A TEST OF OBJECTIFICATION THEORY WITH LESBIAN
AND HETEROSEXUAL WOMEN

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ABSTRACT

Extant research has garnered support for objectification theory, a model of women's body image that indirectly links sexual objectification to eating disorder symptomatology. The purpose of the study was to investigate the applicability of objectification theory to lesbian women. A sample of 181 lesbian women and 196 heterosexual women were recruited through college campuses. Measures for sexual objectification, self-objectification, body shame, appearance anxiety, interoceptive awareness and disordered eating were administered. The results provided evidence that the present model of objectification theory does not hold for lesbian women.
 Dedicated to Zachary Binx,

whose charm prevents me from taking life too seriously
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CHAPTER 1
INTRODUCTION

In a contemporary Western world, the relationship that a woman has with her body can have profound effects on her professional, political and personal life (Wolf, 1991). It has been theorized this relationship may be adversely impacted by society’s treatment of the female body as a sexual object (Bartky, 1990; Berger, 1972; Betzold, 1990; Brooks, 1995; Ciriello, 1993; Johnston, 1997; Kaschak, 1992; Martin, 1996; Stoltenberg, 1989; Young, 1990). Bartky (1990) defined sexual objectification as the process through which a person’s body, body parts or sexual functions are removed from their personal identity, as though the body or body part was capable of representing them. When this type of objectification occurs, the woman’s body or body part is often evaluated by the objectifier according to its ability to meet the societal standards of beauty (Fredrickson & Roberts, 1997). In this way, sexual objectification functions to equate a woman’s worth with the extent to which her body meets cultural ideals of beauty (Berger, 1972).

Sexual objectification is a pervasive phenomenon throughout Western culture that is perpetuated in two prominent ways: a.) the media (Kilbourne, 1994) and b.) interpersonal contact (Fredrickson & Roberts, 1997). A multitude of scholars (e.g. Berger, 1972; Fredrickson & Roberts, 1997; Kilbourne, 1994) have noted the media’s
perpetuation of impossible standards of beauty for women, such as the thin-ideal. These messages may be considered pervasive, as it is estimated that the average American is exposed to 3,000 advertisements per day (Kilbourne, 1994).

It has also been observed (Fredrickson & Roberts, 1997; Kaschak, 1992) that sexual objectification is further perpetuated by interpersonal encounters, such as sexually objectifying verbal remarks, sexual discrimination and sexual assault. It is also common for women to be sexually objectified in interpersonal encounters through the visual gaze of others. Due to its pervasiveness and potentially harmful implications, the sexual objectification of women has been described as a socially sanctioned institution which perpetuates male supremacy and the oppression of women (Westkott, 1986; Brooks, 1995; Stoltenberg, 1989). Fredrickson and Roberts (1997) proposed a theory of body image, called objectification theory, which indirectly links the sexual objectification of women to eating disorder symptomatology.

First, Fredrickson and Roberts argued that sexual objectification is particularly harmful when it is internalized by women. It has been theorized (Striegel-Moore, Silberstein & Rodin, 1986, p. 252) that women who are at greatest risk for body dissatisfaction are those who have most internalized the "sociocultural mores about thinness and attractiveness." Fredrickson and Roberts (1997) asserted that the internalization of sexual objectification results in a phenomenon termed self-objectification, or the internalization of the observer's perspective of one's body. By engaging in self-objectification, women perceive their bodies as sexual objects that exist primarily for the pleasure and evaluation of others. Thus, women who internalize sexual objectification learn to think of and evaluate their bodies from an appearance-oriented,
third-person perspective (Berger, 1992; Fredrickson & Roberts, 1997; McKinley & Hyde, 1996).

Fredrickson and Roberts (1997) posited that self-objectification may result in several negative psychological consequences (i.e., appearance anxiety, body shame and poor interoceptive awareness). They theorized that the internalization of sexual objectification may cause women to feel anxiety regarding their appearance, as self-objectified women may feel uncertain as to when and where their appearance will be evaluated. This appearance anxiety may be exhibited through the frequent checking and adjusting of one’s appearance. Further, Fredrickson and Roberts (1997) proposed that women who self-objectify may experience body shame if their body does not meet the societal standards of beauty. In addition, the authors suggested that adopting the observer’s perspective through self-objectification will leave women with less mental resources to experience awareness of their internal bodily states (i.e., interoceptive awareness), such as cues for hunger, emotions and satiety.

Fredrickson and Roberts (1997) then proposed that the cumulative effect of these negative consequences contribute to the higher prevalence of eating disorder symptomatology in women. In objectification theory, they posit that women who experience more appearance anxiety and body shame will attempt to change those parts of their bodies that do not live up to the cultural standards of thinness (e.g. through dieting or disordered eating). Further, women who suppress hunger cues (i.e., experience poor interoceptive awareness) will be more likely to display eating disorder symptomatology.

Although research has supported the use of this theory with heterosexual
European Americans (e.g. Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Noll & Fredrickson, 1998; Tiggemann & Slater, 2001), more research is needed in order to determine whether this theory holds for certain marginalized groups, such as lesbian women. In order to generalize the empirical findings that support objectification theory to all women, it is necessary that the model be tested on women of differing sexual orientations. For instance, Fredrickson and Roberts (1997, p. 197) observed that belonging to a particular subculture "may mitigate or protect certain subgroups of women against the negative psychological repercussions that we link to sexual objectification".

Therefore, it is possible that belonging to the lesbian subculture may offer certain protections against negative body image that heterosexual women do not experience. Further, sexual orientation may impact women's body image in ways that are not accounted for by the current model of objectification theory. Thus, it is possible that the model of objectification theory created by Fredrickson and Roberts (1997) may not apply to lesbian women.

Moreover, this study will expand upon the present body of research on lesbian women's body image experience. To date, no study has examined a comprehensive model of body image, such as objectification theory, on a sample of lesbian women. In addition, the small body of extant research that has examined individual facets of lesbian body image has been prone to methodological issues due to the use of inadequate lesbian sample sizes and poor sampling techniques (Heffernan, 1994). Thus, it seems necessary that a comprehensive model of lesbian body image be investigated that utilizes sound methodology. The present study will seek to accomplish these purposes by testing the model outlined in objectification theory (see Figure 1) with lesbian and heterosexual
women.

Accordingly, the purpose of the present study is to empirically determine whether the pathways implied by objectification theory are similar for lesbian and heterosexual women. In doing so, this study will further our understanding of the body image and eating disorder symptomatology of both lesbian women, as well as provide further empirical implications of objectification theory. The process of pathway analysis will aid in determining whether the use of the objectification theory is appropriate for these groups.
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Overview

The purpose of the present study is to further understanding of the body image and eating disorder development of lesbian women by determining whether the paths in objectification theory that are specified and empirically supported with samples of heterosexual women are also supported for lesbian and bisexual women. The present chapter reviews the findings in the literature regarding objectification theory as well as the empirical support for the model. Subsequently, the theory and research regarding the body image of lesbian women will be reviewed. Finally, the chapter will conclude with a reiteration of the purposes of the study.

2.2 Sexual Objectification

Sexual objectification is the event in which one's body is treated as an object, particularly an object that exists for the use and pleasure of others (Fredrickson & Roberts, 1997). Many scholars have argued that sexual objectification is an inextricable part of being a woman (Bartky, 1990; Berger, 1992; Betzold, 1990; Brooks, 1995; Ciriello, 1993; Johnston, 1997; Kaschak, 1992; Martin, 1996; Stoltenberg, 1989; Young, 1990). This condition was observed by Karen Horney who noted that "the prerogative of gender [is] the socially sanctioned right of all males to sexualize all females, regardless of age or status" (Westcott, 1986, pp. 94-95). In 1995, Brooks (pp.3-4) further observed:
"As the culture has granted men the right and privilege of looking at women, women have been expected to accept the role of stimulators of men's visual interest, with their bodies becoming objects that can be lined up, compared, and rated".

Stoltenberg (1989) argued that men are socialized to sexually objectify women and that this sexual objectification functions to uphold, perpetuate and embody male supremacy. Further, he held that the sexual objectification of women is often falsely portrayed as a normative and necessary facet of male sexual development by stating: "[M]en's sexual objectifying is deemed a given, a biological mandate . . . male sexuality without sexual objectification is unimaginable" (Stoltenberg, 1989, p.151).

Fredrickson and Roberts (1997) argue that the predominance of sexual objectification within a society may result in its members internalizing this message. A woman's body becomes her identity; her worth is evaluated by herself and others according to the extent to which her body meets the cultural ideal (Fredrickson & Roberts, 1997; Hill, 2001). Kaschak (1992, p.96) described the consequences of such internalization:

Every aspect of the female body is considered to say something about a woman's value as a person and as a woman. She is her body and her face. But it is her appearance that is judged, not her strength, health, or ability to act effectively, not her body's speed or agility but its size and shape, its pleasingness and conformity to masculine standards of the feminine. If her appearance is deemed desirable, then so is she and she is treated accordingly. If not, then she is worth less. She may then be ridiculed or attacked; after all, by her very appearance she is asking for it. It is
assumed that she has chosen to be unattractive and deserves to be treated badly for it. Her appearance is not just something about her, as it is for men: she is her appearance. Virtually every aspect of it is interpreted to have meaning about her— who she is, how she is to be viewed and treated.

Women may be sexually objectified in several ways, including verbal comments, gaze, sexual discrimination and sexual assault (Fredrickson & Roberts, 1997). While a sexually objectifying gaze may appear to be the most innocuous form of sexual objectification, it is also the most prevalent: "It is by virtue of their gaze that men sin against women, that they objectify them, make them prisoners of appearance, of age and color, of physical beauty, of their shape and size" (Kaschak, 1992, p. 63). Fredrickson and Roberts (1997) propose that sexual objectification may be communicated in three main forms: a.) interpersonal contact, b.) visual media depictions of interpersonal contact, and c.) visual media depictions that emphasize female body parts.

Fredrickson and Roberts (1997) proposed a model that indirectly links sexual objectification, perpetuated in these three forms, to disordered eating. In their model, objectification theory (Fredrickson & Roberts, 1997), they proposed that the internalization of sexual objectification may lead to negative psychological consequences for women (i.e., appearance anxiety, body shame and poor interoceptive awareness). Fredrickson and Roberts (1997) then suggested that these negative psychological consequences may lead to an increase in disordered eating among women.

2.3 Objectification Theory

In objectification theory, Fredrickson and Roberts (1997) argued that the higher prevalence among women of certain negative psychological experiences (i.e. body
shame, appearance anxiety, poor interoceptive awareness and decreased experience of peak motivational states) and eating disorders may be the consequence of the internalization of sexual objectification in women. The following section will provide an overview of the model proposed in objectification theory (see Figure 1 for the complete model).

