188 lesbian and bisexual women, Ludwig and Brownell (1999) found that lesbian persons with friends who also identified as lesbian reported a more positive body image than lesbian persons who reported having mostly heterosexual friends. Unfortunately, sample sizes for their study were rather unbalanced in that over 80 women reported having mostly friends who were also lesbian or bisexual, and this group was compared with 27 women reporting having mostly heterosexual female friends, 15 women reporting having mostly gay or bisexual male friends, and 11 women reporting having mostly heterosexual male friends. Nevertheless, these findings suggest that interaction with other lesbian women might be related to positive body image for lesbian women.

Heffernan (1996) examined directly the relationship between connection with the lesbian and gay community and eating disorder symptomatology. In this study, 203 lesbian women completed questionnaires assessing lifestyle, self-esteem, attitudes about attractiveness, body esteem, and eating behavior. Involvement with lesbian/gay community was assessed with the question “How involved are you in lesbian/gay activities?” Results indicated that the lesbian women were not significantly different from heterosexual women in terms of attitudes regarding weight and appearance, and the two groups reported similar rates of bulimia nervosa. Only one difference emerged suggesting that the lesbian participants reported binge eating disorder more frequently than the heterosexual participants.
Thus, in general, between group analyses suggested overall similarity between lesbian and heterosexual women’s eating disorder-related attitudes and behaviors. Within group analyses, however, revealed that among the lesbian women in the sample, involvement in the lesbian/gay community was related to better health outcomes such as lower weight and shape concern. Heffernan (1996) concluded that connection and involvement with the lesbian/gay culture might reduce internalization of society’s thin beauty ideal. Given that Heffernan used only a single item to assess connection with the lesbian/gay community, however, more comprehensive assessment of this important construct is needed in future research.

**The Role of Feminist Ideology in Eating Disorder Symptomatology**

Feminist ideology is a second important individual difference variable that might shape lesbian women’s eating disorder-related attitudes and behaviors. Previous research has demonstrated that women’s endorsement of feminist ideology is related to lower levels of eating disorder-related attitudes and behaviors (Dionne, Davis, Fox, & Gurevich, 1995; Snyder & Hasbrouck, 1996). For example, Snyder and Hasbrouck (1996) examined this possibility in a study of the relationship between feminist identity development attitudes and symptoms of disturbed eating in a sample of 71 female college students. Their results indicated that passive acceptance of traditional gender-role stereotypes (Feminist Identity Development Passive Acceptance scores) was related positively to drive for thinness and body dissatisfaction, whereas, active commitment to feminist ideology (Feminist Identity Development Active Commitment scores) was related negatively to those same outcome measures. Although this study provided some support for the role of feminist ideology in eating disorder attitudes and behaviors, the generalizability of these findings to lesbian women was not examined.
Nevertheless, given that lesbian women are more likely to identify with feminism than are heterosexual women (Guille & Chrisler, 1999), this variable may also play a significant role in the development of eating disorder-related attitudes and behaviors among lesbian women.

Bergeron and Senn (1998) addressed this possibility in their examination of attitudes regarding the body, awareness and internalization of sociocultural standards of beauty, and feminist self-identification among a sample of 108 lesbian and 115 heterosexual women between the ages of 18 and 58. Feminist identification was assessed using the question “Would you describe yourself as a feminist?” A MANOVA revealed that lesbian women reported significantly higher ideal weights, and reported feeling stronger and more fit than their heterosexual counterparts. A standard multiple regression revealed that in the entire sample, internalization of sociocultural standards of beauty and feminist identification both were unique predictors of body attitudes, above and beyond sexual orientation. No differences were found between heterosexual and lesbian women on awareness of sociocultural standards of beauty, and this variable did not predict body attitudes.

Bergeron and Senn’s (1998) findings suggest the importance of examining both feminist identification and internalization when examining body attitudes. A notable strength of this study is the large sample size obtained by snowball sampling. However, over 95% of the participants identified as White. Furthermore, feminist identity was assessed using only a single item and the authors did not examine directly eating disorder symptomatology. Nevertheless, these findings can be taken as additional support for the
importance of examining feminist ideology and its relationship with eating disorder-related attitudes and behaviors.

Further evidence of the relationship between feminist ideology and disordered eating attitudes and behaviors exists in Cogan’s (1999) study of 181 lesbian and bisexual women between the ages of 17 and 58. Participants completed measures assessing reasons for exercise, fitness activity frequency, type, and duration, dieting behavior, body satisfaction, eating disorder symptoms, physical appearance before and after coming out, feminist self-identification, and feminist ideology. To assess feminist self-identification, participants responded to the question “How much do you consider yourself a feminist?” and to assess for feminist ideology, participants completed the 10-item Attitudes Toward Feminism and the Women’s Movement scale (FWM; Fassinger, 1994).

Controlling for Body Mass Index (BMI) and age as covariates, it was found that those who labeled themselves as a feminist (feminist self-identification) and endorsed feminist ideology were overall more satisfied with their bodies than those who did not. More specifically, higher levels of feminist self-identification and endorsement of feminist ideology were related to higher body satisfaction, lower rates of bulimia, drive for thinness, and weight discrepancy, and tendency to exercise for health versus aesthetic reasons. The authors concluded that: “feminism may be a useful tool for unlearning internalized negative body image” (p. 85). Unfortunately, this study did not assess for the internalization of such ideals.

Thus, extant research suggests that feminist ideology should be included in examination of disordered eating symptomatology among lesbian persons. However, since it is still unknown whether or not it is connection with the lesbian community,
feminist ideology, or both that play important roles in the internalization of sociocultural standards of beauty and the manifestation of disordered eating symptoms in lesbian women, both were included in the current research.

**Significance of the Study**

The present research addressed a number of gaps in the literature by examining objectification theory as it applied to understanding eating disorder symptomatology with a lesbian sample. More specifically, the present study examined the previously supported framework of objectification theory that includes links among sexual objectification, internalization of sociocultural beauty standards, self-objectification, body shame, and eating disorder symptomatology (Moradi et al., 2005). Furthermore, extant research has supported the inclusion of two additional variables, connection with the lesbian community and feminist ideology, as key predictor variables in examining the applicability of the objectification theory framework to lesbian women. Thus, the present study included these variables in examining objectification theory’s applicability to understanding eating disorder symptomatology with lesbian women. The online survey method provided for the recruitment of a large sample of lesbian women; therefore, the results obtained were more generalizable.
CHAPTER 2
REVIEW OF THE LITERATURE

In the United States, the rate of eating disorders is quite high among women, and these rates continue to climb. According to the APA Work Group on Eating Disorders (2000), approximately .5 to 3.7% of women suffer from anorexia nervosa, and 1.1 to 4.2% suffer from bulimia nervosa. In addition, the rates of eating disorders have doubled since the 1960’s, and disordered eating behavior can manifest as early as elementary school (Steiner & Lock, 1998). Only 1 in 40,000 women fit the size and shape of a typical supermodel (Wolf, 1991), yet women persistently engage in behaviors to achieve the near impossible through diet, exercise, various beauty products, wardrobe, surgery, and engaging in eating disorder-related behaviors. Chronic dieting has become a way of life for some women, and up to 60% engage in these behaviors by the time they are in high school (Steiner & Lock, 1998). This pattern of chronic restriction of food intake can carry with it serious and sometimes deadly consequences. According to Fredrickson and Roberts (1997), eating disorders are “the extreme end of a continuum of this normative discontent” (p. 191). In sum, eating disorder symptomatology has been identified as a serious mental health concern among women. Attempts to understand, prevent, and treat eating disorder symptomatology have highlighted intrapersonal and contextual variables that could shape the development of such symptoms.

Objectification theory (Fredrickson & Roberts, 1997) provides a framework that integrates both intrapersonal and contextual factors that play a role in mental health problems, such as eating disorder symptomatology, that have higher prevalence rates
among women than men. More specifically, objectification theory posits that women within American culture are exposed to sexually objectifying events that include staring, sexual ogling, catcalls, and blatant sexual harassment and degradation. Women often encounter situations in which emphasis is placed on women’s individual body parts, instead of the whole person, and strong importance is placed on a woman’s body and not her mind, skills, or abilities. Girls and women are taught at an early age that physical appearance is important, as they are frequently objectified through various media images including magazines, television shows, commercials, movies, and pornographic materials. Through such cultural experiences, women are socialized to become “objects to be looked at and evaluated by others” (Fredrickson & Roberts, 1997, p. 177) and they learn to treat other women in the same way.

According to objectification theory, this milieu of cultural experiences of sexual objectification leads to self-objectification, a crucial part of the overall model. Self-objectification involves taking on the perspective of an observer upon one’s own body. In other words, girls and women come to “view themselves as objects or sights to be appreciated by others” (Fredrickson & Roberts, 1997, p. 180). Objectification theory posits that chronic self-objectification, in turn, promotes anxiety, reduces experiences of peak motivational states or flow experiences (i.e., periods of intense concentration on a challenging and rewarding task), decreases awareness of internal bodily states (e.g., heart rate, sexual arousal), and increases body shame. These experiences in turn result in depression, sexual dysfunction, and eating disorders among women.

Within this larger framework of objectification theory (Fredrickson & Roberts, 1997), the links among sexual objectification experiences, self-objectification, and body
shame have been posited as the most critical to understanding eating disorder symptomatology. Empirical research supporting each of the relevant relationships in the model is described in depth below.

**Self-Objectification and Its Link to Body Shame and Eating Disorder Symptomatology**

To date, the relationships proposed in objectification theory among self-objectification, body shame, and eating disorder symptoms have received much empirical support. One such example exists in an experiment conducted by Fredrickson, Roberts, Noll, Quinn, and Twenge (1998). According to objectification theory, self-objectification is likely to occur in situations in which a woman’s sense of her body is accentuated and she is made more aware of her body’s appearance. Fredrickson et al. (1998) elicited such a situation by manipulating the type of clothing worn by participants. Within two separate experiments, 114 college women were assigned randomly to a swimsuit or sweater condition. In the first experiment, 75% of participants were Caucasian, 10% Asian, 7% Hispanic, and 7% identified with other (unspecified) ethnicities. In the second experiment, 83% of participants identified as Caucasian, 6% African American, 5% Asian, 2% Hispanic, and 4% identified with other (unspecified) ethnicities. Information regarding sexual orientation was not collected from these women.

After trying on the designated clothing, participants were asked to look in a full-length mirror to evaluate the clothing, and then sample a cookie for a mock taste test. Body Mass Index (BMI) was calculated and controlled as a covariate in the analyses, in order to account for any potential confounding effects of obesity. Results indicated that women who were wearing a swimsuit reported significantly higher levels of self-objectification and body shame, and ate fewer cookies (i.e., restrained eating) than did
women in the sweater condition. In other words, a situation that heightened self-objectification resulted in restrained eating and higher levels of reported self-objectification and body shame.

Noll and Fredrickson (1998) provided further support for the relationships among self-objectification, body shame, and disordered eating symptomatology. Two samples of undergraduate women attending Duke University (n= 93 and 111, respectively) were administered questionnaires including the Revised Bulimia Test (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991), the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979), the Revised Restraint Scale (Polivy, Herman, & Howard, 1988) and the Self-Objectification and Body Shame Questionnaires (designed by the researchers). The data was analyzed using multiple regression, with BMI held as a covariate.

Results indicated that self-objectification related positively with body shame and symptoms of both bulimia and anorexia, and body shame related positively with both anorexia and bulimia symptoms. Using Baron and Kenny’s (1986) procedure to test for mediation, the authors found that body shame acted as a mediator of the relationship between self-objectification and disordered eating symptomatology. The mediational model accounted for 35% of the variance in bulimic symptoms (p < .01) and 27% of the variance in anorexia symptoms (p < .01). It is also important to note that a direct relationship was found between self-objectification and symptoms of disordered eating. Thus, body shame was a partial mediator of the link between self-objectification and eating disorder symptomatology.

Further support for body shame as a mediator variable, linking self-objectification to eating disorder symptomatology, was found in Tiggemann and Slater’s (2001) study.
This study examined the tenets of objectification theory by administering, to two samples of women, measures of general self-objectification, body surveillance (the specific manifestation of self-objectification as persistent body monitoring), appearance anxiety, flow, awareness of internal bodily states, body shame, and disordered eating. One group of women consisted of 50 former dancers and the other of 51 undergraduate psychology students. The former dancers were Caucasian women between the ages of 17 and 25 who had studied classical ballet for at least two years but no longer engaged in dance. The undergraduate students attended The Flinders University of South Australia, and most (over 95%) identified as Caucasian. The ages of this group ranged from 17 to 24, and none of the undergraduate participants had studied formal dance.

As predicted by the researchers, former dancers scored higher on the measures of general self-objectification, body surveillance, and disordered eating symptomatology than did the group of undergraduate students. In both samples, the relationships of self-objectification and body surveillance to disordered eating symptomatology was mediated by body shame, but not by anxiety, flow, or awareness of internal states. Finally, results indicated that body surveillance emerged as the manifestation of general self-objectification that accounted for unique variance in the reported symptoms of disordered eating. That is, in this study of former dancers and non-dancers, body surveillance was a significant unique predictor of eating disorder symptoms, $F(1,90) = 31.30, p < .001$, but general self-objectification was not, $F(1,90) = 0.43, p > .05$. This finding suggests that it is important to include assessment of body surveillance as the critical manifestation of self-objectification in the context of the objectification theory model.
In sum, the studies described above all were consistent with objectification theory’s proposition that body shame is a key mechanism through which self-objectification is translated into eating disorder symptoms. Furthermore, their findings indicate that a direct relationship also exists between self-objectification and eating disorder symptomatology. Therefore, in congruence with extant research, the current study will examine body shame as a partial mediator of the link of body surveillance (the critical manifestation of self-objectification) to eating disorder symptomatology.