2.31 Consequences of Sexual Objectification

According to objectification theory (Fredrickson & Roberts, 1997), the pervasiveness of sexual objectification within a culture may lead women and girls to internalize this sexual objectification. This internalization has become part of the socialization process; women and girls view their own bodies in sexually objectifying terms (Fredrickson & Roberts, 1997; Kaschak, 1992; McKinley & Hyde, 1997). As a result, women adopt the observer's perspective of their bodies and learn to treat their bodies as sexual objects that exist for the pleasure and evaluation of others (Fredrickson & Roberts, 1997). In his book, "Ways of Seeing", John Berger (1972, pp.46-47) described this perspective:

A woman must continually watch herself. She is almost continually accompanied by her own image of herself. Whilst she is walking across a room or whilst she is weeping at the death of her father, she can scarcely avoid envisaging herself walking or weeping. From earliest childhood she has been taught and persuaded to survey herself continually...Thus she turns herself into an object.

Fredrickson and Roberts (1997) term this internalization of the observer's perspective of one's body as "self-objectification." They describe it as a form of "habitual, self-consciousness body monitoring" of one's physical appearance (p. 180).
It has been argued (Bartky, 1990; Berger, 1972) that self-objectification is an adaptive function that women have learned. As Western culture is based upon a patriarchy in which men have more power than women (Wolf, 1991), a woman learns that:

...how [she] appears to a man can determine how she will be treated. To acquire some control over this process, women must contain it and interiorize it...she has to survey everything she is and everything she does because how she appears to others, and ultimately how she appears to men, is of crucial importance for what is normally thought of as the success of her life (Berger, 1972, p.46).

Through the presence of sexual objectification in Western society, women learn that they are evaluated according to the male standard of beauty and that this evaluation may affect the economic and social treatment that they will receive (Bersheid, Dion, Walster, & Walster, 1971; Cash, Gillen, & Burns, 1977). Therefore, in order for a woman to be successful, she must monitor her own appearance to ensure that it is in accordance with this cultural ideal (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Berger, 1972; Bartky, 1990).

Self-objectification appears to be a consequence of the prevalence of sexual objectification within society. Although self-objectification may serve an adaptive function for women, Fredrickson and Roberts (1997) argued that this habitual internalization of the observer's perspective may have harmful psychological and mental health consequences. Several studies (Calogero, 2004; Fredrickson, Roberts, Noll, Quinn, et al. 1998; Huebner & Fredrickson, 1999) have found evidence linking sexual objectification to self-objectification. For instance, a study by Calogero (2004)
investigated the effects of the anticipation of sexual objectification on college women. As stated previously, the male gaze is one of the most subtle, but pervasive ways in which a woman may be sexually objectified (Fredrickson & Roberts, 1997). Calogero hypothesized that the anticipation of the male gaze would result in an increase in self-objectification in college women. The construct of self-objectification was measured using the Self-Objectification Questionnaire (Noll & Fredrickson, 1998). The sample was composed of 105 undergraduate females enrolled in an introductory psychology class at a small southeastern university. The participants were brought into a room, where some were falsely told that they would have a one-on-one conversation with either a male or a female. They were asked to fill out the questionnaire battery as they waited. A control group filled out the questionnaire, without being informed that they were to have a conversation. The data indicated that the women who anticipated a conversation, particularly with a male (i.e., the male gaze), reported higher levels of self-objectification. This finding appears to suggest that the anticipation of the male gaze triggers self-objectification in women.

In a study, Fredrickson, Roberts, Noll, Quinn, and Twenge (1998) found further evidence linking the experience of sexual objectification to self-objectification. Self-objectification was measured by the 12-item Self-objectification Questionnaire (Noll, 1996), while body shame was measured by the Body Shame Questionnaire (Noll, 1996). The experimenters tested two samples of undergraduate women at Duke University who received partial course credit. The sample was composed of 75 undergraduate women who were randomly assigned to wear a swimsuit or a sweater. While wearing the swimsuit or sweater, the participants completed the measures. The experimenters found
that the women who wore the swimsuit reported significantly higher levels of self-objectification.

Huebner and Fredrickson (1999) garnered empirical support for the presence of the internalized observer's perspective described in self-objectification. According to Nigro and Neisser (1983), it is possible for events to be remembered in either the first-person perspective (i.e. recalling the event through one's own vantage point) or an observer's perspective (i.e. recalling the event through an outside observer's vantage point). The purpose of Huebner and Fredrickson (1999)'s study was to determine whether women would recall more events than men from an observer's perspective, particularly events in which they were at high risk for sexual objectification.

A sample of 104 men and 138 women recruited from an introductory psychology course were asked to recall one of four assigned events: a.) giving a class presentation, b.) eating in a dining hall with men and women, c.) a university party and d.) studying alone in their room. After reading a description of each type of memory (i.e. first person and observer), the participants were asked to rate how much of the memory they recalled was from the observer's perspective, and how much of it was from the first person perspective. The data indicated that, overall, women reported a significantly higher amount of observer perspective in their memories. In addition, women were also found to report a higher amount of observer perspective memories when recalling events in which they were more likely to be objectified (i.e. eating in a dining hall, university party). These findings may indicate that women have learned to adopt an observer's perspective, or self-objectify, due to the risk of sexual objectification within society (Huebner & Fredrickson, 1999).
2.32 Consequences of Self-Objectification

Objectification theory (Fredrickson and Roberts, 1997) proposes that the phenomenon of self-objectification may lead to several negative psychological consequences in women. Fredrickson and Roberts (1997) posited that higher rates of appearance anxiety, body shame, poor interoceptive awareness, and decreased experiences of peak motivational states in women are due to self-objectification (see Figure 1).

2.321 Self-Objectification and Appearance Anxiety

Objectification theory proposes that anxiety is a direct result of self-objectification (Fredrickson & Roberts, 1997). Anxiety is defined as the negative emotion that is associated with the anticipation of danger (Lazarus, 1991; Ohman, 1993). Fredrickson and Roberts (1997) argued that "a culture that objectifies the female body presents women with a continuous stream of anxiety-provoking experiences, requiring them to maintain an almost chronic vigilance both to their physical appearance and to their physical safety" (Fredrickson & Roberts, p.183). Objectification theory (Fredrickson & Roberts, 1997) identifies two major types of anxiety that may result from sexual objectification: appearance anxiety and safety anxiety.

Appearance anxiety is defined as the negative emotion that is associated with the anticipation of dangers as a result of one's appearance (Lazarus, 1991; Ohman, 1993; Fredrickson & Roberts, 1997). Women fear the implicit danger to their economic and social lives should their appearance not meet the cultural ideal (Wolf, 1992). Fredrickson and Roberts (1997) argued that appearance anxiety is a result of women not knowing when and how their bodies might be evaluated. Thus, when women self-objectify, they
are in a state of anticipating possible dangers that may result due to their physical appearance. Indeed, research has found that women report higher levels of appearance anxiety than men (Dion, Dion & Keelan, 1990). Appearance anxiety may often be observed through the frequent checking and adjusting of one's appearance (Fredrickson & Roberts, 1997).

Tiggemann and Slater (2001) provided evidence for the existence of the link between body surveillance and appearance anxiety in populations that are pre-disposed to the risk of body image disturbances. The construct of body surveillance was measured using the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), while the construct of appearance anxiety was measured using the Appearance Anxiety Scale (Dion, Dion & Keelan, 1990). The measures were administered to 50 females who were former ballet students and 51 current, female undergraduates. The results indicated that body surveillance appears to predict appearance anxiety in both female dancers and non-dancers.

In 2001, Tiggemann and Lynch garnered evidence for the link between body surveillance and appearance anxiety across the lifespan. The construct of habitual body monitoring was measured using the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), while the construct of appearance anxiety was measured using the Appearance Anxiety Scale (Dion, Dion & Keelan, 1990). In a cross-sectional study, the measures were administered to 322 women between the ages of 20 and 84. The researcher garnered evidence that body surveillance predicts appearance anxiety throughout the lifespan.

Slater and Tiggemann (2002) found evidence that the association between body
surveillance and appearance anxiety also exists in adolescent populations. The construct of body surveillance was measured using the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), whereas the construct of appearance anxiety was measured using the Appearance Anxiety Scale (Dion, Dion & Keelan, 1990). The measures were administered to 83 pre-adolescents between the ages of 8 and 12. The findings in this study suggest that body surveillance predicts appearance anxiety in pre-adolescents.

Tiggemann and Kuring (2004) provided further support for the link between body surveillance and appearance anxiety, in both women and men. The construct of body surveillance was measured using the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), whereas the construct of appearance anxiety was measured using the Appearance Anxiety Scale (Dion, Dion & Keelan, 1990). The measures were administered to 171 women and 115 men. The results indicated that body surveillance appears to predict appearance anxiety in both women and men.

2.322 Self-Objectification and Body Shame

Fredrickson and Roberts (1997) argue that body shame may directly result from self-objectification. Body shame is defined as the negative emotion that occurs when "people evaluate their body relative to some internalized or cultural ideal and come up short" (Fredrickson & Roberts, 1997, p. 181). Fredrickson and Roberts (1997) argue that women who are habitually monitoring their bodies (i.e. engaging in self-objectification) will compare their bodies to the current, culturally prescribed ideal. However, as only 1 in 40,000 women are the same size and shape of a typical fashion model (Wolf, 1991), it appears as though this cultural ideal is impossible to attain (Maine, 2000). Thus, it is
argued (Fredrickson & Roberts, 1997) that when women compare their bodies to the
cultural ideal, they will almost always come up short. In this way, women who engage in
self-objectification will have an increased opportunity for experiencing body shame.
Fredrickson and Roberts (1997) suggest that "the habitual body monitoring encouraged
by a culture that sexually objectifies the female body can lead women to experience
shame that is recurrent, difficult to alleviate, and constructed as a matter of morality"
(p.182).

Further, research has also supported the link between self-objectification and
body shame (McKinley & Hyde, 1996; Noll & Fredrickson, 1998; Tylka & Hill, 2004;
Tiggemann & Slater, 2001, Slater & Tiggemann, 2002; Tiggemann & Lynch; Greenleaf,
2005). In 1996, McKinley and Hyde first garnered evidence for the link between self-
objectification and body shame. In this study, the researchers created and validated the
Objectified Body Consciousness Scale, which contained subscales designed to measure
the proposed constructs of body surveillance and body shame. The researchers defined
the construct of body surveillance as "viewing one's body as an outside observers
(McKinley & Hyde, 1996: p.760)"; thus, it is conceptually similar to the construct of self-
objectification. The researchers created the Body Surveillance subscale to measure the
construct of body surveillance and the Body Shame subscale to measure the construct of
body shame. The measures were administered to a sample of 278 women between the
ages of 17 and 22 and a sample of 151 women between the ages of 38 and 58, who were
the mothers of the first sample. The results supported the existence of a relation between
body surveillance and body shame in women across the lifespan.

Noll and Fredrickson (1998) also examined the relation between self-
objectification and body shame in college women. The researchers measured the
contuct of self-objectification with the Self-Objectification Questionnaire (Noll, 1996)
and the construct of body shame with the Body Shame Questionnaire (Noll, 1996). The
measures were administered to a sample of 204 college women. Their findings indicated
that self-objectification predicts body shame in college women.