**Sexual Objectification Experiences and Internalization of Sociocultural Standards of Beauty**

Fredrickson and Roberts (1997) identified sexual objectification experiences as a key precursor to self-objectification, body shame, and eating disorder symptoms in objectification theory. However, few studies have included this proposed role of sexual objectification experiences when examining the model. Hill (2002) began to address this gap in her examination of the relationship between sexual objectification experiences and self-objectification.

In Hill’s (2002) study, sexual objectification experiences were defined as experiences in which women are treated as sexual objects, and as a result, “become their bodies” and are evaluated as such (Hill, 2002, p. 5). Experiences of sexual objectification were assessed with a questionnaire designed by Hill, containing 40 items measuring sexualized gaze (with and without verbal comments), instances of sexual harassment, and sexual assault. The CSOS (Cultural Sexual Objectification Scale) was derived from other measures such as the Sexual Victimization Measure (SWV; Belknap, Fischer, & Cullen, 1999) and the Sexual Experiences Questionnaire (SEQ; Fitzgerald, Shullman, Bailey, Richards, Swecker, Gold, Ormerod, & Weitzman, 1988). Self-objectification was defined
as “the extent to which individuals view their bodies in observable, appearance-based (objectified) terms versus non-observable, competence-based (non-objectified) terms” (Noll & Fredrickson, 1998, p. 628). This variable was assessed using the Self-Objectification Questionnaire designed by Noll and Fredrickson (1998), and the Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996).

Over 500 mostly White women (307 heterosexual, 33 bisexual, 155 lesbian, and 7 who did not report sexual orientation) participated in this web-based survey. Participants were recruited from introductory psychology classes at a large public Midwestern university (n = 101), and techniques such as snowball sampling and email listserves also were used (n = 340). In addition, over 300 letters were mailed to randomly selected university faculty and staff, and of those women, approximately 12% accessed the website to complete the survey (n = 61). Upon accessing the website, participants were asked to complete questionnaires measuring reported experiences of sexual objectification as well as self-objectification. Results indicated that reported experiences of sexual objectification were related positively to self-objectification. However, this relationship was moderated by age, such that the magnitude of the relationship between sexual objectification experiences and self-objectification was strong and positive for women between the ages of 50 and 79, but non-significant for those between the ages of 18 and 49 years old. This interaction effect might be explained by the potential larger accumulation of objectification experiences for older women than for younger women. This study adds further support for the inclusion of sexual objectification experiences when examining the overall objectification theory model.
Additional evidence suggests that internalization of sociocultural standards of beauty, a construct not explicitly included in the objectification theory framework and not assessed in Hill’s (2002) study, might also be an important factor in understanding the role for sexual objectification experiences in eating disorder-related attitudes and behaviors. That is, internalization of sociocultural standards of beauty might be a key mechanism that translates sexual objectification experiences into self-objectification and other eating disorder-related variables. Support for this relationship can be found in a study conducted by Morry and Staska (2001). In this study, 89 female introductory psychology students completed measures designed to assess exposure to fitness and beauty magazines (a specific type of sexual objectification experience), awareness and internalization of sociocultural attitudes and standards regarding appearance, self-objectification, eating disorder symptomatology, and body shape satisfaction. The Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ; Heinberg, Thompson, & Stormer, 1995) was used to assess awareness (i.e., recognition of societal standards) and internalization (i.e., acceptance of sociocultural standards of beauty).

Statistical analyses revealed that sexual objectification experiences, operationalized as exposure to beauty magazines, were related to higher levels of reported disordered eating symptoms and body shape dissatisfaction, but these links were mediated by internalization of sociocultural standards of beauty. That is, exposure to beauty magazines (but not fitness magazines) was related to greater acceptance of society’s beauty mandates, and such internalization in turn was related to higher levels of self-objectification, body shape dissatisfaction, and eating disorder symptomatology. Morry and Staska’s (2001) study was an important contribution to objectification theory.
research. A limitation of this study, however, is that body shame was not assessed directly. In addition, Morry and Staska’s study focused on only one manifestation of sexual objectification experience (i.e., exposure to beauty magazines) and did not assess broadly the range of sexual objectification experiences highlighted in objectification theory.

In one of the most comprehensive studies of the objectification theory framework, Moradi et al. (2005) found additional support for the overall model, and further examined the roles of both sexual objectification experiences and internalization of sociocultural standards of beauty. In this study, over 200 undergraduate women in a large southeastern university completed surveys assessing their reported experiences of sexual objectification, internalization of sociocultural beauty standards, self-objectification (manifested through body surveillance), body shame, and eating disorder symptomatology. A path analysis was conducted using AMOS 4.01 (Arbuckle, 1999), and BMI was controlled as a covariate. Results indicated that reported experiences of sexual objectification related positively to body surveillance, body shame, and eating disorder symptoms. In addition, reported sexual objectification experiences related positively to internalization, which in turn was linked positively to body surveillance, body shame, and eating disorder symptoms. Moradi et al. (2005) found evidence for the mediational role of internalization in the objectification theory framework. More specifically, they found that internalization of sociocultural standards of beauty acted as a partial mediator, linking reported experiences of sexual objectification to body surveillance, and also mediated the link of reported experiences of sexual objectification to body shame and eating disorder symptoms. Moradi et al. (2005) also found support for
the previously described mediating role of body shame in the relationship between body surveillance and reported symptoms of disordered eating. The overall model provided a very good fit to the data and accounted for 50% of the variance in eating disorder symptomatology.

Taken together, the studies conducted by Hill (2002), Morry and Staska (2001), and Moradi et al. (2005) supported the role of sexual objectification experiences in the objectification theory framework. In addition, they demonstrated the importance of attending to the role of internalization of sociocultural standards of beauty. However, only Moradi et al. (2005) included all variables related to disordered eating symptomatology as described in objectification theory. The current study will build on Moradi et al.’s study by examining their model, which includes relationships among reported experiences of sexual objectification, internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder-related attitudes and behaviors, with a sample of lesbian women.

**Objectification Theory as it Applies to Lesbian Individuals**

The tenets of objectification theory have been examined with populations such as college women and men (Fredrickson et al., 1998; Huebner & Fredrickson, 1999; Morry & Staska, 2001; Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Tiggemann, & Slater, 2001), older women (Tiggemann & Lynch, 2001), adolescent dancers and non-dancers (Slater & Tiggemann, 2002), and women who exercise (Strelan, Mehaffey, & Tiggemann, 2003). However, to date, only one study has examined the theory as it applies to lesbian persons (Hill, 2002).

In Hill’s (2002) study of objectification theory, sexual orientation and age were examined as potential moderators of the relationship between sexual objectification
experiences and self-objectification. Consistent with objectification theory, in the entire sample (i.e., heterosexual and lesbian women), experiences of sexual objectification were related positively to self-objectification. In addition, sexual orientation did not moderate the link between sexual objectification experiences and self-objectification, as the relationship was similar for lesbian and heterosexual women. Although Hill’s study began to address the gap in data on the applicability of objectification theory to lesbian persons, it represented only a partial investigation of objectification theory because it did not examine key constructs such as internalization, body shame, and disordered eating symptomatology. In addition, the sample only consisted of White heterosexual women and White lesbian women; thereby limiting the generalizability of findings.

Thus, the generalizability of the propositions of objectification theory to understanding eating disorder symptomatology among lesbian women is not known and research is needed to examine the applicability of objectification theory to understanding eating disorder symptoms among a diverse sample of lesbian persons. Furthermore, such research must attend to any unique factors, not included in objectification theory, that might shape lesbian women’s experiences of eating disorder-related attitudes and behaviors. Specifically, extant scholarship has identified two variables, connection with the lesbian community and feminist ideology, as key potential factors that might be related to eating disorder-related attitudes and behaviors among lesbian persons. The following sections provide an overview of available data on eating disorder symptomatology among lesbian women and review extant literature on the links of connection with the lesbian community and feminist ideology to eating disorder-related attitudes and behaviors.
Lesbian Women and Eating Disorder Symptomatology

Findings are mixed as to whether or not lesbian women experience different levels of eating disorder symptoms and body satisfaction when compared with heterosexual women (Beren, Hayden, Wilfley, & Striegel-Moore, 1997). Some studies have revealed no significant differences between lesbian and heterosexual women on measures of body dissatisfaction and eating disorder symptoms (e.g., Brand, Rothblum, & Solomon, 1992; Heffernan, 1996; Striegel-Moore, Tucker, & Hsu, 1990). Other studies, such as Share and Mintz (2002), found that lesbian women experience lower levels of body dissatisfaction, but report similar levels of eating disorder symptoms when compared with heterosexual women. Conflicting results obtained by Siever (1994), showed that lesbian women exhibit lower rates of eating disorder symptoms but report similar levels of body dissatisfaction in comparison with heterosexual women. Finally, some research studies have demonstrated that lesbian women experience higher levels of body satisfaction and lower levels of disordered eating symptoms than heterosexual women (e.g., Herzog, Newman, Yeh, & Warshaw, 1992, Lakkis, Ricciardelli, & Williams, 1999). Examples of research supporting each of these three conflicting findings are described below.

Striegel-Moore et al. (1990) compared 30 lesbian undergraduate women with 52 heterosexual graduate women using questionnaires measuring self-esteem, body esteem, and disordered eating attitudes and behaviors, and very few group differences were found. Using MANOVA, no significant differences were found on the measures of body image satisfaction and symptoms of disordered eating. The differences that were found between the two groups were related to self-esteem, with the lesbian women reporting lower self-esteem than the heterosexual women. The researchers concluded that lesbian and heterosexual college students do not differ in terms of body esteem and eating
disorder symptoms, and that perhaps the lesbian ideology of rejecting culture’s narrowly defined beauty ideals is not enough to overcome the socialized, internalized beliefs about female beauty that women encounter.

Beren, Hayden, Wilfley, and Grilo (1996) also found no significant differences in body esteem and body dissatisfaction between heterosexual women and lesbian women. In this study, 257 participants (69 lesbian women, 72 heterosexual women, 58 gay men, and 58 heterosexual men) completed measures of body dissatisfaction, self-esteem, self-consciousness, affiliation with the lesbian/gay community, and sexual orientation. A MANOVA revealed that the lesbian and heterosexual women in this sample scored similarly on each of the body dissatisfaction measures, suggesting that identifying as a lesbian person may not be enough to overcome society’s pressure to conform to the ideal body type. Unfortunately, this study failed to include any type of measure of eating behavior, and therefore conclusions regarding eating disorder symptomatology between lesbian and heterosexual women could not be ascertained.

Share and Mintz (2002) addressed this gap in their examination of the differences between lesbian and heterosexual women on body esteem, awareness and internalization of cultural attitudes concerning thinness, disordered eating symptoms, physical condition, and sexual attractiveness. This study was based on a sample of 173 women between the ages of 24 and 52. A total of 102 (59%) participants identified as exclusively or primarily heterosexual, 63 (36%) described their sexual orientation as exclusively or primarily homosexual, and 8 (5%) reported identifying as bisexual. The participants completed the Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982) to assess for disturbed eating patterns, the Body Esteem Scale (BES; Branzoi & Shields, 1984), and
the Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ; Heinberg et al., 1995). Body mass index was also obtained and controlled as a covariate in MANCOVAs used to compare the two groups.

Statistical analyses revealed that lesbian women reported higher levels of body esteem and lower levels of internalization of cultural beauty standards, but no differences were found on levels of awareness of cultural standards, disordered eating symptomatology, or body esteem. The authors concluded that although lesbian women are equally aware of sociocultural standards of beauty, they are less likely to internalize the cultural attitudes. However, the non-significant differences in eating disorder symptomatology may be an indication that identification as a lesbian woman may not offer enough of a buffer from disturbed eating.

Siever (1994) also examined eating disorder-related attitudes and behavior in his study of 250 students from the University of Washington and Seattle Central Community College. The sample included 53 lesbian women, 59 gay men, 62 heterosexual women, and 63 heterosexual men. Participation involved responding to three versions of the Body Esteem Scale (Franzoi & Herzog, 1986, 1987; Franzoi & Shields, 1984), the Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987), Body size drawings (Stunkard, Sorensen, & Schulsinger, 1980), the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983), the Eating Attitudes Test (EAT-26; Garner et al., 1982), and a demographic questionnaire designed by the researchers. Results indicated that heterosexual and lesbian women reported similar levels of body dissatisfaction (with lesbian women slightly, but not significantly less dissatisfied), but lesbian women scored lower on the measures of eating disorder symptomatology. The author concluded that
“sociocultural factors can have an immunizing effect - lesbians, because of a decreased emphasis on physical appearance in their community, appear to be less vulnerable to the attitudes and behaviors that typify eating disorders” (p. 257).

Other studies have shown that lesbian women report lower levels of concern with weight and physical appearance, internalization of sociocultural standards of beauty, and disordered eating symptomatology, but higher levels of ideal weights and body satisfaction, than do heterosexual women (Abraham & Beumont, 1982; Strong, Williamson, Netemeyer, & Geer, 2000). An example of such findings can be found in Herzog et al.’s 1992 study. In this study, 109 unmarried women between the ages of 18 and 35 completed a demographic questionnaire, the Eating Disorders Inventory (EDI; Garner et al., 1983), and a set of 12 female figure drawings developed by Furnham and Alibhai (1983). In this task, the participants were instructed to select their current body type and their ideal body type. The results showed that lesbian women weighed significantly more than heterosexual women, desired a significantly heavier ideal weight, were less concerned with physical appearance and weight, and reported a lower drive for thinness. The authors concluded that lesbian women’s higher rates of body satisfaction and lower weight concern may be a factor in their lower rates of reported symptoms of disordered eating.

Myers, Taub, Morris, and Rothblum (1998) used a qualitative research design to search for an explanation of findings of difference versus no difference between lesbian and heterosexual women. In their telephone interviews of 18 lesbian and 2 bisexual women between the ages of 17 and 60 (mean age = 32), respondents reported either “feeling freedom from society’s norms after coming out” or still “feeling the pressure to
be thin.” This finding highlights the importance of attending to individual differences among lesbian women that shape their experiences of sexual objectification and eating disorder-related attitudes and behaviors. Extant literature on eating disorder-related attitudes and behaviors among lesbian persons has identified two factors, connection with the lesbian community and feminist ideology, as critical individual difference variables that should be examined.

**Connection with the Lesbian Community**

One explanation for the conflicting pattern of findings regarding lesbian women and eating disorder symptoms is that even though lesbian persons are exposed to the same cultural messages as all women, sexual relations with other women may encourage body acceptance and lower concern regarding appearance and weight (Beren, et al., 1997; Siever, 1994). It may be that exposure to other lesbian women decreases the opportunity to internalize sociocultural standards of beauty, subsequently contributing to higher body esteem and lower rates of disordered eating symptomatology (Share & Mintz, 2002). This lower level of internalization of sociocultural standards of beauty may be due to multiple causes. For example, the lesbian subculture may be more accepting of a variety of body types and shapes (Siever, 1994). An example of this can be found from one respondent in the Myers et al. (1998) study who stated that in general, the lesbian community is more accepting of larger women.

In their interviews with 26 lesbian, liberal arts college students, Beren et al. (1997) elicited opinions regarding lesbian beauty ideals and their sources, the experience of conflict regarding beauty in society, the need to overcome negative stereotypes as a lesbian woman, and concerns about feminist identity that may potentially influence feelings about one’s body. Results indicated that lesbian women reported a conflict
between lesbian ideology and cultural values regarding beauty, but that intimate involvement with other lesbian women positively influenced feelings about their bodies and decreased the importance of appearance. Thus, connection with others who identify as lesbian may lead to positive health outcomes such as higher body esteem and reduced symptoms of disordered eating.

Ludwig and Brownell (1999) further examined this possibility by studying the relationship between gender roles, group affiliation, and body satisfaction in a sample of 188 lesbian and bisexual women. Participants in this study were recruited through the Internet and email, and thus a wide range of ages was represented among participants. Information regarding race and ethnicity, however, was not assessed. Results indicated that lesbian persons with friends who also identified as lesbian reported a more positive body image than lesbian persons who reported having mostly heterosexual friends. Unfortunately, Ludwig and Brownell’s sample sizes were rather unbalanced in that over 80 women reported having mostly friends who were also lesbian or bisexual, and this group was compared with 27 women reporting having mostly heterosexual female friends, 15 women reporting having mostly gay or bisexual male friends, and 11 women reporting having mostly heterosexual male friends. Furthermore, body image was assessed using a single measure of body satisfaction, and information pertaining to other eating disorder-related attitudes or symptoms was not obtained. Nevertheless, these findings suggest that interaction with women of the same sexual orientation might be related to positive body image for lesbian women.

Heffernan (1996) examined directly the relationship between connection with the lesbian and gay community and eating disorder symptomatology. In this study,
questionnaires were used to examine lifestyle, disordered eating symptomatology, body esteem, attitudes about attractiveness, and self-esteem in 203 lesbian women between the ages of 17 and 65 (mean age = 34). Involvement with lesbian/gay community was assessed with the question “How involved are you in lesbian/gay activities?” Participants were asked to rate their response using a Likert-type scale. Findings indicated that the rate of bulimia nervosa among lesbian women was comparable to that of heterosexual women, but binge eating disorder was more frequent in the lesbian women sample. Lesbian women were not significantly different from heterosexual women regarding their attitudes about weight and appearance, or dieting. But among the lesbian women, higher levels of participation in lesbian and gay activities and organizations was related to lower weight concern.

Thus, between group analyses suggested overall similarity between lesbian and heterosexual women’s eating disorder-related attitudes and behaviors. Within group analyses, however, revealed that among the lesbian women in the sample, involvement in the lesbian/gay community was related to better health outcomes such as lower weight and shape concern. Heffernan (1996) concluded that connection and involvement with the lesbian/gay culture might reduce internalization of society’s thin beauty ideal. Given that Heffernan used only a single item to assess involvement in the lesbian/gay community, however, more comprehensive assessment of this important construct is needed in future research and the present study addressed this need.

**Feminist Ideology**

Feminist ideology is a second important individual difference variable that might shape lesbian women’s eating disorder-related attitudes and behaviors. Indeed, previous research has demonstrated that women’s endorsement of feminist ideology is related to
lower levels of eating disorder-related attitudes and behaviors (e.g., Dionne, Davis, Fox, & Gurevich, 1995; Snyder & Hasbrouck, 1996). For example, Dionne et al. (1995) studied the relationship between feminist attitudes and body satisfaction in a sample of 200 primarily White women between the ages of 17 and 48. Participants were volunteers solicited from the student, staff, and faculty population at a large Canadian university. The authors reported recruiting a diverse sample, but did not include descriptive information about the ethnic and racial background of the participants. Participation involved completing the Body Cathexis Scale (Secord & Jourard, 1953) to assess general body dissatisfaction, the EDI (Garner & Olmsted, 1984) to assess specific body dissatisfaction, and the Composite Feminist Ideology Scale (CFIS; Dionne, 1992) to measure the degree of support for the tenets of the women’s movement. Results revealed that women’s feminist attitudes regarding physical attractiveness (i.e., the rejection of traditional societal beauty standards) was related significantly and positively to body satisfaction.

Leavy and Adams (1986) also examined feminism and its potential link to positive health outcomes such as social support, self-esteem, and self-acceptance. Questionnaires were used to examine the relationship between feminism, self-esteem, self-acceptance, and social support in a sample of 123 women who identified as either predominantly or exclusively homosexual. The ages of participants ranged from 15 to 52 (mean age = 26), and 98% of the sample identified as White. In their study, Leavy and Adams defined feminism as having two components: “a set of beliefs about women’s rights” and “involvement in feminist activities” (p. 322). Thus, feminism was assessed through a two-component questionnaire adapted by the authors. The first component contained
seven items measuring strength of agreement with feminist beliefs concerning sex roles and political action, and one self-perception item that required participants to rate their perception of themselves as feminists. The second component of the questionnaire included an inventory of feminist activities, and respondents were required to report their level of participation on a 5-point Likert scale (from never to many times).

Statistical analysis revealed that lesbian women who reported being active in feminist organizations possessed better social support systems, higher self-esteem, and greater self-acceptance than those who did not. Feminist beliefs, however, were not correlated significantly with self-esteem, social support, or self-acceptance. These findings must be interpreted in light of the fact that participants’ endorsement of feminist beliefs was extremely positively skewed and such severe range restriction attenuates the potential observed relationship between feminist beliefs and the health related outcomes examined in this study. Nevertheless, when feminist activity was examined, lesbian women who reported being active in lesbian or feminist organizations reported having better social support systems, higher self-esteem, and greater self-acceptance than those who did not. The findings of this study suggest that involvement in feminist activities might be related to positive health outcomes in lesbian women. Thus, it is possible that this link might also generalize to eating disorder symptomatology.

Snyder and Hasbrouck (1996) examined this possibility in a study of the relationship between feminist identity development attitudes and symptoms of disturbed eating in a sample of 71 female college students between the ages of 17 and 22. In this study, the relationships between feminist identity development attitudes, gender traits, and eating disorder symptomatology were examined through the use of questionnaires.
The sample was predominantly White (95%), and the study was conducted at a middle class, liberal arts college in which research participation credit was given as compensation.

Results indicated that those women who endorsed feminist values reported less dissatisfaction with their body weight and overall size, less concern for thinness, fewer bulimic symptoms, and fewer feelings of ineffectiveness. More specifically, passive acceptance of traditional gender-role stereotypes (Feminist Identity Development Passive Acceptance scores) related positively to drive for thinness and body dissatisfaction, whereas, active commitment to a feminist ideology (Feminist Identity Development Active Commitment scores) related negatively to those same outcome measures. Although this study provided some support for the potential role of feminist ideology in reducing eating disorder attitudes and behaviors, the generalizability of these findings to lesbian women was not examined. Given that lesbian women are more likely to identify with feminism than are heterosexual women (Guille & Chrisler, 1999), however, feminist ideology may also play a significant role when examining eating disorder-related attitudes and behaviors among lesbian women.

This possibility was addressed in Guille and Chrisler’s (1999) research. In this study, 217 women were recruited from college campuses, community groups, bookstores, and lesbian support and activist groups from the Connecticut, Boston, and San Francisco areas. This sample consisted of 52 adult lesbians between the ages of 25 and 70 (mean age = 38), 56 adult heterosexual women between the ages of 25 and 84 (mean age = 37), 51 young adult lesbian women between the ages of 16 and 24 (mean age = 20) and 58
young adult heterosexual women between the ages of 15 and 24 (mean age = 19) who participated in a study of "women and body image."

Participation involved the completion of questionnaires measuring feminist identity and eating disorder symptoms. Feminist identity was assessed using the Feminist Identity Scale (FIS; Worell & Remer, 1992), which consists of four subscales: acceptance (of traditional gender roles), revelation (realization of sexism), embeddedness (immersion in female culture), and commitment (active work to improve the status of women). Eating disorder symptomatology was measured using the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979), the Compulsive Eating Scale (CES; Dunn & Ondercin, 1981), and the Three-Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985). Taken together, these last three questionnaires were used to assess attitudes and behaviors associated with bulimia and anorexia nervosa, food obsessions, beliefs regarding the ability to resist the urge to eat, dietary restraint, disinhibition (i.e., difficulty in ceasing once one has started eating), and general hunger.

The researchers used both univariate analyses and standard multiple regression to analyze the obtained data. Results indicated that lesbian women were significantly more likely to endorse feminist attitudes than were heterosexual women. That is, lesbian women scored significantly lower on the acceptance subscale and significantly higher on the commitment subscale than did the heterosexual women. In other words, lesbian women in this study were significantly more likely to report actively working to improve the status of all women than heterosexual women, and at the same time were less likely to report attitudes and behaviors associated with eating disorders. In addition, for all women, those with higher scores on the commitment subscale were less likely to restrict
their food intake than those with higher acceptance scores. Based on these findings, Guille and Chrisler posited that feminist ideology might reduce eating disorder-related attitudes and behaviors. However, the generalizability of Guille and Chrisler’s findings is unclear since the authors did not report the demographic characteristics of their sample such as race, ethnicity, and socioeconomic status. Furthermore, BMI was obtained for the sample, but since it was not controlled as a covariate in the analyses, the potential for confounding exists.

In a more comprehensive study, Bergeron and Senn (1998) examined attitudes regarding the body, awareness and internalization of sociocultural standards of beauty, and feminist self-identification with a sample of 108 lesbian and 115 heterosexual women between the ages of 18 and 58. Participants completed a demographic measure, the Body Attitude Questionnaire (BAQ; Ben-Tovim & Walker, 1991) and the Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ; Heinberg et al., 1995). Feminist identification was assessed using the question “Would you describe yourself as a feminist?” A MANOVA revealed that lesbian women reported significantly higher ideal weights, and reported feeling stronger and more fit than their heterosexual counterparts. A standard multiple regression revealed that in the entire sample, internalization and feminist identification both were unique predictors of body attitudes, above and beyond sexual orientation. No differences were found between heterosexual and lesbian women on awareness of sociocultural standards of beauty, and this variable did not predict body attitudes. For all women, internalization predicted body attitudes, and lesbian women were less likely to report internalization of sociocultural norms than heterosexual women.
A notable strength of this study is the large sample size obtained by snowball sampling. However, over 95% of the participants identified as White. Furthermore, feminist identity was assessed using only a single item and the authors did not examine directly eating disorder symptomatology. Nevertheless, these findings of Bergeron and Senn (1998) suggest the importance of examining both feminist identification and internalization when examining body attitudes.