In a study by Tylka and Hill (2004), the association between self-objectification
and body shame was investigated in the female college population. The purpose of the
study was to examine the impact of the sociocultural variables described in
objectification theory on the prediction of eating disorders. The researchers measured the
construct of self-objectification with the Body Surveillance subscale of the Objectified
Body Consciousness Scale (McKinley & Hyde, 1996) and the construct of body shame
with the Body Shame subscale of the Objectified Body Consciousness Scale (McKinley
& Hyde, 1996). The measures were administered to a sample of 460 college women.
Their findings indicated that self-objectification predicts body shame in the college
women.

In Tiggemann and Slater's study (2001), the authors also examined the relation
between body surveillance and body shame in female dancers and non-dancers. The
researchers measured the construct of body shame with the Body Shame subscale of the
Objectified Body Consciousness Scale (McKinley & Hyde, 1996). Their findings
appeared to indicate that body surveillance predicts body shame in both female dancers
and non-dancers.

In Slater and Tiggemann's study (2002), the authors examined the relation
between body surveillance and body shame in adolescent populations. The researchers
measured the construct of body surveillance with the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996) and the construct of body shame with the Body Shame subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). Their findings indicated that the link between body surveillance and body shame also exists in adolescent populations.

In Tiggemann and Lynch’s study (2001), the authors also examined the relation between body surveillance and body shame across the female lifespan. The researchers measured the construct of body shame with the Body Shame subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). Their findings provided support for the link between body surveillance and body shame across the entire lifespan in women.

In 2005, Greenleaf provided further evidence for the existence of the link between self-objectification and body shame among younger and older physically active women. The purpose of the study was to investigate the relation of variables associated with objectification theory across the lifespan in physically active women. The researchers measured the construct of self-objectification with the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996) and the construct of body shame with the Body Shame subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). The measures were administered to a sample of 200 physically active women between the ages of 18 and 30 and a sample of 194 physically active women between the ages of 39 and 64. The results of the study indicated that self-objectification predicts body shame in younger and older women who are physically active.
In Tiggemann and Kuing (2004)'s study, further support was provided for the link between body surveillance and body shame in both women and men. The authors utilized the Body Shame subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996) to measure the construct of body shame. The results of the study appeared to indicate that body surveillance appears to predict body shame in both women and men.

2.323  *Self-Objectification and Poor Interoceptive Awareness*

In objectification theory, Fredrickson and Roberts (1997) proposed that poor interoceptive awareness is a direct psychological consequence of self-objectification. Interoceptive awareness is defined as the awareness of one's internal bodily sensations (Lerner, 1993). A principle of objectification theory holds that there are two ways in which poor interoceptive awareness results from self-objectification. First, it has been theorized that that women and young girls, in an attempt to attain the cultural ideal of thinness through dieting, learn to suppress their bodily cues for hunger (Hirschmann & Munter, 1995; Tribol & Resch, 1995). However, as it is impossible to suppress one specific physiological cue (i.e. hunger), all of women's physiological cues (e.g. satiety, emotional awareness) are also suppressed (Fredrickson & Roberts, 1997).

Secondly, Fredrickson and Roberts (1997) argue that women experience a disconnect from their physical selves when they adopt an observer's perspective of their bodies (i.e. self-objectification). This habitual monitoring of one's body leaves women with "fewer perceptual resources available for attending to inner body experience" (Fredrickson & Roberts, p. 185). In this way, women's awareness of their bodily cues is lessened.
Extant research has garnered empirical support for the link between self-objectification and body shame (Muehlenkamp & Saris-Balgama, 2002; Tylka & Hill, 2004; Tylka & Subich, 2004). For instance, a study by Muehlenkamp and Saris-Balgama (2002) sought to investigate the psychological outcomes of self-objectification for college women. The construct of poor interoceptive awareness was measured using a combination of the Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994), the Private Body Consciousness subscale of the Body Consciousness Questionnaire (Miller, et al., 1981) and the Interoceptive Awareness subscale of the EDI (Garner, Olmsted & Polivy, 1983). Further, the construct of disordered eating was measured using the EAT-26 (Garner & Garfinkel, 1979). The sample was composed of 413 college age women who were recruited from an introductory psychology class. The results of the study appeared to indicate that self-objectification predicts poor interoceptive awareness in college women.

More evidence for this relation was garnered by Tylka and Hill (2004), in a study described previously. The construct of self-objectification was measured using the Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley & Hyde, 1996), whereas poor interoceptive awareness was measured using the Interoceptive Awareness subscale of the EDI-2 (Garner, 1991). The results of the study indicated that self-objectification predicts poor interoceptive awareness in college women and provides further validation of the above findings.

2.33 Consequences of Appearance Anxiety, Body Shame and Poor Interoceptive Awareness

Objectification theory (Fredrickson & Roberts, 1997) proposes that the negative
psychological consequences of self-objectification (i.e. anxiety, body shame and poor interoceptive awareness) have been theorized to interact in several additional ways. Women who are ashamed of their bodies are predicted to experience poor interoceptive awareness. Further, women who experience appearance anxiety are predicted to experience body shame and poor interoceptive awareness.

In addition, Fredrickson and Roberts (1997) proposed that these variables (i.e. anxiety, body shame, poor interoceptive awareness, and decreased experience of peak motivational states) accumulate to result in an increased risk for disordered eating in women (See Figure 1). They suggested that eating disorders are merely the extreme end of the spectrum of the "normative discontent" that women feel regarding their bodies. Due to the indirect link between sexual objectification and eating disorder symptomatology, Fredrickson and Roberts (1997) posit that disordered eating is a result of "simply being a female in a culture that objectifies the female body" (p.185). The next section will outline the theory and extant research to support these relationships.

2.331 Appearance Anxiety

Fredrickson and Roberts (1997) propose that women that experience a greater amount of anxiety relating to the ability of their appearance to meet societal standards will be more likely to feel ashamed if their body does meet this cultural ideal. Further, the finding that appearance anxiety predicts a significant portion of the variance in poor interoceptive awareness in heterosexual women is also consistent with objectification theory (Fredrickson & Roberts, 1997). It is proposed that the experience of appearance anxiety will leave women with less mental resources to monitor their internal bodily states, such as hunger and satiety. To date, little research has examined the construct of
appearance anxiety. Therefore, there is currently no empirical research to support the relation between appearance anxiety and these two variables.

Additionally, Fredrickson and Roberts (1997) propose that women who experience a greater amount of anxiety relating to the ability of their appearance to meet with societal standards will be more likely to feel ashamed if their body does meet this cultural ideal. Extant research has supported the link between appearance anxiety and eating disorder symptomatology (Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). For instance, in a study described previously, Tiggemann and Kuring (2004) found support for this relation in men and women. The construct of appearance anxiety was measured using the Appearance Anxiety Scale (Dion, Dion & Keelan, 1990), whereas the construct of disordered eating symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study appeared to indicate that appearance anxiety predicts eating disorder symptomatology in both men and women.

In addition, further support for this link was found by Tiggemann and Lynch (2001) garnered evidence for the relation in women of all ages. The Appearance Anxiety Scale (Dion, Dion & Keelan, 1990) was utilized to measure the construct of appearance anxiety, whereas the EAT-26 (Garner & Garfinkel, 1979) was used to measure disordered eating. The results of the study appeared to indicate that appearance anxiety predicts eating disorder symptomatology throughout the lifespan.

2.332 Body Shame

In objectification theory, Fredrickson and Roberts (1997) posit that women who feel ashamed of their bodies may attempt to suppress cues related to hunger in order to
attempt to lose weight. Extant research has supported this link between body shame and poor interoceptive awareness (Muehlenkamp & Saris-Balgama, 2002; Tylka & Hill, 2004; Tylka & Subich, 2004).

In Muehlenkamp and Saris-Balgama’s study (2002), support was garnered for this assertion. The authors found evidence that body shame predicts poor interoceptive awareness. The construct of body shame was measured with the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of poor interoceptive awareness was measured with a combination of the Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994), the Private Body Consciousness subscale of the Body Consciousness Questionnaire (Miller, Murphy & Buss, 1981) and the Interoceptive Awareness subscale of the EDI (Garner, Olmsted & Polivy, 1983). The results of the study indicated that body shame predicts poor interoceptive awareness in female college students.

Further support for this link was garnered by Tylka and Hill’s study (2004). The authors measured body shame using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of poor interoceptive awareness was measured with the Interoceptive Awareness subscale of the EDI-2 (Garner, 1991). Their findings appeared to indicate that body shame predicts poor interoceptive awareness in college women.

Further, objectification theory (Fredrickson & Roberts, 1997) posits that women who experience body shame will attempt to change those parts of their bodies that do not live up to the cultural standard of thinness (e.g. through dieting or disordered eating). Indeed, extant research has supported the link between eating disorder symptomatology
and body shame (Greenleaf, 2005; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001; Tylka & Hill, 2004). In a study described previously, Greenleaf (2005) garnered evidence for the link between body shame and eating disorder symptomatology through the lifespan of physically active women. The construct of body shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). Greenleaf found evidence that body shame predicts eating disorder symptomatology in physically active women of all ages.

In Noll and Fredrickson (1998)'s study, the authors provided further support for the link between body shame and eating disorder symptomatology in college women. The construct of body shame was measured using the Body Shame Questionnaire (Noll, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study indicated that body shame predicts eating disorder symptomatology in college women.

Slater and Tiggemann (2002) also found evidence that body shame predicts eating disorder symptomatology in adolescent girls. In a study described previously, the construct of body shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). Their findings indicated that body shame predicts eating disorder symptomatology in adolescent girls.

Further support for the relation between body shame and eating disorder symptomatology was found by Tiggemann and Kuring (2004). The construct of body

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shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study appeared to indicate that body shame predicts eating disorder symptomatology in both men and women.

Further, Tiggemann and Slater (2001) garnered evidence for the link between body shame and eating disorder symptomatology in dancers and non-dancers, in a study previously described. The construct of body shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study provided support for the relation between body shame and eating disorder symptomatology for women in dancers and non-dancers.

Tiggemann and Lynch (2001) garnered evidence for the link between body shame and eating disorder symptomatology across the lifespan of women. The construct of body shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study provided support for the relation between body shame and eating disorder symptomatology for women of all ages.

Tylka and Hill (2004) provided further support for the relation between body shame and eating disorder symptomatology in college women. The construct of body shame was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study indicated that body shame
predicts eating disorder symptomatology in college women.

2.333 *Poor Interoceptive Awareness*

A principle of objectification theory (Fredrickson and Roberts, 1997) asserts that poor interoceptive awareness predicts the degree to which women will experience eating disorder symptomatology. In support of this link, Garner (1991) noted that women who exhibit eating disorder symptomatology often lack the ability to identify feelings of hunger, satiety and emotions. Fredrickson and Roberts (1997) posit that women who suppress cues of hunger and satiety in their body are more likely to develop disordered eating symptomatology as they may more easily ignore their nutritional needs. Further, Heatherton and Baumeister (1991) theorized that women who develop disordered eating patterns are attempting to escape awareness of their internal bodily states.