Further evidence of the relationship between feminist ideology and eating disorder symptomatology exists in Cogan’s (1999) study of 181 lesbian and bisexual women recruited from Sacramento, California. Participants were between the ages of 17 and 58 (mean age = 34), with 88% identifying as lesbian, and 12% identifying as bisexual. In terms of ethnicity, 73% of the sample identified as White, 8% as Latina, 7% as Asian American, 6% as African American, 4% as Native American, and 2% as multiracial. Participants completed measures assessing reasons for exercise, fitness activity frequency, type, and duration, dieting behavior, body satisfaction, eating disorder symptoms, physical appearance before and after coming out, feminist self-identification, and feminist ideology. To assess for feminist self-identification, participants responded to the question “How much do you consider yourself a feminist?” and to assess for feminist ideology, participants completed the 10-item Attitudes Toward Feminism and the Woman’s Movement scale (FWM; Fassinger, 1994).

Using ANOVAs (holding BMI constant), Cogan (1999) found that when compared with a sample of heterosexual women (Cogan, Bhalla, Sefa-Dedeh, & Rothblum, 1996), these lesbian women demonstrated similar drive for thinness and body dissatisfaction. Controlling for BMI and age as covariates, it was found that those who labeled
themselves as a feminist (feminist self-identification) and endorsed feminist ideology were overall more satisfied with their bodies than those who did not. More specifically, higher levels of feminist self-identification and endorsement of feminist ideology were related to higher body satisfaction, lower rates of bulimia, drive for thinness, and weight discrepancy, and tendency to exercise for health versus aesthetic reasons. Cogan (1999) concluded that feminism might provide a means by which women can unlearn a negative body image that had been internalized by repeated exposure to thin body ideals. Unfortunately, this study did not assess for the internalization of such ideals.

Thus, extant research suggests that feminist ideology should be included in examination of disordered eating symptomatology among lesbian persons. However, since it is still unknown whether or not it is connection with the lesbian community, feminist ideology, or both that play important roles in the internalization of sociocultural standards of beauty and the manifestation of disordered eating symptoms in lesbian women, both were included in the current research. That is, this study examined both connection with the lesbian community and feminist ideology as key predictor variables in the overall objectification theory framework.

In conclusion, this study aimed to expand upon the existing objectification theory literature by providing a comprehensive examination of the framework as it applies to a diverse sample of lesbian women. The simultaneous examination of sexual objectification experiences, internalization of sociocultural standards of beauty, self-objectification manifested through body surveillance, body shame, and eating disorder symptomatology builds on prior work by Moradi et al. (2005) and provides a comprehensive test of the objectification theory framework as applied to eating disorder
symptomatology. In addition, the present research included examination of two key constructs, connection with the lesbian community and feminist ideology, that have been identified in extant literature as important factors that might shape lesbian women’s experiences of eating disorder-related attitudes and behaviors. The present study included a more comprehensive assessment of connection with the lesbian community and feminist ideology than in prior studies of these variables, thus allowing for a thorough investigation of their roles in the overall objectification theory framework.

**Hypotheses**

Based on the literature on objectification theory and extant research on eating disorder-related attitudes and behaviors with lesbian persons, the present study will test a model (See Figure 1) that includes the following hypotheses:  

1). Reported experiences of sexual objectification will be related positively to body surveillance, body shame, and eating disorder symptomatology.

2). A negative relationship will exist between feminist ideology and disconnection from the lesbian community.

3). Disconnection from the lesbian community will be related positively to internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder symptomatology.

4). Feminist ideology will be related negatively to internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder symptomatology.

5). Internalization of sociocultural standards of beauty will mediate the links of sexual objectification experiences to body surveillance, body shame, and eating disorder symptomatology (as found in Moradi et al., 2005).
6). Body surveillance will mediate the link of sexual objectification experiences to body shame (as found in Moradi et al., 2005).

7). Body shame will partially mediate the relationship between body surveillance and eating disorder symptomatology as found in previous research (Moradi et al., 2005; Noll & Fredrickson, 1998).
CHAPTER 3
METHODS

Participants

A total of 616 persons participated in this web-based, survey study (after three duplicate submissions were discarded). Of these 616 participants, 32 persons were excluded because they self-identified as a man (n = 2), heterosexual (n = 2), or bisexual (n = 28), and therefore did not meet the inclusion criteria outlined in the invitation to participate. Additional respondents were excluded from analyses due to substantial missing data (n = 17), or failure to correctly respond to at least 5 of 6 validity check items (n = 36). Two women who did not indicate sexual orientation were included in the sample because their responses to questions regarding physical attraction, emotional attraction, and sexual behaviors indicated that they were mostly or exclusively attracted to and had sex with women. Thus, the final sample used for analyses in the present study included 531 persons between the ages of 18 and 69 (M = 35.39; Mdn = 34.0; SD = 11.68) who self-identified as either exclusively (73%; n = 385) or mostly (27%; n = 144) lesbian.

Participants were from a variety of geographic locations with 94% reporting that they were currently living in the United States (n = 498) and 6% reporting that they were currently living in other countries (n = 30). Three participants did not indicate their current residence. As for the 498 participants residing in the United States, reports of states of residence indicated that 27% were living in the South (n = 136), 24% in the West (n = 117), 20% in the Midwest (n = 98), 14% in the Southwest (n = 70), 11% in the
Middle Atlantic (n = 56), and 4% in New England (n = 21) regions of the United States (regional categories derived from www.infoplease.com which divided locations in the United States according to similarities in climates, geographies, traditions, and histories). Of the 30 participants living in countries other than the United States, 37% reported living in South Korea, 27% in Canada, 10% in Australia, 10% in India, 3% in the United Kingdom, 3% in Ecuador, 3% in New Zealand, 3% in Norway, and 3% in Romania. These participants’ correct responses to validity check items indicated that they were able to read and understand the questions throughout the survey.

With regard to race/ethnicity, 77% of the sample identified as White/Caucasian, 7% as African American/Black, 5% as Hispanic/Latina, 3% as Asian American/Pacific Islander, 1% as American Indian/Native American, and 7% as multi-racial or other. Forty percent of the sample reported being married/partnered, 30% identified as single, 22% reported being in a long-term dating relationship, and 8% reported being in a casual dating relationship. In terms of highest educational degree obtained, 33% of the sample had obtained a professional degree (e.g., M.A., M.S., Ph.D., M.D.), 32% had obtained a college degree (e.g., B.A., B.S.), 30% had completed some college, and the remaining 5% had completed either a high school degree, some high school, or less than a high school degree. In terms of employment, 64% reported that they were employed full time, 21% part time, and 15% were not employed. With regard to social class, 54% identified as middle class, 27% as working class, 17% as upper middle class, 2% as lower class, and 1% as upper class; 3 participants did not indicate social class.

**Instruments**

The web survey was prepared by combining the measures described below into one large questionnaire. The order of instruments for each of the two forms of the survey and
the assignment of participants to each form was determined randomly. Due to the fact that not all measures were designed for lesbian persons specifically, two consultants who were lesbian women, and one of whom had expertise in multicultural research, reviewed, completed, and provided feedback about the survey. Following recommendations of the consultants, slight grammatical changes were made to some items in order to increase clarity. In addition, one item was adjusted slightly so that it was more appropriate for lesbian women (see description of the SOS scale below).

**Reported Sexual Objectification Experiences**

The Sexual Objectification Subscale (SOS) of Swim, Cohen, and Hyer’s (1998) measure of daily sexist events was used to assess reported experiences of unwanted and sexual objectifying behaviors and comments. The 7 SOS items reflect the objectification experiences dimension of a larger pool of items developed based on daily diaries in which college men and women reported gender-based unfair or differential treatment that they observed or experienced. Because Hill (2002) found that reported experiences of sexual objectification over the past year were significantly related to self-objectification, and to make the instructions applicable to participants who were not students, instructions for SOS items were adjusted to assess experiences over the past year (instead of past semester as originally used by Swim et al.).

Furthermore, to obtain a more thorough assessment of sexual objectification experiences, SOS items were supplemented with 6 of 18 items from Burnett’s (1995) Objectification Experiences Questionnaire (OEQ). These six items were chosen because they tapped distinct experiences of sexual objectification from those assessed by SOS items. Thus, participants reported their experiences of a total of 13 sexual objectification
events using a 5-point rating scale, ranging from 1 (never) to 5 (about two or more times a week over the past year).

Because Hill (2002) found that experiences of sexual objectification perpetrated by both men and women over the course of a year were related positively to self-objectification, SOS and OEQ item instructions were adjusted so that participants responded to each of the 13 items twice, once considering their experiences with men, and again considering their experiences with women. Sample items from the SOS include: “Had people shout sexist comments, whistle, or make catcalls at me” and “Experienced unwanted staring or ogling at myself or parts of my body when the person knew or should have known I was not interested or it was inappropriate for the situation or our relationship.” As recommended by the two consultants, the item “Had someone refer to me with a demeaning or degrading label specific to my gender (bitch, chick, bastard, faggot, etc) was adjusted to include the word “dyke” as additional example of a derogatory term. Sample items from the OEQ include: “Someone stared at your breasts while talking to you” and “Someone made offensive, sexualized gestures toward you (e.g., pantomime of masturbation or intercourse)?”

In order to examine the appropriateness of averaging across SOS and OEQ item ratings to compute an overall reported sexual objectification score, a principal components factor analysis was conducted with the 13 sexual objectification experiences perpetrated by women items (both SOS and OEQ). The scree plot and factor loadings suggested that all items loaded substantially on a single factor (item loadings: .75, .74, .74, .74, .68, .67, .66, .66, .65, .65, .61, .54, .44). Similarly, a principal components factor analysis was conducted on the 13 sexual objectification experiences perpetrated by men
items (both SOS and OEQ). Again, results of the scree plot and factor loadings suggested that items loaded substantially on a single factor (item loadings: .84, .83, .81, .80, .79, .77, .75, .71, .68, .67, .63, .56, .48). Furthermore, to examine whether sexual objectification experiences by men and women should be examined separately or could be combined, an additional principal components factor analysis was conducted with all 26 sexual objectification experiences items (i.e., SOS and OEQ items for both women and men). Factor loadings and a scree plot indicated that all items loaded substantially on a single factor (item loadings: .77, .75, .75, .74, .73, .72, .71, .69, .69, .67, .67, .66, .62, .61, .61, .61, .60, .59, .58, .56, .55, .55, .54, .50, .44, .41). Furthermore, scores on sexual objectification experiences perpetrated by women and sexual objectification experiences perpetrated by men were significantly correlated with each other ($r = .62, p < .001$) and suggested substantial overlap in these scores. Thus, SOS and OEQ items regarding sexual objectification experiences perpetrated by both men and women were combined into one scale, and an overall reported sexual objectification experiences mean score was computed for each participant.

Moradi et al. (2005) reported an alpha internal consistency reliability of .87 for SOS scores. In terms of validity, Swim et al. (2001) found that women reported more sexual objectification experiences than men, and that these along with other sexist events were related more strongly to anxiety for women than for men. However, these reported experiences of sexual objectification and other sexist events were not related to neuroticism (discriminant validity).

With regard to OEQ scores, Burnett (1995) reported alphas that ranged from .69 to .91 and test-retest reliability that ranged from .69 to .88 across a period of two to five
weeks. By conducting a factor analysis, Burnett (1995) found evidence for discriminant validity in that sexual objectification experiences were distinct from gender harassment and sexual abuse/coercion experiences. Scores on the OEQ also demonstrated convergent validity, as they were moderately to strongly related to depression (Burnett, 1995), self-objectification, body image disturbances, and disordered eating scores (Brownlow, 1997).

When the combination of SOS and OEQ items was examined, alpha internal consistency reliabilities obtained for the current sample were .93 for sexual objectification experiences perpetrated by men, .90 for sexual objectification experiences perpetrated by women, and .94 for overall reported sexual objectification experiences (used in the present study).

**Connection/Disconnection with Lesbian Community**

The Connection with the Lesbian Community subscale (CLC) of the Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2001) was used to assess connection with the lesbian community. The CLC subscale is appropriate for use in the present study in that it assesses the extent to which a lesbian woman is connected/disconnected from the larger lesbian community, and responses can demonstrate isolation from the community, or social embeddedness in the community. The CLC consists of 13 items to which participants responded using a 7-point Likert-type scale ranging from “strongly agree” to “strongly disagree.” Higher scores indicate greater disconnection from the lesbian community. Sample statements from the Connection with the Lesbian Community subscale include: “Attending lesbian events and organizations is important to me” and “I am familiar with lesbian music festivals and conferences.” Scores are computed by reverse coding the appropriate items and then obtaining a mean score.
In terms of reliability, the reported alpha for Connection/disconnection with the Lesbian Community scores was .87 (Szymanski & Chung, 2001). With regards to validity, Szymanski and Chung (2001) administered the LIHS to 303 female participants, and findings indicated that as expected, disconnection from the lesbian community correlated negatively with self-esteem ($r = -.22$, $p < .01$) and positively with loneliness ($r = .38$, $p < .01$). Also supporting the validity of CLC scores, responses to the present study’s demographic question “How connected or involved are you in the lesbian community?” were correlated significantly with CLC scores ($r = -.67$; $p < .001$). Alpha for CLC scores with the current sample was .85.