Extant research has supported this link (Garner et al., 1984; Pike, 1995; Tylka & Subich, 2004). In 1984, Garner, Olmsted, Polivy and Garfinkel garnered evidence for the relation between poor interoceptive awareness and eating disorder symptomatology. The purpose of the study was to identify the subscales of the Eating Disorder Inventory (Garner, et al., 1984) which had the ability to differentiate women who exhibited different levels of body image disturbance: 1.) women diagnosed with anorexia nervosa; 2.) women who were classified as weight preoccupied but did not exhibit clinical symptoms of disordered eating; 3.) women who were not classified as weight preoccupied.

The sample was composed of 50 women with anorexia nervosa, 35 weight preoccupied women and 134 non-weight preoccupied women. The sample was recruited from college campuses and ballet classes. All of the subscales (i.e., Drive for Thinness,
Interpersonal Distrust, Perfectionism, Interoceptive Awareness, Body Dissatisfaction and Ineffectiveness) of the Eating Disorder Inventory (Garner, Olmsted & Polivy, 1983) were administered to the sample. The results indicated that the Ineffectiveness, Interpersonal Distrust and Interoceptive Awareness subscales best differentiated the women with anorexia nervosa from the women who were weight preoccupied.

Further evidence was found for the relation between poor interoceptive awareness and eating disorder symptomatology by Pike (1995). The purpose of Pike’s study was to identify specific family, peer and personality factors that contribute to the development of bulimia in high school girls. The construct of poor interoceptive awareness was measured using the Interoceptive Awareness subscale of the Eating Disorder Inventory (Garner, Olmsted & Polivy, 1983), whereas the construct of bulimic symptomatology was measured using the Bulimia Test (Smith & Thelen, 1984). The measures were administered to a sample composed of 410 adolescent girls in the 9th through 12th grade. The results of this study indicated that poor interoceptive awareness directly predicts eating disorder symptomatology in adolescent girls.

Tylka and Hill (2004) garnered additional evidence for the relation between poor interoceptive awareness and eating disorder symptomatology. The construct of poor interoceptive awareness was measured using the Interoceptive Awareness subscale of the EDI-2 (Garner, 1991), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The results of the study indicated that poor interoceptive awareness predicts eating disorder symptomatology in college women.

In 2004, Tylka and Subich provided further empirical support for the link between
poor interoceptive awareness and eating disorder symptomatology. The purpose of their study was to examine a multidimensional model for eating disorder symptomatology for women. The construct of poor interoceptive awareness was measured using the Interoceptive Awareness subscale of the EDI-2 (Garner, 1991), whereas the construct of eating disorder symptomatology was measured using the EAT-26 (Garner & Garfinkel, 1979). The sample was composed of 463 college women recruited from introductory psychology classes and sororities at two college campuses. The results of the study appeared to indicate that poor interoceptive awareness predicts eating disorder symptomatology.

2.4 Body Image of Lesbian Women

A major limitation of the extant research on body image is the limited population that researchers often sample. Most research is performed with samples composed largely of White, middle-class, heterosexual college women. In order to examine the applicability of objectification theory to lesbian women, it is necessary to review the available literature that exists concerning the body image and eating disorder symptomatology of lesbian women. This next section will offer such a review.

2.41 Theories on the Body Image of Lesbian Women

In the existent literature on lesbian women's body image and eating disorder symptomatology, two opposing theoretical perspectives have emerged. While some scholars (e.g. Brown, 1987; Siever, 1994) argue that lesbian women are less prone to body dissatisfaction and eating disorder symptomatology than heterosexual women, others (e.g. Dworkin, 1989; Striegel-Moore, Tucker, & Hsu, 1990) argue that lesbian women experience a similar amount of risk. Several arguments have arisen to support
both viewpoints.

2.411 Theory for an Altered Model of Lesbian Body Image

Striegel-Moore, Silberstein and Rodin (1986, p. 252) argue that women who are at greatest risk for body dissatisfaction are those who have most internalized the “sociocultural mores about thinness and attractiveness.” For instance, they theorize that women are prone to body image disturbance only to the extent to which they internalize the “thin-ideal” of the dominant culture. However, certain scholars (Blumstein & Schwarz, 1983; Brown, 1987; Stein, 1987) argue that there is reason to believe that lesbian women internalize the beauty ideals of the dominant culture to a lesser extent than heterosexual women.

For instance, Brown has described the lesbian subculture as being resistant to these beauty ideals (Brown, 1987). Brown (1987) observes that traditional lesbian ideology rejects the “thin ideal” of dominant culture and encourages women to nurture their bodies. She hypothesizes that this focus on healthy body image allows lesbian women to eat without feeling the guilt that heterosexual women often associate with eating. In this way, Brown suggests that belonging to the lesbian subculture, and its association with feminism, may act as a protective factor against body dissatisfaction and subsequent eating disorder symptomatology because lesbian women are less likely to internalize the messages of the dominant culture regarding weight.

An example of the level of resistance is embodied in “fat activism”, a movement that pushes for the social acceptability of being overweight. Fat activists argue that women of all sizes are oppressed by the fear of becoming or being fat (Mitchell, Newmark, & Purnell, 1981). Since the 1970s, the movement of “fat activism” has
flourished within the lesbian subculture (Heffernan, 1994).

Furthering this argument, Dworkin (1989) has suggested that since lesbian women have already rejected the dominant culture’s value of heterosexism, they are more likely to reject other patriarchal values, such as the thin-ideal. Dworkin (1989, p.28) asserted: “...Lesbians do not think of themselves as objects to be defined by male subjects. Therefore, it seems lesbians ought to be able to escape from the negative body image and lack of self-acceptance that other women in our society suffer from”.

Other scholars argue that a difference will exist between the body image of lesbian and heterosexual women due to the differences in the value orientations of their potential romantic partners. For instance, it is argued that men primarily value physical attractiveness in a potential partner, while women value other factors like personality, status, power, and income (Hatfield and Sprecher, 1986; Blumstein & Schwarz, 1983; Stroebe, Insko, Thompson, & Layton, 1971). Thus, Siever (1994) asserts that, “because physical appearance is less essential in attracting a female partner, heterosexual men and lesbians are subject to less pressure to be physically attractive.” Due to this lessened emphasis on physical attractiveness by their partners, lesbian women may experience less pressure to internalize the cultural ideals of beauty (Siever, 1994).

2.412 Theory for a Similar Model of Lesbian Body Image

Other scholars (e.g. Dworkin, 1989) have argued that there are no differences between lesbian and heterosexual women on dimensions of body image and eating disorder symptomatology. Dworkin (1989) argued that lesbian women must grow up in the same culture as heterosexual women and are thus socialized with the same cultural values concerning thinness. Though the values of the lesbian subculture (e.g. feminism,
body acceptance) may cause many lesbian women to disagree with the beauty ideals of the dominant culture, the media’s message is so pervasive (Kilbourne, 1994) that it may be impossible for lesbian women to avoid being impacted by it (Dworkin, 1989).

Moreover, the development of sexual orientation identity is typically something that occurs in late adolescence or early adulthood (Cass, 1979). Therefore, during the early stages of their life (i.e., childhood and adolescence), lesbian women are exposed to the media’s message of thinness, unmitigated by the theorized protections of the lesbian subculture. Thus, though lesbian women may consciously disagree with the beauty ideals of the dominant culture, they were still socialized with these messages and may have internalized them at a young age.

Further, lesbian women must live and function within the dominant culture’s heterosexist framework and “...privilege and power comes with an acceptable, i.e. male defined, appearance” (Dworkin, 1989, p.33). Thus, even though lesbian women may not personally endorse the values of the dominant culture (e.g. thin-ideal, sexual objectification), it is necessary that this group adapt to the mores of the dominant culture in order to be successful. Dworkin (1989) argued that this adherence to the thin-ideal is an adaptive function that all women learn, regardless of sexual orientation. In this way, Dworkin (1989) posited that lesbian women are at equal risk for body dissatisfaction and disordered eating.

The theories discussed provide different theoretical vantage points from which to understand lesbian women’s body image and eating disorder symptomatology. Unfortunately, until recently, most research on body image and eating disorder symptomatology has been completed on predominantly heterosexual samples of women.
The following section reviews the small body of research that has been done with samples of lesbian women.

2.42 Empirical Research on the Body Image of Lesbian Women

Currently, research examining the body image of lesbian women has found mixed findings. There appears to be some support for both viewpoints discussed above. For instance, one such study was performed by Siever (1994). The purpose of this study was to investigate the relation of sexual orientation to body image satisfaction and eating disorder symptomatology. Siever hypothesized that body image-related distress results from sexual objectification. He posited that men are more likely to engage in sexual objectification, thus the romantic partners of men (i.e. heterosexual women and gay men) will experience more body image-related distress. Therefore, Siever hypothesized that gay men and heterosexual women will experience a greater amount of body image dissatisfaction and eating disorder symptomatology than heterosexual men and lesbian women.

The construct of body esteem was measured the 35-item Body Esteem Scale (BES; Franzoi & Herzog, 1986), whereas concern with physical attractiveness and appearance was measured using the 5-item Physical Attractiveness Questionnaire (PAQ; Berscheid, et al., 1972). Concern with body shape was measured using the 34-item Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper and Fairburn, 1987) and eating disorder symptomatology was measured using the EDI (Garner, Olmsted & Polivy, 1983) and the EAT-26 (Garner & Garfinkel, 1979). The sample was composed of 53 lesbian women, 59 gay men, 62 heterosexual women and 63 heterosexual men. The heterosexual sample was recruited from a large university, whereas the gay and lesbian sample was
recruited through gay student organizations, newspapers and local bars.

Through multivariate analysis, Siever found that lesbian women exhibited significantly less concern with their own physical attractiveness than gay men and heterosexual women. However, Siever found no statistically significant difference between heterosexual women and lesbian women on measures of body satisfaction. In addition, Siever found that lesbian women scored significantly lower than heterosexual women on the EAT and drive for thinness subscale of the EDI. However, he found no statistically significant difference on the bulimia subscale of the EDI. Overall, Siever’s results appear to indicate that lesbian women and heterosexual men experience the least amount of body dissatisfaction and eating disorder symptomatology, whereas heterosexual women and gay men experience the most. However, the findings of this study are limited by the potential non-comparativeness of the samples due to the differing recruitment tactics.

Share and Mintz (2002) found similar findings. The researchers examined differences between lesbian and heterosexual women in disordered eating, internalization of the thin-ideal and body esteem. The construct of eating disorder symptomatology was measured using the Eating Attitudes Test (EAT; Garner, et al., 1982), whereas body esteem was measured using the Body Esteem Scale (BES; Franzoi & Shields, 1984). In addition, internalization of the thin-ideal was measured using the Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ; Heinberg, Thompson & Stormer, 1995). The heterosexual sample was composed of 102 women, whereas the lesbian sample was composed of 63 women. Participants were between the ages of 24 and 52. There were no significant differences found between the mean ages for the two samples (lesbian: $M =$
36.1; heterosexual: $M = 38.1$). The lesbian sample was found to report significantly lower levels of internalization of the thin-ideal. However, there were no significant differences found between the lesbian and heterosexual women on measures of eating disorder symptomatology and body esteem.

In a study by Herzog, et al (1992), participants were asked to choose figure drawings that represented their current figure, their ideal figure, the figure that they would expect to be attractive to a potential partner, and a figure to which they would be most attracted. In addition, the participants completed the Drive for Thinness and Body Dissatisfaction subscales of the EDI (Garner, Olmsted & Polivy, 1983). The sample was composed of 64 heterosexual women recruited from a large university, whereas 45 lesbian women were recruited from gay bars and organizations. The participants were between the ages of 18 and 35.

The authors found that lesbian women chose heavier weights than heterosexual women for all of the figure drawings. This finding suggests that lesbian women have a higher ideal weight standard than heterosexual women. In addition, lesbian women were found to score significantly lower on both subscales of the EDI. These finding appear to indicate that lesbian women experience less of a drive for thinness and are more satisfied with their bodies than heterosexual women. However, the authors found it important to note that, despite these differences, 40% of lesbian women reported feeling overweight, 50% reported wanting to lose weight, and 40% reported being concerned with their appearance on a daily basis. While the lesbian women in this study seemed to demonstrate lower levels of weight concern, almost half were dissatisfied with their bodies. This appears to indicate that, in general, both lesbian and heterosexual women
are dissatisfied with their weight and appearance.

More recently, a study by Moore and Keel (2003) examined the differences between lesbian and heterosexual women on disordered eating attitudes and behaviors. The construct of body esteem was measured using the Body Esteem Scale (Franzoi & Shields, 1984), while the construct of disordered eating behaviors was measured using the 64-item Eating Disorder Inventory-2 (Garner, Olmsted & Polivy, 1992). The sample was composed of 45 lesbian and 47 heterosexual women. The results of this study appeared to indicate that lesbian women exhibit less of a drive for thinness than heterosexual women. However, despite this difference, lesbian and heterosexual women were found to report similar levels of eating disorder symptomatology and body dissatisfaction. The findings of this study are limited by the small sample size.

A study by Heffernan (1994) sought to estimate the rates of bulimia nervosa and binge eating, as well as risk factors of eating disorders, within the lesbian population. Further, Heffernan sought to examine the degree to which lesbian women endorse traditional attitudes towards women. The construct of self-esteem was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965), body esteem was measured using the 35-item Body Esteem Scale (Franzoi & Shields, 1984), and the construct of disordered eating was measured using the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon, & First, 1990). In order to assess the degree to which lesbian women endorse traditional attitudes towards women, participants were administered the 13-item Attitudes Toward Attractiveness Scale (ATAS; Rodin, Striegel-Moore & Silberstein, 1985).

A sample of 203 lesbian women was recruited from campus lesbian organizations,
women’s music festivals, and metropolitan lesbian and gay centers. Heffernan (1994) found that lesbian women were significantly more critical of traditional attitudes towards women than heterosexual women. This finding may indicate that lesbian women internalize societal expectations of gender norms to a lesser extent than heterosexual women. However, despite this finding, Heffernan found that bulimia appears to be present in lesbian women at a .98%, which is comparable to the female national average of 1.0% (Fairburn & Beglin, 1990). In addition, lesbian women reported similar mean attitudes concerning weight and appearance as heterosexual women. Further, as found in heterosexual women, self-esteem was found to be significantly related to body esteem and actual-ideal weight discrepancy for lesbian women. This appears to indicate that lesbian women experience a similar drive for thinness and risk for disordered eating as heterosexual women.

A study by Striegel-Moore, Tucker and Hsu (1990) compared the body esteem and level of eating disorder symptomatology of lesbian and heterosexual women. The construct of body esteem was measured using the 35-item Body Esteem Scale (Franzois & Shields, 1984), while the construct of disordered eating was measured using the 64-item Eating Disorder Inventory (Garner, Olmsted & Polivy, 1984). A sample of 30 lesbian women was recruited from lesbian student organization at a small private university, while a sample of 52 heterosexual women were recruited through an introductory psychology course. The data indicated no significant differences between lesbian and heterosexual women on measures of body esteem and disordered eating. However, this study is severely limited by the small sample size and the homogeneity of the sample.

A study by Brand, Rothblum and Solomon (1992) examined the relative salience
of gender and sexual orientation in the prediction of body satisfaction and disordered eating. The construct of disordered eating was measured using the Bulimia subscale, the Drive for Thinness subscale and the Body Dissatisfaction subscale of the Eating Disorder Inventory (Garner, Olmsted & Polivy, 1984), whereas the construct of compulsory participation in exercise was measured using the Obligatory Running Questionnaire (Blumenthal, O'Toole, & Chang, 1984). A sample of 124 lesbian women recruited from a Southeastern women's music festival, a sample of 13 gay men recruited from a Southeastern gay conference, a sample of 133 heterosexual women and a sample of 39 heterosexual men recruited from an introductory psychology course, were administered the measures.

The authors found gender to have a stronger main effect than sexual orientation. Yet, lesbian women did report lower ideal weights and less preoccupation with weight than heterosexual women. However, both lesbian and heterosexual women reported a greater amount of concern with weight, body dissatisfaction and a greater frequency of dieting than did heterosexual and gay men. These findings suggest that the common experience of being a woman is stronger than sexual orientation in predicting body satisfaction and disordered eating. It is important to note that this study was limited by an extremely small male sample size, as well as a significant age difference between the heterosexual and gay or lesbian samples.

In 1996, Beren, Hayden, Wilfley and Grilo investigated the relation between body image satisfaction and sexual orientation. The authors hypothesized that lesbian women who were more affiliated with the lesbian community would experience less body dissatisfaction. The researchers measured the constructs of perceptual body
dissatisfaction with Body Size Drawings (BSD; Fallon & Rozin, 1985), affective body
dissatisfaction with the BSQ (Cooper, Taylor, Cooper & Fairburn, 1987) and frequency
of preoccupation with distress about body size with the Body Dissatisfaction subscale of
the EDI (Garner, Olmsted & Polivy, 1983). Affiliation with the lesbian community was
assessed using the Involvement Questionnaire (Green & Clunis, 1988). The sample was
composed of 69 lesbian women, 72 heterosexual women, 58 gay men and 58
heterosexual men. The mean age for the lesbian and heterosexual women differed
significantly (lesbian: $M = 34.91$; heterosexual: $M = 18.42$). The data indicated that
lesbian women and heterosexual women reported similar levels of body dissatisfaction.
In addition, involvement in the lesbian community was not found to significantly impact
the body dissatisfaction of lesbian women. The results of this study appear to indicate
that lesbian and heterosexual women experience similar amounts of body dissatisfaction.
Further, involvement in the lesbian community does not appear to be protective against
body dissatisfaction. However, it is important to note that the findings of this study are
severely limited by the huge age differences in the sample.

2.43 Summary of Empirical Findings on Lesbian Body Image

It is important to reiterate that many of the studies (e.g. Brand, Rothblum,
Solomon, 1992; Herzog, Newman, Yeh, and Warshaw, 1992; Moore & Keel, 2003;
Siever, 1988; Striegel-Moore, Tucker, & Hsu, 1990) in this literature review have serious
methodological flaws. For instance, due to the difficulty in obtaining lesbian
participants, several studies (Brand, Rothblum, Solomon, 1992; Herzog, Newman, Yeh,
and Warshaw, 1992; Moore & Keel, 2003; Striegel-Moore, Tucker, & Hsu, 1990)
utilized unacceptably small sample sizes (Heffernan, 1994). Further, other studies
utilized lesbian and heterosexual samples with mean ages that differed significantly (Beren, Hayden, Wilfley, Grilo, 1996; Brand, Rothblum, Solomon, 1992). Finally, a several studies (Herzog, Newman, Yeh, & Warshaw, 1992; Siever, 1994; Striegel-Moore, Tucker, & Hsu, 1990) recruited their lesbian sample from specific venues (i.e., student organizations, gay clubs) in which the sample may be expected to be highly homogeneous, and potentially nonrepresentative of the lesbian subculture as a whole. Thus, due to the limitations of extant research on lesbian body image, it appears imperative that efforts be taken in future research to procure larger, more comparable and more representative samples of lesbian women.

In summary, studies have generally found that lesbian women report less concern with appearance and weight, as well as higher ideal weights than heterosexual women (Brand, Rothblum & Solomon, 1992; Moore & Keel, 2003; Herzog, Newman, Yeh & Warshaw, 1992; Siever, 1994). Further, Heffernan’s finding (1994) that lesbian women are more critical of traditional attitudes towards women is also noteworthy. These findings may be interpreted as evidence that lesbian women have internalized the societal ideals for women (i.e. thinness and beauty ideals) to a lesser extent than heterosexual women.

Thus, according to the position of Striegel-Moore, Silberstein and Rodin (1983) that women who internalize the cultural ideals are the most at risk for body image disturbances, lesbian women should be expected to exhibit less body dissatisfaction and eating disorder symptomatology. However, there appears to be an overwhelming lack of evidence to support this prediction; extant research has been inconsistent on measures comparing the body esteem and body satisfaction of lesbian and heterosexual women.
While the research of Herzog, et al. (1992) and Siever (1994) found that lesbian women report higher body satisfaction than heterosexual women, a plethora of studies (Beren, Hayden, Wilfley, Grilo, 1996; Brand, Rothblum, Solomon, 1992; Share & Mintz, 2002; Siever, 1994; Striegel-Moore, Tucker, Hsu, 1990) have found no differences in body satisfaction. Further, several studies reported that lesbian women experience similar rates of eating disorder symptomatology (Heffernan, 1994; Striegel-Moore, Tucker & Hsu, 1990).

The research has found several apparent differences (i.e. drive for thinness, ideal weights, concern with weight) in the body image of lesbian and heterosexual women. However, it is not apparent whether these differences are great enough to have any tangible influence on behavioral outcomes, such as disordered eating (Heffernan, 1994). Striegel-Moore et al. (1990, p.498) suggests:

Although lesbian ideology rejects our culture’s narrowly defined ideal of female beauty and opposes the overemphasis placed on women’s physical attractiveness, such ideology may not be strong enough to enable lesbians to overcome already internalized cultural beliefs and values about female beauty…even as the lesbian woman increasingly identifies with a lesbian community…she is still a part of a greater cultural context that values beauty and thinness in women.

In light of these findings, it is possible then that lesbian women’s body image experience functions in a different way than heterosexual women. For instance, whereas for heterosexual women, the internalization of societal ideals of thinness tend to predict the likelihood that they will experience body image dissatisfaction and eating disorder symptomatology, lesbian women’s experience appears to differ.
Due to these mixed findings, it seems necessary that further research closely examine the body image of lesbian women by investigating a comprehensive model of body image that has garnered empirical evidence for heterosexual women (i.e., objectification theory). If several body-image related variables were examined simultaneously, more insight may be gained as to the overall functioning of lesbian women’s body image and how it compares to heterosexual women.