**Feminist Ideology**

The Attitudes Toward Feminism and the Women’s Movement (FWM) Scale (Fassinger, 1994) was used to assess feminist ideology. The FWM is a brief, 10-item questionnaire designed to measure agreement with feminism and the women’s movement. Participants were asked to respond to each of the 10 statements using a 5-point rating scale from 1 (strongly disagree) to 5 (strongly agree). Sample items include: “Feminist principles should be adopted everywhere” and “The leaders of the women’s movement may be extreme, but they have the right idea.” Scores are obtained by reverse coding appropriate items and then obtaining a mean, with higher scores indicating greater endorsement of feminist ideology.

To examine reliability and validity, Fassinger (1994) administered the FWM to 117 (76 women and 41 men) undergraduate psychology students at a large eastern public university. FWM score reliabilities were .90 for men, .87 for women, and .89 for the entire sample. As for validity, FWM scores demonstrated adequate convergent and discriminant validity. For example, Fassinger (1994) found that FWM scores were
independent from scores on measures of gender roles ($r = .02, p > .05$) but correlated strongly and positively with scores on four other feminism scales (correlations ranging from .68 to .79) and negatively with dogmatism ($r = -.23, p < .05$). Other evidence for validity of FWM scores exists in Enns’s (1987) study, in which convergent validity coefficients ranged from .36 (for involvement in activities associated with feminism) to .62 (for subjective identification with feminism). Enns also found discriminant validity coefficients of .23 (for gender roles) and -.24 (for dogmatism). In the current study, responses to the demographic question asking “To what extent do you describe yourself as a feminist?” were significantly correlated with FWM scores ($r = .71, p < .001$), adding further evidence of validity for FWM scores. The alpha internal consistency reliability estimate for FWM scores with the current sample was .85.

**Internalization of Sociocultural Standards of Beauty**

The Internalization subscale of the Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ; Heinberg, Thompson, & Stormer, 1995) is an 8-item, 5-point Likert-type scale that assesses acceptance of sociocultural standards of beauty. Sample items include: “Women who appear in TV shows and movies project the type of appearance that I see as my goal” and “Photographs of thin women make me wish that I were thin.” Participants responded on a scale ranging from 1 (completely disagree) to 5 (completely agree). Appropriate items were reverse coded and item ratings were then averaged with higher scores on the Internalization subscale demonstrating greater levels of internalization of sociocultural beauty standards.

In Heinberg et al.’s (1995) study of 194 female undergraduate students, Internalization scores yielded an alpha of .88. In Morry and Staska’s (2001) study, scores obtained from a sample of 89 women and 61 men produced an alpha of .85. With regards
to validity, scores on the Internalization subscale have been shown to be distinct from scores generated from awareness of sociocultural standards of beauty, but significantly and positively related to disordered eating attitudes (Griffiths, Beumont, Russell, Schotte, Thornton, Touyz, & Varano, 1999), restrained eating and body dissatisfaction (Griffiths, Mallia-Blanco, Boesenberg, Ellis, Fischer, Taylor, & Wyndham, 2000), and preoccupation with body image (Morry & Staska, 2001). Alpha with the current sample was .87.

**Body Surveillance as an Indicator of Sexual Objectification**

The Body Surveillance subscale of the Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996) was utilized to assess self-objectification, or concern with outward appearance as opposed to concern regarding how the body feels. Participants responded to eight items using a 7-point Likert-type scale, ranging from 1 (strongly disagree) to 7 (strongly agree), but NA could be selected if the item was not applicable. Following scoring instructions, appropriate items were reverse coded and “NA” responses were coded as missing. Non-missing item ratings were then averaged in order to yield a scale score, with higher scores indicating higher levels of body surveillance. The Body Surveillance subscale includes items such as “I often worry about whether the clothes I am wearing make me look good” and “During the day, I think about how I look many times.”

Scores on the Body Surveillance subscale have demonstrated adequate reliability. In their sample of both young and middle-aged women, McKinley and Hyde (1996) found alpha internal consistency reliability estimates ranging from .76 to .89. Furthermore, a two-week test-retest was conducted, producing a reliability coefficient of .79. In their sample of over 200 women, Moradi et al. (2005) reported an alpha of .82. In
terms of validity, consistent with objectification theory, women have been found to score higher than men on Body Surveillance (McKinley, 1998). In addition, in a factor analysis, Body Surveillance emerged as a construct that was distinct from other factors such as body shame, although as expected, it was correlated positively with body shame and negatively with body esteem (McKinley, 1998). Alpha internal consistency reliability estimate with the current sample was .86.

**Body Shame**

Body shame was measured using the Body Shame Subscale of the Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996). This 8-item subscale assesses guilt and negative feelings as a result of failing to live up to perceived cultural standards. For example, one item reads: “When I can’t control my weight, I feel like something must be wrong with me.” Participants responded using a 7-point Likert-type scale, ranging from 1 (strongly disagree) to 7 (strongly agree), but NA could be selected if the item was not applicable. Following scoring instructions, appropriate items were reversed coded and “NA” responses were coded as missing. Non-missing items were then averaged to produce a scale score in which higher scores indicate higher levels of body shame.

OBC Body Shame subscale scores have demonstrated adequate reliability. Across a sample of young and middle-aged women, alpha internal consistency estimates ranged from .70 to .84 (McKinley & Hyde, 1996; McKinley, 1998). Moradi et al. (2005) found an alpha estimate of .81. In terms of validity, as expected, Body Shame scores have been shown to be correlated with but have emerged as a distinct factor from control beliefs and body surveillance (McKinley & Hyde, 1996). McKinley (1998) found that scores on the
Body Shame subscale correlated negatively with body esteem and positively with body surveillance. Alpha with the current sample was .87.

Eating Disorder Symptomatology

The Eating Attitudes Test-26 (EAT-26; Garner, 1997; Garner, Olmsted, Bohr, & Garfinkel, 1982) consists of 26 questions designed to assess dieting behaviors, bulimia and food preoccupation, and oral control. The EAT-26 was selected because of its ability to assess the continuum of disturbed eating attitudes and behaviors. This follows the recommendation of Kashubeck-West, Mintz, and Saunders (2001) to examine the broad range of eating attitudes and behaviors. Participants indicated the frequency of such attitudes and behaviors using a 6-point, Likert-type scale ranging from 1 (never) to 6 (always). As recommended by Garner (1997), ratings of each of the items were then weighted from zero to three, with a score of three signifying the most symptomatic responses. Total EAT scores were then obtained by summing all of the weighted item scores. The minimum score that can be obtained on the EAT-26 is 0, and the maximum is 78, with higher scores indicating greater eating disorder symptomatology.

Scores on the EAT-26 have demonstrated good reliability and validity, yielding Cronbach’s alphas ranging from .90 to .93 (Share & Mintz, 2002). Kashubeck-West et al. (2001) reported alphas ranging from .79 to .94 across samples. In terms of validity, scores on the EAT-26 are related to scores on other measures of eating disorder and the EAT-26 has been used to distinguish between clinical and non-clinical groups.cáGeneration Model's output is based on the assumption that the document contains text related to eating disorders and their assessment through the EAT-26 test. The text discusses the EAT-26's ability to assess a broad range of eating attitudes and behaviors, and its reliability and validity as measured by Cronbach’s alphas and correlations with other measures. The text also notes that higher scores on the EAT-26 indicate greater eating disorder symptomatology.
clinical groups (Kashubeck-West et al., 2001). Alpha for EAT-26 scores in the current sample was .86.

**Demographics**

Participants were asked to report several personal characteristics including age, height and weight (used to compute body mass index), race/ethnicity, relationship status, employment status, income, educational level, and social class. Sexual orientation was assessed utilizing a Kinsey-type scale ranging from 1 (exclusively lesbian) to 5 (exclusively heterosexual). To provide a more thorough assessment of sexual orientation, participants were also asked to rate on a scale of 1 (low) to 5 (high) their physical and emotional attraction to both members of the same and opposite sex. They were also asked a question regarding sexual behavior in which they indicated whether their sexual interactions were with their same gender only, same gender mostly, both genders equally, other gender mostly, or other gender only. They could also select “never had sex” if appropriate.

The demographic questionnaire also included an item assessing degree of connection with the lesbian community. The item read: “How connected or involved are you in the lesbian community?” Participants responded using a 5-point Likert scale ranging from 1 (not involved) to 5 (very involved). A single item was included to assess feminist self-identification. Participants responded to the question “To what extent do you describe yourself as a feminist?” by using a 9-point Likert scale ranging from 0 (not at all) to 9 (very much a feminist), as used by Cogan (1999). These items were used as further validity checks for CLC and FWM scores.
Procedure

Participants were recruited through personal contacts, lesbian and/or women’s organizations and internet listserves. Advertisements for the study were sent to 116 listserves that were selected due to their ability to reach lesbian women throughout the United States. These listserves included national organizations such as the Gay and Lesbian National Hotline, the National Coalition for LGBT health, and the Gay, Lesbian, Straight Education Network (GLSEN). In addition, advertisements were sent out through listserves of numerous lesbian and gay college organizations. Participants also were recruited by sending email advertisements about the study to Yahoo and MSN groups for lesbian and gay persons. Listserves that were not used for promotion of the study included those that were designated for men, heterosexual or bisexual women, non-English speaking women, and lesbian women under the age of 18. Flyers promoting the study also were posted in the Gainesville, Florida community to promote the study. These advertisements described the purpose of the research, and highlighted the need for diversity in terms of age, race/ethnicity, and level of “outness” in the sample. The principal investigator attended club meetings, organizations, events, and other activities targeted for the lesbian community to further advertise the study.

Participation involved completing a series of questionnaires online via a website designed by the researcher. Although internet methodology can limit participation to individuals who have access to a computer and the internet, it has a number of benefits for recruiting large samples of lesbian or gay participants. More specifically, in the present study, a web-based survey was selected because it provides greater anonymity for lesbian participants. Maximizing anonymity and reducing interpersonal threat is particularly important for recruiting individuals who are not “out” about their sexual
orientation and might not feel comfortable with participating in-person in a study about
lesbian or gay persons. Furthermore, the convenience of completing a survey online
(participants could log on to the website from any computer with an internet connection)
facilitated the recruitment of a larger and more diverse sample in terms of age and
geographic location.

When participants connected to the website, they were first shown an informed
consent page that described the purpose of the study, discussed issues of confidentiality,
informed respondents that they could stop filling out the survey at any time without
penalty, and provided contact information to participants who had questions or comments
about the study. After reading the informed consent information, participants clicked a
link stating: “Click here to proceed” to indicate that they had read and understood the
informed consent document. Clicking the button at the bottom of the screen brought
participants to one of two forms of the survey to be completed (the measures were
counterbalanced into two different forms in order to control for order effects).
Throughout the survey, participants encountered six validity check items that asked them
to choose a certain response. For example, one item read: “Please select Strongly Agree.”
This procedure was used to help identify random responding and to provide some
indication that participants read and understood the questions. Upon completing the
survey, participants received information about how to contact the researcher if they had
any questions or concerns. They also received information for national support networks
for eating disorders and lesbian women.

**Statistical Analyses**

As mentioned previously, data from those who identified as a man, bisexual, or
heterosexual, as well as those who did not respond to substantial portions of the survey,
were excluded from analyses, resulting in a final sample size of 531 for the present analyses. Body Mass Index was computed by calculating weight/height\(^2\) and was entered as a covariate in analyses. This is consistent with previous research, as BMI has been considered a potential confounding variable (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998).

Reliability coefficients were calculated (and reported in the Instruments section) for all measures before testing the overall path model. Partial-correlations, controlling for BMI, were computed to examine the intercorrelations among the variables of interest. Finally, all direct and indirect relations among variables of interest, depicted in Figure 1, were examined by conducting a path analysis using AMOS, Version 5.0 (Arbuckle, 2003), a program designed specifically for structural equation modeling. The path analysis provided the strengths of all unique links among the variables of interest, with BMI controlled.

To test proposed mediator effects, guidelines outlined by Baron and Kenny were followed (1986). According to Baron and Kenny, a mediator functions as such if it accounts for all or some of the relationship between the predictor variable and the criterion variable. More specifically, for a variable to be considered a mediator, significant relationships must exist between (a) the predictor and the mediator, (b) the mediator and the criterion, and (c) the predictor and criterion. If these preconditions are satisfied, mediation is significant if the mediator accounts for a significant amount of the predictor-criterion relationship. To test for the significance of mediations, Sobel’s formula (1982) was used (Baron & Kenny, 1986; Frazier, Tix, & Barron, 2004).
CHAPTER 4
RESULTS

Descriptive Statistics

The mean body mass index for the present sample was 29.04 (SD = 7.96) which
was comparable to Heffernan’s (1996) obtained mean of 26.98 (SD = 6.82) in a sample
of 203 lesbian women. Levels of sexual objectification experiences, feminist ideology,
disconnection from the lesbian community, internalization of sociocultural standards of
beauty, body surveillance, body shame, and eating disorder symptomatology for the
current sample were generally close to the mid range of possible scores for each measure
(see Table 1). Furthermore, the present samples’ scores on variables of interest were
comparable to those from studies that used the same instruments with similar samples of
women. More specifically, the current sample’s means and standard deviations for
feminist ideology ($M = 3.92, SD = .57$), disconnection from the lesbian community ($M =
2.45, SD = .94$), internalization ($M = 2.13, SD = .90$), body surveillance ($M = 4.01, SD =
1.27$), body shame ($M = 3.12, SD = 1.38$), and eating disorder symptomatology ($M =
7.54, SD = 8.37$) were comparable to those reported by Fassinger (1994) for feminist
ideology scores in a sample of 117 female and male college students ($M = 3.52, SD =
.66$), Szymanski and Chung (2003) for disconnection from the lesbian community scores
in sample of 210 lesbian and bisexual women ($M = 2.36, SD = .91$), Bergeron and Senn
(1998) for internalization scores in a sample of 108 lesbian women ($M = 2.17, SD = .69$),
Hill (2001) for body surveillance scores in a sample of 134 lesbian women ($M = 4.12, SD
= 1.19$), McKinley and Hyde (1996) for body shame scores in a sample of 108
undergraduate women ($M = 3.25, SD = 1.04$), and Strong et al. (2001) for eating disorder symptoms in a sample of 82 lesbian women ($M = 7.74, SD = 9.59$). Because the sexual objectification experiences measure used in the present study was a combination of previously used scales, the present samples’ scores on sexual objectification experiences ($M = 1.72, SD = .63$) could not be compared to that of prior samples.