2.5 *Lesbian Body Image and Objectification Theory*

Fredrickson and Roberts (1997) suggest that demographic variables such as ethnicity and sexuality “may mitigate or protect certain subgroups of women against the negative psychological repercussions that we link to sexual objectification” (p. 197). However, a major limitation of the extant research on objectification theory is the limited population that researchers often sample. Most of the research has been with White, middle-class, heterosexual college women. Very few of the studies on objectification theory inquire about the sexual orientation of the participants; the few that do, report very few participants who identify as lesbian (Heffernan, 1994).

Furthermore, sexual objectification, a key component of the model outlined in objectification theory (see Figure 1), is based upon a value system that perpetuates heterosexism and male supremacy (Stoltzenberg, 1989). As lesbian women defy this value system by not using their bodies for the sexual pleasure of men, it may be expected that sexual objectification may function differently in the body image experience of lesbian women. Thus, a better model than that outlined in objectification theory (see Figure 1) may exist to explain the body image experience of lesbian women. Accordingly, it would be useful to gain better insight into the relationship of sexual
Note. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.

Figure 1: Structural model of objectification theory (i.e., Model 1).
objectification to lesbian women’s body image experience. To date, it appears that Hill (2003) offers the closest approximation to an application of objectification theory to a sample of lesbian women. In Hill’s dissertation (2003), she explores the potential impact of sexual orientation to the relation between sexual objectification and self-objectification. The construct of sexual objectification was measured by a scale created by the author, whereas the construct of self-objectification was measured using the 12-item Self-Objectification Questionnaire (Noll & Fredrickson, 1998). In addition, the construct of body surveillance was measured using the Body Shame subscale of the OBCS (McKinley & Hyde, 1996). A sample of 307 heterosexual women, 33 bisexual women, and 155 lesbian women were recruited through introductory psychology courses, LGB campus organizations and email correspondence. The participants were administered the measures. Hill did not find any evidence to suggest that sexual orientation moderated the relationship between sexual objectification and self-objectification. This appears to indicate that the relation between sexual objectification and self-objectification is similar for women of various sexualities.

2.6 Purpose of Study

The purpose of the present study is to test the applicability of objectification theory on women of differing sexual orientation identifications (i.e., lesbian and heterosexual women). In doing so, this study will contribute incrementally to the extant research on both objectification theory and lesbian women’s body image. The extant research on objectification theory will be expanded by providing confirmatory or disconfirmatory evidence if the theory’s applicability to a more diverse group of women. As stated previously, objectification theory has been tested primarily on heterosexual
women. All of the research on objectification theory that has been presented in the present literature review has utilized a sample that did not inquire into the sexual orientation of the participants or contained samples with nonsignificant numbers of lesbian women. In order to generalize the empirical findings that support objectification theory to all women, it is necessary that the model be tested on women of differing sexual orientations.

Moreover, this study will expand upon the present body of research on lesbian women’s body image experience. No study has examined a comprehensive model of body image, such as objectification theory, on a sample of lesbian women. Further, as outlined above, the small body of extant research that has examined individual facets of lesbian body image has been prone to the use of samples that are too small, non-representative and non-comparable. Thus, it seems necessary that a comprehensive model of body image, such as objectification theory, be investigated with lesbian women, while utilizing sound methodology. The present study will seek to accomplish these purposes by testing the model outlined in objectification theory (see Figure 1) with lesbian and heterosexual women.

This study will add incrementally to Hill’s research by applying a more comprehensive model of objectification theory to a comparative sample of lesbian and heterosexual women. The model applied here will further extend Hill’s model by (a) incorporating some of the negative psychological consequences of self-objectification (i.e., appearance anxiety, body shame, poor interoceptive awareness) and (b) examining the links of these psychological consequences to eating disorder symptomatology.
2.7 Hypotheses of Study

Accordingly, this study will seek to empirically verify that the model outlined in objectification theory (see Figure 1) is upheld in heterosexual and lesbian women. Thus, the hypotheses of this study are as follows for the heterosexual sample:

Hypothesis 1: Interpersonal sexual objectification will predict self-objectification.

Hypothesis 2: Self-objectification will predict appearance anxiety.

Hypothesis 3: Self-objectification will predict body shame.

Hypothesis 4: Self-objectification will predict poor interoceptive awareness.

Hypothesis 5: Appearance anxiety will predict body shame.

Hypothesis 6: Appearance anxiety will predict poor interoceptive awareness.

Hypothesis 7: Appearance anxiety will predict eating disorder symptomatology.

Hypothesis 8: Body shame will predict poor interoceptive awareness.

Hypothesis 9: Body shame will predict eating disorder symptomatology.

Hypothesis 10: Poor interoceptive awareness will predict eating disorder symptomatology.

Further, each of these hypotheses will be tested with a sample composed of lesbian women. If the model implied by these hypotheses (see Figure 1) is not supported by the data, a new model will be proposed for lesbian women.
CHAPTER 3

METHOD

3.1 Participants

Participants were 181 women who self-identified as lesbian and 196 heterosexual women who were current college or university students. These sample sizes exceeded the minimal number of participants needed to estimate the model (using the recommendation of a cases-to-parameter ratio of between 5 and 10 participants for each parameter estimated; Hu & Bentler, 1999) for both groups of women. The lesbian sample was recruited through Lesbian, Gay, Bisexual and Transgender student services and groups at colleges and universities throughout the country. Students who classified themselves as lesbian as their primary identification were encouraged to respond to the survey. These students were offered the opportunity to enter their name into a raffle for $50.

The heterosexual women were recruited through an introductory psychology course at a large Midwestern university. Students in the introductory psychology course received course credit for participation and were able to choose from approximately 30 experiments advertised on the course website. All of the women who participated in the study through the introductory psychology course identified themselves as heterosexual.

The sample of lesbian women included 149 White/European American students
(82%), 4 African American students (2%), 2 Asian American students (1%), 8 Hispanic students (4%), 4 Native American students (2%) and 14 multiracial students (9%). The majority of the participants only identified as lesbian (63%), while 27% additionally identified as bisexual. In addition, 3% identified as queer, 2% reported an identification not otherwise specified (e.g. "dyke", "pansexual") and 6% identified as a combination of identifications (e.g. "pansexual lesbian"). Further, while 100% of the participants identified as female, 10 of the participants also identified as transgender (6%). Because all participants in this sample reported "lesbian" as their primary sexual orientation identification and "female" as their primary gender identity identification, no participant was deleted if they also identified as bisexual, transgender, or "other."

In terms of class rank, the lesbian students were 7% freshmen, 17% sophomores, 20% juniors, 31% seniors, 17% graduate students and 6% post-baccalaureate. Regarding socioeconomic status, the lesbian sample was composed of 3% upper class, 22% upper-middle class, 50% middle class and 26% working class. Most lesbian participants reported being single (53%), while 12% were married or partnered, 34% were in a long-term relationship; no participant in this sample reported being divorced. Most geographic regions of the United States were represented; participants indicated living in the Midwest (54%), Northeast (23%), West (5%), South (2%), East (6%), Southeast (7%), and Northwest (3%). The mean age of this sample was 21.2 years ($SD = 1.9$, range = 18-26 years).

The sample of heterosexual women included 156 White/European American students (80%), 21 African American students (11%), 8 Asian American students (4%), 5 Hispanic students (3%) and 5 multiracial students (2%). In terms of class rank, the
heterosexual students were mostly freshmen (89%), followed by sophomores (7%), juniors (3%), and seniors (2%). Regarding socioeconomic status, the heterosexual sample was composed of 2% upper class, 29% upper-middle class, 59% middle class and 12% working class. Most heterosexual participants reported being single (77%), while 23% were in a long-term relationship, no participants reported being married, partnered, or divorced. The mean age of this sample was 18.36 years ($SD = .71$, range = 18-22 years).

3.2 Procedure

3.2.1 Lesbian Sample

In order to recruit the lesbian sample, an email describing the study was sent to directors of LGBT resources and leaders of student groups at university and college throughout the country. The email requested that the director or student leader include a small advertisement describing the study in any newsletter or Listserv that their program or group distributes. This advertisement accurately portrayed the study, stating that participants were desired for a study investigating the body image concerns of women who self-identified their sexual orientation as lesbian. Additionally, the advertisement contained the URL where the study was located. Interested participants could click on the link in the email to be taken directly to the study.

The study was hosted online by SurveyMonkey, an internet survey software company. SurveyMonkey provided the URL and server space for the data to be stored temporarily until administration was completed. Before beginning the study, participants in the lesbian sample were shown an informed consent statement and asked to click a box to indicate their consent. Further, participants in this sample were notified that they could
choose to skip any question that they did not wish to answer. Following completion of the study, the participants were shown a detailed debriefing statement, which elaborated on the purposes of the study and listed the contact information of the researchers. While no identifying information was collected from the participants, the participants in this sample were offered an opportunity to include their email address in order to be entered into a drawing for $50. In order to ensure anonymity, the participant’s email addresses were not connected to their responses.

The method of Internet data collection has many strengths, yet may result in erroneous data if certain precautions are not taken (Schmidt, 1997). Several strategies were utilized in order to minimize the likelihood that fallacious data would be obtained. First, as suggested by Schmidt (1997) and Dillon and Worthington (2003), the date, time and origin of the responses were examined to ensure that no duplicate surveys were submitted. One set of duplicates were found and removed from the data set. In order to control for random responding and inattentiveness, 10 items were placed throughout the survey that asked the participants to choose a specific response choice (e.g. “Please choose ‘Rarely’ for this question”). One submission was deleted because it did not comply by entering the response choices that were requested. Two items asked the participants to identify their gender identification and sexual orientation (to screen out non-lesbian participants). In addition, the total-item scores for each scale were normally distributed and the full range of response choices were represented in the data. Thus, it does not appear as though self-selection bias strongly influenced the results of this study.

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3.22 Heterosexual Sample

The heterosexual sample was recruited through a Psychology 100 course. Students were able to choose this experiment among many others offered simultaneously. The heterosexual students were administered a paper version of the questionnaire battery and asked to circle their response choice to each item. The participants in this sample were notified that the study was anonymous and that they could choose to discontinue the experiment without penalty. Further, these participants were told that they were allowed to skip any question that they did not wish to answer. At the end of the study, participants in this sample were offered debriefing materials, containing a statement of the purpose of the study and contact information for the researchers. This sample took approximately twenty minutes to complete the questionnaires.

3.3 Instruments

The measures administered included the Interpersonal Sexual Objectification Questionnaire, the Body Surveillance subscale and the Body Shame subscale of the Objectified Body Consciousness Scale, the short form of the Appearance Anxiety scale, the Interoceptive Awareness subscale of the Eating Disorder Inventory, and the Eating Attitudes Test-26.