To test for order effects across the two orders of the survey, a MANOVA was conducted with survey order as the independent variable and the variables of interest (i.e., BMI, sexual objectification experiences, feminist ideology, disconnection from the lesbian community, internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder symptomatology) as the dependent variables. A small, but significant overall effect was found ($F[1, 530] = 1.99, p < .05, \eta_p^2 = .03$) but the only significant univariate effect was a difference between the two groups on reported experiences of sexual objectification ($F[1, 530] = 4.10, p < .05, \eta_p^2 = .008$). Given that survey order accounted for less than 1% of variance in sexual objectification scores and did not result in a significant difference in any of the other seven variables of interest, survey order was not deemed to be problematic.

**Intercorrelations among Variables of Interest**

Partial correlations, controlling for BMI, were computed to test the relations among variables of interest and evaluate whether pre-conditions for mediation were met (see Table 1). Consistent with Hypothesis 1, after controlling for BMI, reported experiences of sexual objectification were correlated positively with body surveillance ($r = .22, p < .001$), body shame ($r = .19, p < .001$), and eating disorder symptomatology ($r = .17, p < .001$). In addition, consistent with Hypothesis 2, after controlling for BMI, a negative
correlation existed between feminist ideology and disconnection from the lesbian community \((r = -.33, p < .001)\). After controlling for BMI, Hypothesis 3 also was supported, as indicated by significant positive correlations between disconnection with the lesbian community and internalization of sociocultural standards of beauty \((r = .14, p = .001)\), body surveillance \((r = .14, p = .001)\), body shame \((r = .17, p < .001)\), and eating disorder symptoms \((r = .09, p < .05)\). Hypothesis 4 was only partially supported; with BMI controlled, feminist ideology was not significantly correlated to internalization, body shame, and eating disorder symptoms, but was significantly and negatively correlated to body surveillance \((r = -.10, p < .05)\).

**Mediations**

To test the mediations proposed in Hypotheses 5, 6, and 7, Baron and Kenny’s (1986) procedures were followed. According to these authors, for a variable to be considered as a mediator, significant relations must exist between (a) the predictor and the mediator, (b) the mediator and the criterion, and (c) the predictor and criterion. These preconditions were satisfied for Hypotheses 5, 6, and 7 (see Table 1 for partial-correlations). That is, for Hypothesis 5, reported experiences of sexual objectification (predictor) were correlated significantly with internalization (potential mediator), which in turn was correlated significantly with body surveillance, body shame, and eating disorder symptomatology (criterion variables). In addition, reported sexual objectification experiences (predictor) were correlated significantly with body surveillance, body shame, and eating disorder symptomatology (criterion variables). With regard to Hypothesis 6, reported sexual objectification experiences (predictor) were significantly related to body surveillance (potential mediator), which in turn was significantly related to body shame (criterion). Reported sexual objectification experiences (predictor) were also significantly
related to body shame (criterion). For Hypothesis 7, body surveillance (predictor) was correlated significantly with body shame (potential mediator), and body shame was correlated significantly with eating disorder symptomatology (criterion). Body surveillance (predictor) was also significantly correlated with eating disorder symptomatology (criterion).

According to Baron and Kenny (1986), if these conditions are satisfied, a variable acts as a mediator to the extent that it accounts for the relationship between the predictor and criterion variable(s). In order to test the significance of mediations, Amos 5.0 (Arbuckle, 2003) was used to conduct a path analysis of a fully saturated model in which all direct and indirect paths were estimated (see the model presented in Figure 1). Again, body mass index was entered as a covariate in the model. Maximum likelihood estimation was utilized with the covariance matrix of the variables of interest as input. Given that the model tested was fully saturated, values for the Goodness of Fit Index (GFI), Incremental Fit Index (IFI), Comparative Fit Index (CFI), and the Normed Fit Index (NFI) were all 1.0. The overall model account for 45% of the variance in body shame, 38% of the variance in eating disorder symptoms, 32% of the variance in body surveillance, and 5% of the variance in internalization of sociocultural standards of beauty. As indicated in Figure 2, most standardized path coefficients were significant, indicating significant unique direct links. Significant unique direct links did not emerge, however, from feminist ideology to internalization, body surveillance, and eating disorder symptomatology; from disconnection from the lesbian community to body surveillance and eating disorder symptomatology; and from reported sexual objectification experiences to body shame and eating disorder symptomatology. The only unique link that
was in the unexpected direction was the significant, albeit small (.07, \( p < .05 \)) positive unique link between feminist ideology and body shame (with BMI and other exogenous variables controlled).

To test the significance of mediations through internalization of sociocultural beauty standards, body surveillance, and body shame (the proposed mediators), appropriate standardized path coefficients were multiplied to compute indirect effects, a procedure recommended by Cohen and Cohen (1983). Next, Sobel’s formula (1982) was used to determine whether or not the indirect effects were significantly different from zero. Hypothesis 5 proposed that internalization of sociocultural standards of beauty would mediate the links of sexual objectification experiences to body surveillance, body shame, and eating disorder symptomatology (as found in Moradi et al., 2005). Consistent with this hypothesis, through internalization of sociocultural standards of beauty, reported experiences of sexual objectification had a significant indirect link of .08 (.15 x .52; \( z = 3.41; p < .001 \)) to body surveillance, .05 (.15 x .31; \( z = 3.21, p < .01 \)) to body shame, and .02 (.15 x .14; \( z = 2.31, p < .05 \)) to eating disorder symptomatology. In addition to these significant indirect relations, reported experiences of sexual objectification also had a significant direct link to body surveillance, but not to body shame or eating disorder symptoms. Therefore, consistent with Hypothesis 5, internalization of sociocultural beauty standards partially mediated the link between reported sexual objectification experiences and body surveillance, and fully mediated the links of reported sexual objectification experiences to body shame and eating disorder symptomatology.

Hypothesis 6 proposed that body surveillance would mediate the link of sexual objectification experiences to body shame (as found in Moradi et al., 2005). Consistent
with this hypothesis, through body surveillance, a significant indirect link of .05 (.13 x .38; z = 3.31, p < .001) was obtained between reported sexual objectification experiences and body shame. Because no significant direct link existed between reported sexual objectification experiences and body shame, body surveillance acted as a full mediator of this link, supporting Hypothesis 6.

Hypothesis 7 proposed that body shame would partially mediate the relationship between body surveillance and eating disorder symptomatology as found in previous research (Moradi et al., 2005; Noll & Fredrickson, 1998). Consistent with this hypothesis, through body shame, a significant indirect link of .13 (.38 x .34; z = 5.84, p < .001) was found between body surveillance and eating disorder symptomatology. Because there was also a direct relationship between body surveillance and eating disorder symptomatology, body shame acted as a partial mediator. Thus, Hypothesis 7 was supported.

Finally, the fully saturated model was compared to an alternative trimmed model that eliminated the non-significant direct paths (a) from feminist ideology to internalization, body surveillance, and eating disorder symptoms, (b) from disconnection from the lesbian community to body surveillance and eating disorder symptomatology, and (c) from reported sexual objectification experiences to body shame and eating disorder symptoms. The goodness of fit indices for this model were above the acceptable cut offs and nearly identical to those obtained from the original model (GFI = .99; IFI = .99; CFI = .99; NFI = .99). The trimmed model explained 45% of the variance in body shame, 38% of the variance in eating disorder symptomatology, 31% of the variance in body surveillance, and 5% of the variance in internalization of sociocultural standards of
beauty. The variance accounted for by the trimmed model was the same as that accounted for in the fully saturated model, except for variance accounted for in body surveillance, which dropped from 32% to 31%. In addition, the magnitude of path coefficients was comparable across the two models. Thus, compared with the fully saturated model, the trimmed model appears to be more parsimonious but equally appropriate in explaining the relationships among the variables of interest.
CHAPTER 5
DISCUSSION

Objectification theory (Fredrickson & Roberts, 1997) and empirical investigations of its tenets point to the importance of sexual objectification experiences, self-objectification (manifested as body surveillance), and body shame as predictors of women’s eating disorder symptomatology. In addition, Moradi et al.’s (2005) findings highlighted the role of internalization of sociocultural standards of beauty in the objectification theory framework. The present study was the first to examine the objectification theory framework and the additional role of internalization of sociocultural standards of beauty in eating disorder symptomatology with a large sample of lesbian women. Furthermore, in the context of objectification theory, this study examined the roles of feminist ideology and connection/disconnection from the lesbian community, each of which has been identified as a key predictor of eating disorder symptoms among lesbian persons.

Overall, findings of the present study suggested that relations outlined in objectification theory and supported in prior tests of objectification theory with heterosexual women are also supported with lesbian women. More specifically, consistent with objectification theory’s conceptualization of the role of sexual objectification experiences in eating disorder symptoms and their precursors, in the present study, partial correlations (with BMI controlled) indicated that reported sexual objectification experiences were significantly and positively related to body surveillance, body shame, and eating disorder symptomatology. Furthermore, results of the path
analysis suggested that sexual objectification experiences were related positively and uniquely to internalization of sociocultural beauty standards and body surveillance when feminist ideology, disconnection from the lesbian community, and BMI were accounted for. In addition, internalization of sociocultural standards of beauty partially mediated the links of sexual objectification experiences to body surveillance, body shame, and eating disorder symptomatology, suggesting that through internalization, reported experiences of sexual objectification might be translated into body surveillance, body shame, and eating disorder symptoms. These findings are consistent with previous research (Moradi et al., 2005; Morry & Staska, 2001) with heterosexual women and further highlight the importance of including both sexual objectification experiences and internalization of sociocultural standards of beauty when investigating the tenets of objectification theory.

Also consistent with prior tests of objectification theory, (e.g., Moradi et al., 2005), the current findings supported body surveillance as a full mediator of the relation between sexual objectification experiences and body shame. Thus, it appears that body surveillance might be a key mechanism through which sexually objectifying experiences are translated into body shame. In addition, body shame acted as a partial mediator in the link of body surveillance to eating disorder symptomatology, supporting the findings of extant literature (Greenleaf, 2005; Moradi et al., 2005, Noll & Fredrickson, 1998) and suggesting that chronic body monitoring might be translated into eating disorder symptomatology by promoting body shame. Taken together, these findings support the generalizeability and potential utility of the objectification theory framework as applied to understanding eating disorder symptomatology among lesbian women. Indeed, the
overall path model examined in the present study explained 38% of the variance of eating disorder symptoms in this sample of 531 lesbian women.

In addition to extending research on objectification theory to lesbian women, the present study integrated the previously highlighted potential roles of feminist ideology and connection/disconnection from the lesbian community in its examination of objectification theory. Consistent with previous findings (Syzmanski & Chung, 2003), present results indicated that feminist ideology and disconnection from the lesbian community were significantly and negatively correlated with one another (with BMI controlled). Furthermore, as hypothesized, disconnection from the lesbian community was significantly and positively related to internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder symptomatology. In other words, disconnection from the lesbian community was correlated with greater levels of eating disorder symptoms and their correlates for lesbian women. This finding supports extant literature in which interaction and involvement with other lesbian women has been found to be related to positive health outcomes such as higher body esteem, higher body image, lower weight concern, and lower levels of eating disorder symptoms (Beren et al., 1997; Heffernan, 1996; Ludwig & Brownell, 1999).

In terms of feminist ideology as a predictor variable, partial correlations (with BMI controlled) revealed only one significant, but negative relationship between feminist ideology and body surveillance. Thus, it seems that endorsing feminist ideology may be related to lower levels of body monitoring. Interestingly, a partial correlation (with BMI controlled) indicated no relationship between feminist ideology and body shame; however, when feminist ideology was considered in the context of disconnection from
the lesbian community via the path analysis, feminist ideology was significantly and
positively related to body shame. Although this relationship was very small (.07; p < .05),
it may be that the positive health outcomes associated with feminist ideology as found in
previous literature (e.g., Leavy & Adams, 1986) are accounted for largely by overlap
with connection with the lesbian community. Indeed, the present results indicated that
compared with feminist ideology, disconnection from the lesbian community was a
stronger and more consistent correlate of eating disorder constructs included in the
model, as evidenced by the pattern of partial correlations (with BMI controlled) and path
coefficients between disconnection with the lesbian community versus feminist ideology
and the four outcome variables.