3.3.1 Interpersonal Sexual Objectification

The Lifetime subscale of the Interpersonal Sexual Objectification Questionnaire (ISOQ; Kozee, Tylka, Denchik & Augustus-Horvath, 2005) was used to measure the construct of interpersonal sexual objectification. The ISOQ was developed based upon Fredrickson and Roberts’ (1997) description of common experiences of sexual objectification. This subscale was created to measure individual differences in the
frequency of interpersonally sexually objectifying experiences over a woman's lifetime. The ISOQ asked respondents to rate how often statements were true for them on a 5-point scale ranging from 1 (Never) to 5 (Almost always). The scale consisted of 20 items. Items such as "How often have you been whistled at while walking down a street?" or "How often have you noticed someone leering at your body?" are illustrative of the scale's content. Total scores on this scale were calculated by summing the individual item responses. Overall scores can range from 0 to 120 with higher scores indicating that the respondent has experienced a higher frequency of interpersonally sexually objectifying experiences over their lifetime.

Kozee et al. (2005) reported an alpha of .90 for the Lifetime subscale. The scale demonstrated good convergent validity by correlating moderately ($r = .52$) with a scale of sexist discrimination, the Schedule of Sexist Events (Klonoff & Landrine, 1995). The ISOQ demonstrated convergent validity by correlating moderately with measures of self-objectification, such as the Sociocultural Attitudes Towards Appearance Questionnaire ($r = .36$; Smolak, Levine & Thompson, 2001) and the Surveillance subscale of the Objectified Body Consciousness Scale ($r = .34$; McKinley & Hyde, 1996). Further, the scale demonstrated moderate correlations with measures of negative body image, such as the Body Shame subscale of the OBCS ($r = .32$; McKinley & Hyde, 1996). The scale also displayed some evidence of discriminant validity as it correlated slightly and negatively with a measure of impression management ($r = -.22$). In addition, the scale demonstrated a 3-week test-retest reliability of .82. The present sample demonstrated adequate internal consistency reliability for the lesbian sample ($\alpha = .90$) and the heterosexual sample ($\alpha = .88$).
3.32 Self-Objectification

The Body Surveillance subscale (SURV) is one of three subscales of the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996). This subscale was used to assess individual differences in levels of self-objectification. McKinley and Hyde define body surveillance as the extent to which one thinks of their body in terms of how their body looks rather than how their body feels. Body surveillance has been proposed (e.g., McKinley & Hyde, 1996; Tylka & Hill, 2004) to be a ubiquitous form of self-objectification, as it reflects the tendency to evaluate oneself based on external rather than internal characteristics.

This subscale consists of 8 items to which the respondent rates their agreement on a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). In addition, respondents were allowed to choose “NA” to indicate that the item did not apply to them. Items such as “During the day, I think about how I look many times” and “I often worry about whether the clothes I am wearing make me look good” are illustrative of its content. Total scores were obtained by averaging the item responses across answered items, with a higher total score indicative of a higher degree of body shame.

The subscale was shown to have adequate internal consistency reliability ($\alpha = .89$; McKinley & Hyde, 1996). McKinley and Hyde (1996) have demonstrated that the Body Shame subscale has sufficient stability over a two-week period in a sample of college women ($r = .79$). The subscale has demonstrated convergent validity by correlating strongly with measures of public self-consciousness ($r = .73$). The scale demonstrated an adequate level of internal consistency reliability for both the current sample of lesbian women ($\alpha = .87$) and heterosexual women ($\alpha = .88$).
3.33 Appearance Anxiety

The Appearance Anxiety Scale (AAS; Dion, Dion, & Keelan, 1990) was used to measure individual differences in women’s levels of appearance anxiety. The scale consists of 14-items. Respondents were asked to indicate the degree to which they agree with self-statements on a 5-point Likert scale, ranging from "Never" (i.e. indicating no appearance anxiety; scored as a 1) to "Almost Always" (i.e. indicating a lot of appearance anxiety; scored as a 5). Items such as "I feel nervous about aspects of my appearance" or "I worry about how others are evaluating how I look" are illustrative of the content of the scale. The items were averaged to yield a total score, with a higher total score interpreted as a higher degree of appearance anxiety.

This scale was found to have adequate construct validity. It is strongly correlated with self-esteem, public self-consciousness, and audience anxiety (Dion, Dion & Keelan, 1990). It has also been found that women score higher on this scale than men, supporting its construct validity. Tiggeman and Lynch (2001) reported a satisfactory internal consistency reliability estimate for this measure (α = .88). For the present study, this scale demonstrated an adequate level of internal consistency reliability for both the sample of lesbian women (α = .88) and heterosexual women (α = .90).

3.34 Body Shame

The Body Shame subscale (BS) is another subscale of the OBCS (McKinley & Hyde, 1996). This subscale consists of 8 items to which the respondent rates their agreement on a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). In addition, respondents were allowed to choose “NA” to indicate that the item did not apply to them. Items such as “When I’m not the size I think I should be, I feel
ashamed" or "I feel like I must be a bad person when I don't look as good as I could" are illustrative of the content of the subscale. Total scores were obtained by averaging the item responses across answered items, with a higher total score indicative of a higher degree of body shame. The subscale was shown to have adequate internal consistency reliability ($\alpha = .75$; McKinley & Hyde, 1996). McKinley and Hyde (1996) have demonstrated that the Body Shame subscale has sufficient stability over a two-week period in a sample of college women ($r = .79$) and that the subscale negatively correlates with the Body Esteem Scale ($r = - .51$), meaning that higher body shame is experience by people with lower body esteem. The internal consistency reliability estimates were adequate for the current sample of lesbian women ($\alpha = .88$) and heterosexual women ($\alpha = .86$).

### 3.35 Poor Interoceptive Awareness

The Interoceptive Awareness Subscale (IA-EDI) is one of 11 subscales of Eating Disorder Inventory - 2 (Garner, 1991). The subscale was used to assess respondents' awareness of hunger, satiety and emotions. The subscale consists of 10 items to which the respondent rates their level of agreement on a 6-point Likert scale, ranging from 1 (never true of me) to 6 (always true of me). Items such as "I get confused as to whether or not I am hungry" or "When I am upset, I don't know if I am sad, frightened, or angry" are illustrative of the content of this subscale. Total scores were obtained by averaging the item responses, with a higher total score indicating a poorer level of interoceptive awareness. It is important to note that the Interoceptive Awareness subscale is one of the EDI-2 subscales that measure different psychological variables that are related to disturbed eating. However, this subscale does not measure behavioral symptoms of
disordered eating (i.e., the Bulimia and the Drive for Thinness EDI-2 subscales are the only subscales that can be used to directly assess eating disorder symptomatology; see Garner, 1991). It has been argued that this subscale is distinct from disordered eating (Garner, 1991; Brookings & Wilson, 1994; Pike, 1995; Tylka & Subich, 1999). Garner and Olmsted (1984) report an adequate internal consistency reliability of .81. Additionally, the scale demonstrated a satisfactory level of stability over a three-week period \( r = .85 \) (Wear & Pratz, 1987), and was correlated to the ratings given by therapist-consultants of client interoceptive awareness \( r = .51 \) (Garner & Olmsted, 1984). The internal consistency reliability estimates were adequate for the current sample of lesbian women \( (\alpha = .85) \) and heterosexual women \( (\alpha = .88) \).

3.36 *Disordered Eating*

The Eating Attitudes Test - 26 (EAT-26; Garner & Garfinkel, 1979) was used to assess individual differences in participants' levels of disordered eating. The EAT-26 is a 26-item version of the 40-item Eating Attitudes Test developed by Garner and Garfinkel (1979). Research has shown the EAT-26 to be valid as a continuous measure of disordered eating among clinical and nonclinical samples of women (Mazzeo, 1999; Noll & Fredrickson, 1998; Tylka, 2004). Respondents were asked to indicate their level of agreement with each statement on a 6-point scale ranging from 1 (*never*) to 6 (*always*). Items such as "I have gone on eating binges where I feel that I may not be able to stop" or "I avoid eating when I'm hungry" are illustrative of its content. The present study calculated total scores by averaging the item responses, with a higher total score reflecting a more severe level of eating disorder symptomatology. The authors of the measure suggest that a cut-off score of 20 be utilized when scoring. However, due to the
implications of a restricted range with pathway analysis, the present study used a continuous scale. Mintz and O’Halloran (2000) found evidence that increased scores on the EAT-26 reflect an increase in disorder eating, supporting the use of a continuous scale.

Estimates of the internal consistency reliability range from .91 for a sample of college women (Mazzeo, 1999) to .94 for a sample of both women with and without eating disorder symptomatology (Garner & Garfinkel, 1979). The EAT-26 has demonstrated an adequate level of stability over a three-week period in a sample of college women (r = .86; Mazzeo, 1999). Construct validity was demonstrated for the EAT-26 as it was correlated with other measures of disordered eating, such as the Drive for Thinness subscale (r = .84; Garner, 1991) and the Bulimia subscale (r = .55; Brookings & Wilson, 1994) of the Eating Disorder Inventory - 2. Additionally, the EAT-26 was shown to correctly classify and identify individuals with disordered eating in samples of clinical and nonclinical women (Garner, Olmsted, Bohr, & Garfinkel, 1982). The internal consistency reliability was adequate for the current sample of lesbian women (α = .89) and heterosexual women (α = .93).

3.37 Demographic Questionnaire

In addition, a brief questionnaire requesting the age, sexual orientation, year in school, geographical location, ethnicity, relationship status, and socioeconomic status of the respondent was included within the measures. Participants were able to select as many identifications for their sexual orientation as they wished. The study was structured in this way so that the methodology did not artificially limit the participant’s sexual orientation identification to one. Due to this allowance, several women chose multiple
self-identifications (e.g. lesbian and bisexual). However, the mean scores between participants who identified solely as lesbian and those who identified with multiple identifications did not differ significantly for any of the instruments administered.

3.38 Ordering of Instruments

Both the lesbian and heterosexual sample was given the instruments in the order listed below. This was done due to constraints caused by the software used for the survey. However, this prevented the researchers from counter-balancing the order of the instruments. It is possible that fatigue effects occurred near the end of the study, thus this must be regarded as a limitation of this study.

The instruments that assessed the least personalized constructs (i.e. interpersonal sexual objectification) were given first. The questionnaire battery then ended with measures assessing more psychologically-oriented constructs (appearance anxiety, body shame, interoceptive awareness and disorder eating). This was done in order to lessen social desirability effects by easing the participants into being asked personal questions about their feelings and behaviors towards their bodies.

3.4 Design

Path analysis was utilized to analyze the model. This form of analysis was employed because it allows all of the pathways specified within the model to be analyzed concurrently, while generating specific indices with which to evaluate the model (Kelloway, 1998). The software program Mplus (Muthén & Muthén, 2001) was used to estimate the fit of the model and the model paths. As all of the measures that were used in this study have enough possible data points to be classified as continuous, the Maximum Likelihood (ML) method of model estimation was utilized. This method
employs a covariance matrix with conventional standard errors and a mean-adjusted chi-square test statistic.

The Mplus software generates several fit indices: the $\chi^2/df$ test, the comparative fit index (CFI), the Tucker-Lewis index (TLI), the standardized root-mean-square residual (SRMR), and the root-mean-square error of approximation (RMSEA). Conservative standards for evaluating model fit were utilized. For instance, Hu and Bentler (1999) and Kelloway (1998) recommend that an adequate model fit to the data is indicated when the CFI and TLI values are equal to or greater than .95, SRMR and RMSEA values are below .05, and $\chi^2/df$ values are smaller than 5.0.