The small but positive relation that emerged between feminist ideology and body
shame, when connection/disconnection from the lesbian community, sexual
objectification experiences, and BMI were accounted for, might be interpreted in light of
a study conducted by Eliason and Morgan (1998), in which lesbian women were asked to
define what it meant to be a lesbian. Those who gave political definitions (e.g., “woman
identification,” “affiliation with other oppressed groups”) were more likely to identify
themselves as feminist and get involved in political activities promoting lesbian women,
but at the same time, were significantly more likely to have a history of eating disorders
than those who gave non-political answers (e.g., “sex/love with women,” “lesbianism as
one small aspect of a person”). Interpreted in light of the present findings and prior
research on feminist ideology and connection/disconnection from the lesbian community,
Eliason and Morgan’s findings suggest an interesting possibility. When considered
separately, connection with the lesbian community and feminist ideology each are related
to lower levels of eating disorder-related variables. However, lesbian women who have an integrated lesbian and feminist political identity may have experienced greater levels of eating disorder symptoms in the past and possibly also experience greater body shame. It may be that under some conditions, eating disorder symptoms become so detrimental that some lesbian women turn to the rejection of society’s beauty standards through increasing their endorsement of feminist principles and by becoming more connected with the lesbian community. This causal hypothesis is speculative, and longitudinal research is needed to ascertain the direction of relations between connection/disconnection with the lesbian community, feminist ideology, and eating disorder symptomatology.

**Limitations**

The present findings must be interpreted in light of a number of limitations. First, the present data were collected using an online, self-report survey in which participation was voluntary. As such, the stigma associated with eating disorder-related attitudes and behaviors may have limited participation from those experiencing high levels of such symptoms. Although scores from this sample are similar to those obtained in other nonclinical samples of lesbian women, the generalizability of the present findings are limited to nonclinical lesbian populations. To address this limitation, future research is needed to test the tenets of objectification theory with samples of lesbian women who are experiencing clinically significant levels of eating disorder symptomatology.

Another potential limitation of the present study (that is shared by any study that explicitly recruits lesbian and gay participants) is that the majority of participants might be “out” about their sexual orientation and so at least somewhat comfortable with participating in a study about lesbian persons. Because “outness” is an individual
difference variable that may inhibit some individuals from participating in a study advertised for lesbian women, the present sample may not capture the experiences of lesbian women who are less “out” about their sexual orientation. As such, the participants in the present study may have been more connected to the lesbian community. Because current findings indicated that disconnection from the lesbian community was related to internalization of sociocultural standards of beauty, body surveillance, body shame, and eating disorder symptomatology, it may be that lesbian women who are less out and more disconnected from the lesbian community might be at greater risk for eating disorder attitudes and behaviors. The current sample obtained scores that were around the midrange for connection/disconnection with the lesbian community. Therefore, future studies should attend to the experiences of lesbian women who are less “out” and more disconnected from the lesbian community than those in the current sample.

A third potential limitation is that even though the survey included validity check items to ensure that participants understood the survey instructions and items, there was no way to ensure that the respondents actually met the participation requirements. This limitation is inherent in all volunteer, self-report studies (online or in person) and for the present study; however, the benefits of the online survey (e.g., facilitating participation of less out participants, larger sample size) outweighed the costs. With such a large sample size, it is unlikely that any submissions from those who failed to meet participation criteria would substantially skew results, but findings should still be interpreted with this limitation in mind.

A fourth potential limitation is that although the present sample was diverse in terms of age and geographical location, respondents were predominantly Caucasian and
well-educated. This imbalance, which has occurred within other lesbian samples (e.g., Bergeron & Senn, 1998; Hill, 2002), limits the generalizability of findings to Caucasian lesbian women with at least a college education. To address this limitation, future research is needed to develop and evaluate recruitment strategies designed to increase representation of racial/ethnic minority lesbian women as well as lower and working class lesbian women.

A final potential limitation, which is shared in much of the eating disorder research, is that there was no way to ensure that self-reports of weight and height were accurate. However, prior evidence exists that self-report information for BMI are comparable to actually measured information (e.g., Koslowsky, Scheinberg, & Bleich, 1994; Tienboon, Wahlqvist, & Rutishauser, 1992). In addition, as one participant addressed in a feedback email, medical conditions that may affect BMI (e.g., diabetes, hypoglycemia) were not assessed. In general, participants’ health backgrounds are not assessed in eating disorder research, and future studies could address this potential confound by including a brief medical history measure in the questionnaire. Despite these limitations, the present findings can inform research and practice in a number of important ways.

**Directions for Future Research**

Findings from the current study can be used to inform future research conducted on objectification theory with lesbian persons. More specifically, findings indicate that it is important to include sexual objectification experiences, internalization of sociocultural standards of beauty, body surveillance, and body shame as key predictors of eating disorder symptomatology with this population. Furthermore, the present findings suggest that connection/disconnection from the lesbian community is an important variable to consider in applications of objectification theory to lesbian women. Indeed,
A critical direction for future research is to further examine the temporal links between lesbian feminist ideology and eating disorder symptomatology. More specifically, longitudinal research is needed to expand upon Eliason and Morgan’s (1998) findings and identify the exact role of lesbian feminist ideology as it relates to involvement in political activities and both past and present eating disorder symptoms. Furthermore, future research is needed to understand the nature of the relations between feminist ideology and eating disorder-related attitudes and behaviors in the context of connection/disconnection with the lesbian community. The present study focused on feminist ideology as a potential predictor variable in the model and found that links of feminist ideology to eating disorder constructs were generally nonsignificant when BMI and connection/disconnection from the lesbian community were accounted for. An additional possibility that is worth exploring in future research is that feminist ideology might act as a moderator variable, affecting the relations of connection with the lesbian community with internalization of sociocultural standards of beauty and body shame. That is, for lesbian women who are disconnected from the lesbian community, feminist ideology may be related to lower levels of eating disorder-related constructs. For lesbian women who are highly connected to the lesbian community, feminist ideology may be related to greater levels of eating disorder-related constructs. Eliason and Morgan’s findings are consistent with such a possibility, if past eating disorder symptoms are
considered. Future research is needed that will test the potential interaction effect between connection with the lesbian community and feminist ideology in relation to past and present eating disorder symptomatology for lesbian women.

Another important area for further investigation is to explore what aspects of lesbian identity and community might be related to lower eating disorder-related attitudes and behaviors. For example, Kaminski (2000) conducted 19 interviews with lesbian women about their identity and health, and found that, compared to those who experienced their environments to be hostile, homophobic, or conservative, participants who perceived their environment to be supportive were more likely to adopt feminist principles and were more likely to experience positive health outcomes such as greater self-acceptance and reduced anxiety, depression, and substance abuse. Thus, it seems that perceived social support, which may be obtained through connection with the lesbian community, could be an important factor to consider when examining predictors of health-related concerns such as eating disorders among lesbian women. Clearly, future research is needed to tease apart aspects of connection/disconnection from the lesbian community such as feminist self-identification, feminist ideology, and social support that might play a role in the promotion of health and reduction of eating disorder and other symptomatology for lesbian (and other) women.

**Implications for Practice**

In addition to informing future research, findings from the current study can also be used to inform counselors’ and clinicians’ efforts to reduce eating disorder-related attitudes and behaviors among lesbian women. Findings from the current study and previous research with heterosexual women (e.g., Moradi, 2005) support tenets of the objectification theory framework, and it would be beneficial for mental health
professionals to provide appropriate education regarding objectification theory so that both heterosexual women and lesbian women can recognize sexual objectification experiences as they occur. More specifically, findings from the current study indicate that sexual objectification experiences are related to internalization of sociocultural beauty standards and body surveillance, both of which are related to eating disorder symptomatology. These correlational findings provide the groundwork for testing the directions of causality implied in objectification theory among these variables. If such causality is supported, learning to identify sexual objectification experiences when they occur may be beneficial for women because they can then actively work against internalizing societal beauty standards, become aware of daily chronic body monitoring, work towards reducing feelings of shame regarding their bodies, and thus, lower their risk of developing eating disorder symptomatology.

Strategies specific to lesbian women might include the development of a workshop in which counselors and clinicians can educate lesbian women regarding the potential benefits of connection with the lesbian community, reduction of the internalization of sociocultural standards of beauty, and prevention of body shame. Together, lesbian women can discuss their perceptions of the lesbian community, identify cultural beauty standards, develop strategies to actively work against endorsing such standards, identify goals to reduce body monitoring, and promote positive attitudes toward their bodies. Based on extant literature (e.g., Kaminski, 2000) as well as findings from the present study, such association and interaction with other lesbian women may lead to positive health outcomes. The present cross-sectional findings provide the groundwork for
exploring whether such interventions would result in reducing the risk for eating disorder symptomatology among lesbian women.

As for individual therapy, it may be beneficial for mental health professionals to adopt treatment strategies for their lesbian clients that include providing education regarding society’s current standards of beauty (specifically those associated with lesbian women and beauty), promoting acceptance of one’s physical appearance, and encouraging increased connection with the lesbian community. Future research regarding the exact role of feminist ideology is needed to ascertain whether or not therapy should include the provision of education and support regarding the development of feminist ideology. It is important to note that these therapeutic strategies have the potential to help heterosexual women as well. Future research is needed that will address the potential benefits of connection with the lesbian community for heterosexual women of all ages and backgrounds.

**Summary**

Overall, findings of the present study supported the applicability of the tenets of objectification theory to understanding eating disorder symptomatology of lesbian women. The present findings also pointed to the importance of considering the role of connection with the lesbian community when investigating eating disorder symptomatology with lesbian women, but also raised questions about the unique role of feminist ideology beyond connection with the lesbian community. Finally, the present findings lay the groundwork for examining the objectification theory framework with more diverse samples of lesbian women, exploring longitudinal links between sexual objectification experiences, connection with the lesbian community, feminist ideology,
and the predictors of eating disorder symptoms, and using experimental designs to begin to elucidate potential causal relations between variables in the model.
APPENDIX A
THE SEXUAL OBJECTIFICATION SUBSCALE

Please use the following scale to indicate how often during the past year you have experienced each of the events below. For each item, respond once considering your experiences with men and respond again considering your experiences with women.

1. Never
2. About once during the past year
3. About once a month during the past year
4. About once a week during the past year
5. About two or more times per week during past year

<table>
<thead>
<tr>
<th>Event</th>
<th>Scale for Men</th>
<th>Scale for Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had people shout sexist comments, whistle, or make catcalls at me.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Had someone refer to me with a demeaning or degrading label specific to my gender (bitch, chick, dyke, bastard, faggot, etc).</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Had sexist comments made about parts of my body or clothing.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Heard someone make comments about sexual behavior I might do or things they would want to do with me.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Someone did or said something that made me feel threatened sexually.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Experienced unwanted staring or ogling at myself or parts of my body when the person knew or should have known I was not interested or it was inappropriate for the situation or our relationship.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
8. Experienced unwanted flirting when the person knew or should have known I was not interested or it was inappropriate for the situation or our relationship.

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<thead>
<tr>
<th></th>
<th>By men</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

<table>
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<tr>
<th></th>
<th>By women</th>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
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APPENDIX B
OBJECTIFICATION EXPERIENCES QUESTIONNAIRE

Please use the following scale to indicate how often during the past year you have experienced each of the events below. For each item, respond once considering your experiences with men and respond again considering your experiences with women.

1. Never
2. About once during the past year
3. About once a month during the past year
4. About once a week during the past year
5. About two or more times per week during past year

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</thead>
<tbody>
<tr>
<td>1. Been &quot;checked out&quot; (i.e., had your body stared at in an intrusive way) by a person in public.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Your appearance/body commented on in a way that you felt was inappropriate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Your romantic partner (current or former) &quot;checked out&quot; other women in your presence.</td>
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<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Someone stared at your breasts while talking to you.</td>
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</tr>
<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Someone made offensive, sexualized gestures toward you (e.g., pantomime of masturbation or intercourse)?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Felt that a date was more interested in your body (and gaining access to it) than in you as a person.</td>
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<tr>
<td></td>
<td>By men</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>By women</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
APPENDIX C
THE SOCIOCULTURAL ATTITUDES TOWARD APPEARANCE
INTERNALIZATION SUBSCALE (SATAQ)

Please read each of the following items and select the number that best reflects your agreement with the statement.

1. = completely disagree
2. = somewhat disagree
3. = neither agree nor disagree
4. = somewhat agree
5. = completely agree

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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Women who appear in TV shows and movies project the type of appearance that I see as my goal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I believe that clothes look better on thin models.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Music videos that show thin women make me wish that I were thin.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I do not wish to look like the models in the magazines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I tend to compare my body to people in magazines and on TV.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>Photographs of thin women make me wish that I were thin.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I wish I looked like a swimsuit model.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I often read magazines like <em>Cosmopolitan, Vogue,</em> and <em>Glamour</em> and compare my appearance to the models.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>
APPENDIX D
CONNECTION WITH THE LESBIAN COMMUNITY SUBSCALE (CLC)

Please read each of the following items and select the number that best reflects your agreement with the statement.

6. Strongly Disagree
7. Moderately Disagree
8. Slightly Disagree
9. Neither Agree nor Disagree
10. Slightly Agree
11. Moderately Agree
12. Strongly Agree

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Many of my friends are lesbians.</td>
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<tr>
<td>2</td>
<td>Attending lesbian events and organizations is important to me.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>I feel isolated and separate from other lesbians.</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>When interacting with members of the lesbian community, I often feel</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>different and alone, like I don’t fit in.</td>
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<tr>
<td>5</td>
<td>Having lesbian friends is important to me.</td>
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<tr>
<td>6</td>
<td>I am familiar with lesbian books and/or magazines.</td>
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<tr>
<td>7</td>
<td>Being a part of the lesbian community is important to me.</td>
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<tr>
<td>8</td>
<td>I feel comfortable joining a lesbian social group, lesbian sports team,</td>
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<tr>
<td></td>
<td>or lesbian organization.</td>
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</tr>
<tr>
<td>9</td>
<td>Social situations with other lesbians make me feel uncomfortable.</td>
<td></td>
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<td></td>
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<tr>
<td>10</td>
<td>I am familiar with lesbian movies and/or music.</td>
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<tr>
<td>11</td>
<td>I am aware of the history concerning the development of lesbian</td>
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<tr>
<td></td>
<td>communities and/or the lesbian/gay rights movement.</td>
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<tr>
<td>12</td>
<td>I am familiar with lesbian music festivals and conferences.</td>
<td></td>
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<tr>
<td>13</td>
<td>I am familiar with community resources for lesbians (i.e., bookstores,</td>
<td></td>
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<td></td>
<td>support groups, bars, etc.).</td>
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<td></td>
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</tbody>
</table>

79
APPENDIX E
ATTITUDES TOWARD FEMINISM AND THE WOMEN’S MOVEMENT (FWM)
SCALE

Please read each of the following items and select the number that best reflects your agreement with the statement.

13. Strongly Disagree
14. Somewhat Disagree
15. Neither Agree nor Disagree
16. Somewhat Agree
17. Strongly Agree

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The leaders of the women’s movement have the right idea.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>There are better ways for women to fight for equality than</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>through the women’s movement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Feminists are too visionary for a practical world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>People would favor women’s liberation more if they knew more</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>about it.</td>
<td></td>
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<tr>
<td>5</td>
<td>The women’s movement has positively influenced relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>between men and women.</td>
<td></td>
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<tr>
<td>6</td>
<td>The women’s movement is too radical and extreme in its views.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Feminist principles should be adopted everywhere.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I would be overjoyed if women’s liberation gained more</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>strength in this country.</td>
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<tr>
<td>9</td>
<td>The women’s movement has made important gains in equal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>rights and political power for women.</td>
<td></td>
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<tr>
<td>10</td>
<td>Feminists are a menace to this nation and the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX F
BODY SURVEILLANCE SUBSCALE OF THE OBJECTIFIED BODY CONSCIOUSNESS SCALE (OBC)

Please read each of the following items and select the number that best reflects your agreement with the statement. Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with the statement. For example if the statement says "When I am happy, I feel like singing" and you don't feel like singing when you are happy, then you would circle one of the disagree choices. You would only circle NA if you were never happy.

18. Strongly Disagree
19. Moderately Disagree
20. Slightly Disagree
21. Neither Disagree nor Agree
22. Slightly Agree
23. Moderately Agree
24. Strongly Agree
25. Item does not apply

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>I rarely think about how I look.</td>
</tr>
<tr>
<td>2</td>
<td>I think it is more important that my clothes are comfortable than whether they look good on me.</td>
</tr>
<tr>
<td>3</td>
<td>I think more about how my body feels than how my body looks.</td>
</tr>
<tr>
<td>4</td>
<td>I rarely compare how I look with how other people look.</td>
</tr>
<tr>
<td>5</td>
<td>During the day, I think about how I look many times.</td>
</tr>
<tr>
<td>6</td>
<td>I often worry about whether the clothes I am wearing make me look good.</td>
</tr>
<tr>
<td>7</td>
<td>I rarely worry about how I look to other people.</td>
</tr>
<tr>
<td>8</td>
<td>I am more concerned with what my body can do than how it looks.</td>
</tr>
</tbody>
</table>
APPENDIX G
BODY SHAME SUBSCALE OF THE OBJECTIFIED BODY CONSCIOUSNESS SCALE (OBC)

Please read each of the following items and select the number that best reflects your agreement with the statement. Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with the statement. For example if the statement says "When I am happy, I feel like singing" and you don't feel like singing when you are happy, then you would circle one of the disagree choices. You would only circle NA if you were never happy.

26. Strongly Disagree
27. Moderately Disagree
28. Slightly Disagree
29. Neither Disagree nor Agree
30. Slightly Agree
31. Moderately Agree
32. Strongly Agree
33. Item does not apply

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When I can’t control my weight, I feel like something must be wrong with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>2</td>
<td>I feel ashamed of myself when I haven’t made the effort to look my best.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>3</td>
<td>I feel like I must be a bad person when I don’t look as good as I could.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>4</td>
<td>I would be ashamed for people to know what I really weigh.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>5</td>
<td>Even when I can’t control my weight, I think I’m an okay person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>6</td>
<td>I never worry that something is wrong with me when I am not exercising as much as I should.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>7</td>
<td>When I’m not exercising enough, I question whether I am a good enough person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>8</td>
<td>When I’m not the size I think I should be, I feel ashamed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>NA</td>
</tr>
</tbody>
</table>
APPENDIX H

THE EATING ATTITUDES TEST – 26 (EAT-26)

For each of the following questions, please select the response that best describes you.

34. Never
35. Rarely
36. Sometimes
37. Often
38. Usually
39. Always

1. Am terrified about being overweight. 1 2 3 4 5 6
2. Avoid eating when I am hungry. 1 2 3 4 5 6
3. Find myself preoccupied with food. 1 2 3 4 5 6
4. Have gone on eating binges where I feel that I may not be able to stop. 1 2 3 4 5 6
5. Cut my food into small pieces. 1 2 3 4 5 6
6. Aware of the calorie content of foods that I eat. 1 2 3 4 5 6
7. Particularly avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.). 1 2 3 4 5 6
8. Feel that others would prefer if I ate more. 1 2 3 4 5 6
9. Vomit after I have eaten. 1 2 3 4 5 6
10. Feel extremely guilty after eating. 1 2 3 4 5 6
11. Am preoccupied with a desire to be thinner. 1 2 3 4 5 6
12. Think about burning up calories when I exercise. 1 2 3 4 5 6
13. Other people think that I am too thin. 1 2 3 4 5 6
14. Am preoccupied with the thought of having fat on my body. 1 2 3 4 5 6
15. Take longer than others to eat my meals. 1 2 3 4 5 6
16. Avoid foods with sugar in them. 1 2 3 4 5 6
17. Eat diet foods. 1 2 3 4 5 6
18. Feel that food controls my life. 1 2 3 4 5 6
19. Display self-control around food. 1 2 3 4 5 6
20. Feel that others pressure me to eat. 1 2 3 4 5 6
21. Give too much time and thought to food. 1 2 3 4 5 6
22. Feel uncomfortable after eating sweets. 1 2 3 4 5 6
23. Engage in dieting behavior. 1 2 3 4 5 6
24. Like my stomach to be empty. 1 2 3 4 5 6
25. Enjoy trying new rich foods. 1 2 3 4 5 6
26. Have the impulse to vomit after meals. 1 2 3 4 5 6
APPENDIX I
DEMOGRAPHIC QUESTIONNAIRE

Please tell us a little about yourself. This information will be used only to describe the sample as a group.

1. Age: _______

2. Gender _____Male _____Female ____Transgender

3. Your current relationship status (please select the best descriptor):
   ____Single ____Married/Partnered ____Dating, long term ____Dating, casual

4. Completed Education (please select one):
   _____ Less than High School
   _____ Some High School
   _____ High School Graduate
   _____ Some College
   _____ College Degree (e.g. B. A., B.S.)
   _____ Professional Degree (e.g., MBA, MS, Ph.D, M. D.)

5. Current Employment status (please select the one best descriptor):
   _____ Employed Full Time _____Employed Part Time _____Not employed

6. Yearly household income (income of those on whom you rely financially):
   _____Below $10,000        _____$60,001 to $70,000
   _____$10,001 to $20,000    _____$70,001 to $80,000
   _____$20,001 to $30,000    _____$80,001 to $90,000
   _____$30,001 to $40,000    _____$90,001 to $100,000
   _____$40,001 to $50,000    _____$100,001 to $110,000

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8. Your current social class (please select the one best descriptor):
   _____ lower class   _____ working class   _____ middle class
   _____ upper middle class   _____ upper class

9. Race/ethnicity (Please check one)
   _____ African American/Black
   _____ Asian American/Pacific Islander
   _____ American Indian/Native American
   _____ Hispanic/Latino/a – White
   _____ Hispanic/Latino/a – Black
   _____ Multi-racial, please specify: ____________________________
   _____ White/Caucasian
   _____ Other, please specify: ____________________________

10. Current height _____ feet _____ inches

11. Current weight in pounds__________________

12. Your sexual orientation (please check the one best descriptor):
   _____ Exclusively lesbian
   _____ Mostly lesbian
   _____ Bisexual
   _____ Mostly Heterosexual
   _____ Exclusively Heterosexual

13. How much are you physically attracted to members of your own sex?
   __________   ______   _____
   low         moderate         high
14. How much are you **physically attracted** to members of the **other sex**?

   _______   _______   _______   _______
   low    moderate    high

**15. How much are you **emotionally attracted** to members of your **own sex**?**

   _______   _______   _______
   low    moderate    high

16. How much are you **emotionally attracted** to members of the **other sex**?

   _______   _______   _______
   low    moderate    high

17. Sexual behavior: Have you had sex with persons of your own gender, the other gender, or both genders?

   _______   _______   _______   _______   _______   _______   _______
   Never had sex   My own gender only   My own gender mostly   Both genders equally
   Other gender mostly   Other gender only

18. How connected or involved are you in the lesbian community? Please select one.

   _______   _______   _______   _______   _______   _______   _______   _______   _______   _______
   very slightly   a little   moderately   quite a bit   extremely   not at all

19. To what extent do you describe yourself as a feminist?

   _______   _______   _______   _______   _______   _______   _______   _______   _______   _______
   0     1     2     3     4     5     6     7     8     9

not at all   very much a feminist

20. Finally, we would like to obtain information regarding the geographic location of our sample. This information will remain confidential. Please fill in the city, state, and country in which you currently reside down below:

   City:_____________________
   State:_____________________
   Country:__________________
### Summary Statistics and Partial Correlations Among Variables of Interest with Body Mass Index Controlled

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Possible Range</th>
<th>Sample Range</th>
<th>M</th>
<th>SD</th>
<th>α</th>
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<tbody>
<tr>
<td>1. Reported Sexual Objectification Experiences</td>
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<td></td>
<td></td>
<td></td>
<td>1.00-5.00</td>
<td>1.00-4.69</td>
<td>1.72</td>
<td>.63</td>
<td>.94</td>
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<tr>
<td>2. Feminist Ideology</td>
<td>-.16**</td>
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<td></td>
<td>1.00-5.00</td>
<td>1.30-5.00</td>
<td>3.92</td>
<td>.57</td>
<td>.85</td>
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<tr>
<td>3. Disconnection from Lesbian Community</td>
<td>.10*</td>
<td>.33**</td>
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<td></td>
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<td>1.00-7.00</td>
<td>1.00-5.92</td>
<td>2.45</td>
<td>.94</td>
<td>.85</td>
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<td>4. Internalization</td>
<td>.15**</td>
<td>.01</td>
<td>.14**</td>
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<td></td>
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<td>1.00-5.00</td>
<td>1.00-5.00</td>
<td>2.13</td>
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<td>.87</td>
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<tr>
<td>5. Body Surveillance</td>
<td>.22**</td>
<td>-.10*</td>
<td>.14*</td>
<td>.54**</td>
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<td></td>
<td>1.00-7.00</td>
<td>1.00-7.00</td>
<td>4.01</td>
<td>1.27</td>
<td>.86</td>
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<tr>
<td>6. Body Shame</td>
<td>.19**</td>
<td>.00</td>
<td>.17**</td>
<td>.55**</td>
<td>.58**</td>
<td></td>
<td>1.00-7.00</td>
<td>1.00-7.00</td>
<td>3.12</td>
<td>1.38</td>
<td>.87</td>
</tr>
<tr>
<td>7. Eating disorder symptoms</td>
<td>.17**</td>
<td>.01</td>
<td>.09*</td>
<td>.45**</td>
<td>.51**</td>
<td>.55**</td>
<td>0.00-78.00</td>
<td>0.00-51.00</td>
<td>7.54</td>
<td>8.37</td>
<td>.86</td>
</tr>
</tbody>
</table>

Note. *p < .05. **p < .001. Higher scores indicate higher levels of the construct assessed.
Hypothesized Path Model

Trimmed Model Depicting Relationships Among Variables of Interest with Body Mass Index Controlled
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Tiffany Leigh Graham was born in Fort Lauderdale, Florida, and graduated summa cum laude from Ball State University in May 2003 with a B.S. in psychology. She immediately entered graduate school in the Department of Psychology at the University of Florida, where she is pursuing a Ph.D. in counseling psychology.