It was determined that, if non-significant paths are found in the model for either the sample of lesbian women or heterosexual women, they will be deleted in order to make the model more parsimonious. In addition, as suggested by Kelloway (1998), Mplus was specified to detect modification indices above 5.0, which is indicative of a significant pathway between variables that is not examined in the model. If any modification indices were greater than 5.0, the model was modified accordingly and reanalyzed.
CHAPTER 4
RESULTS

4.1 Descriptive Statistics

Five women had a significant amount of missing data and were not entered into
the data set. These women had 25% or more of the data points missing from at least one
scale or subscale. Of the 377 participants included in the data set, 28 had a total of either
one or two data points missing; no participant left more than one item on a measure
blank. These missing data points were handled by substituting participants’ mean scale or
subscale scores for the missing value.

Each measure was examined for evidence of skewness and kurtosis through the
use of significance tests and visual appearance of the measure distributions. It was
determined (per Tabachnick & Fidell, 1996) that no violations existed that would
jeopardize the assumptions of our analyses. Scale means, standard deviations, alpha
levels, and intercorrelations were examined and are presented in Table 1 for the lesbian
sample and Table 2 for the heterosexual sample.
<table>
<thead>
<tr>
<th>Scale</th>
<th>ISOQ</th>
<th>SUR</th>
<th>AAS</th>
<th>BS</th>
<th>IA-EDI</th>
<th>EAT-26</th>
<th>M</th>
<th>SD</th>
<th>α</th>
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<td>.31**</td>
<td>.25**</td>
<td>.41**</td>
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<td>.60**</td>
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<td>.55**</td>
<td></td>
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<td>1.14</td>
<td>.87</td>
</tr>
<tr>
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<td></td>
<td>.40**</td>
<td>.55**</td>
<td></td>
<td>3.09</td>
<td>0.75</td>
<td>.88</td>
</tr>
<tr>
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<td>.70**</td>
<td></td>
<td></td>
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<td>1.38</td>
<td>.88</td>
</tr>
<tr>
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<td>.35**</td>
<td></td>
<td></td>
<td></td>
<td>2.91</td>
<td>0.78</td>
<td>.85</td>
</tr>
<tr>
<td>EAT-26</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2.35</td>
<td>0.69</td>
<td>.89</td>
</tr>
</tbody>
</table>

*Note.* n = 186. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.

*<sup>1</sup>p < .05.

*<sup>2</sup>p < .01.

Table 1: Means scores and intercorrelations among interpersonal sexual objectification, self-objectification, appearance anxiety, body shame, poor interoceptive awareness and eating disorder symptomatology for lesbian sample.
<table>
<thead>
<tr>
<th>Scale</th>
<th>ISOQ</th>
<th>SUR</th>
<th>AAS</th>
<th>BS</th>
<th>IA-EDI</th>
<th>EAT-26</th>
<th>M</th>
<th>SD</th>
<th>α</th>
</tr>
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<tr>
<td>ISOQ</td>
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<td>.62**</td>
<td>.32**</td>
<td>.49**</td>
<td>.36**</td>
<td>.38**</td>
<td>50.90</td>
<td>12.81</td>
<td>.88</td>
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<tr>
<td>SUR</td>
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<td>.54**</td>
<td>.73**</td>
<td>.42*</td>
<td>.52**</td>
<td></td>
<td>3.75</td>
<td>1.52</td>
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<td>.67**</td>
<td>.56**</td>
<td>.60**</td>
<td></td>
<td></td>
<td>2.82</td>
<td>0.81</td>
<td>.86</td>
</tr>
<tr>
<td>BS</td>
<td>1</td>
<td>.60**</td>
<td>.68**</td>
<td></td>
<td></td>
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<td>3.50</td>
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<td>.90</td>
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<tr>
<td>IA-EDI</td>
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<td>2.70</td>
<td>0.87</td>
<td>.88</td>
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<tr>
<td>EAT-26</td>
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<td></td>
<td></td>
<td>1</td>
<td>2.56</td>
<td>0.81</td>
<td>.93</td>
</tr>
</tbody>
</table>

Note. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26. n = 186.

*p < .05.  
**p < .01.

Table 2: Means scores and intercorrelations among interpersonal sexual objectification, self-objectification, appearance anxiety, body shame, poor interoceptive awareness and eating disorder symptomatology for heterosexual sample.
4.2 Heterosexual Sample

For the group of heterosexual women, the fit of the model proposed in Figure 1 (Model 1) was evaluated using Mplus with maximum likelihood estimation. All of the fit indices supported the fit of the model (CFI= 1.00; TLI=1.00; $\chi^2/df =1.06$; SRMR=.03; RMSEA=.02). None of the modification indices exceeded 5.0, indicating that no additional pathways needed to be added to the model. In addition, none of the residual variances exceeded 3.0, further supporting the integrity of the model.

The path coefficients are presented in Figure 2. All of the pathways that were hypothesized in Model 1 were found to be significant ($p < .05$), except for the path from poor interoceptive awareness to eating disorder symptomatology. As recommended by Kelloway (1998), in order to create a more parsimonious model, the nonsignificant pathway was deleted and the data were reanalyzed. All of the fit indices for the revised model indicated an excellent fit (CFI= 1.00; TLI=1.00; $\chi^2/df =1.04$; SRMR=.02; RMSEA=.02) and all of the path coefficients were significant ($p < .05$). The path coefficients of this revised model are presented in Figure 3. This final model accounted for 39% of the variance in body surveillance, 28% of the variance in appearance anxiety, 65% of the variance in body shame, 40% of the variance in poor interoceptive awareness, and 58% of the variance in eating disorder symptomatology.
Note. Presented are path coefficients analyzed using Mplus with maximum likelihood estimation. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.

*p < .05.

**p < .01.

Figure 2: Structural model of objectification with heterosexual sample (i.e., Model 1).
Note. Presented are path coefficients analyzed using Mplus with maximum likelihood estimation. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.

*p < .05.

**p < .01.

Figure 3: Final structural model of objectification with heterosexual sample with the path from the IA-EDI to the EAT-26 deleted.
4.3 *Lesbian Sample*

For the group of lesbian women, the fit of the model proposed in Figure 1 (Model 1) was evaluated using *MPlus*. The results of Model 1 indicated a poor fit of the data to the model; none of the fit indices supported the fit of the model (CFI=.94; TLI=.82; $\chi^2/df = 6.29$; SRMR=.09; RMSEA=.17). Several of the path coefficients were nonsignificant (i.e., the path from body surveillance to poor interoceptive awareness; the path from appearance anxiety to eating disorder symptomatology; the path from the poor interoceptive awareness to eating disorder symptomatology). The path coefficients for this model are presented in Figure 4.
Note. Presented are path coefficients analyzed using Mplus with maximum likelihood estimation. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Conscouonsness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Conscouonsness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.
*p < .05.
**p < .01.

Figure 4: Structural model of objectification with the lesbian sample (i.e. Figure 1).
In addition, several of the modification indices exceeded 5.0, indicating that there were additional pathways that needed to be added to the model (i.e. the path from sexist objectification to body shame was 5.0; the path from sexist objectification to poor interoceptive awareness was 5.05; the path from sexist objectification to eating disorder symptomatology was 12.46 and the path from body surveillance to eating disorder symptomatology was 8.72). Due to this finding, these additional paths were added to the model and the data were reanalyzed.

The fit indices indicated that this revised model fit the data well (CFI = 1.00; TLI=1.01; $\chi^2/df = .70$; SRMR = .01; RMSEA = .00). None of the modification indices exceeded 5.0, indicating that no additional pathways needed to be added to the model. In addition, none of the residual variances exceeded 3.0, further supporting the adequacy of the data to the model. However, not all of the paths were significant. As can be seen in Figure 5, the path from appearance anxiety to eating disorder symptomatology and the path from poor interoceptive awareness to eating disorder symptomatology were nonsignificant. Thus, in order to create a more parsimonious model, the two nonsignificant pathways were deleted and the data were reanalyzed.
Note. Presented are path coefficients analyzed using Mplus with maximum likelihood estimation. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26.

*p < .05.

**p < .01.

Figure 5: Revised structural model of objectification with lesbian sample with the included paths from the ISOQ to the BS, from the ISOQ to the IA-EDI, from the ISOQ to the EAT-26 and from the SURV to the EAT-26.
All of the fit indices for this final model indicated an excellent fit (CFI = 1.00; TLI = 1.01; χ²/df = .05; SRMR = .02; RMSEA = .00), and all of the path coefficients were significant (p < .05). The path coefficients are presented in Figure 6. None of the modification indices exceeded 5.0, indicating that no additional pathways needed to be added to the model. In addition, none of the residual variances exceeded 3.0. This final model accounted for 8% of the variance in body surveillance, 37% of the variance in the appearance anxiety, 57% of the variance in body shame, 23% of the variance in poor interoceptive awareness, and 54% of the variance in eating disorder symptomatology.
Note. Presented are path coefficients analyzed using Mplus with maximum likelihood estimation. ISOQ = Interpersonal Sexual Objectification Questionnaire; SUR = Body Surveillance subscale of the Objectified Body Consciousness Scale; AAS = Appearance Anxiety Scale; BS = Body Shame subscale of the Objectified Body Consciousness Scale; IA-EDI = Interoceptive Awareness subscale of the Eating Disorders Inventory; EAT-26 = Eating Attitudes Test-26. *p < .05. **p < .01.

Figure 6: Final structural model of objectification with lesbian sample with the path from AAS to EAT-26 and the path from IA-EDI to the EAT deleted.
CHAPTER 5
DISCUSSION

5.1 Overview

The present study examined the body image experience of lesbian women by applying the model described in objectification theory (Fredrickson & Roberts, 1997) which has garnered a great deal of empirical support for heterosexual women (Greenleaf, 2005; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Lynch, 2001; Tiggemann & Kuring, 1997; Tiggemann & Slater, 2001; Tylka & Hill, 2004). Previously, research has not adequately addressed the body image experience of lesbian women due to poor sampling techniques, lack of comparable comparison (i.e., heterosexual) samples, examination of few variables and use of unsophisticated statistical analyses. This study sought to build upon the knowledge of lesbian body image by avoiding the aforementioned problems, and therefore contributes incrementally to the literature in several ways.

5.2 Discussion of Findings for Heterosexual Sample

The present study garnered additional empirical support for the model proposed by Fredrickson and Roberts (1997) of objectification theory in heterosexual, college women; all but one of the variables and paths specified within this model were upheld with the sample of heterosexual women. Overall, the present study’s findings are consistent with the theoretical model of objectification theory (Fredrickson & Roberts,
1997), as well as extant research (Greenleaf, 2005; McKinley & Hyde, 1996; Muehlencamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Kuring, 1997; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001; Tylka & Hill, 2004). The next section will review the implications of the findings of each variable in the sample of heterosexual women.

5.21 Interpersonal Sexual Objectification

As theorized by objectification theory (Fredrickson & Roberts, 1997), sexual objectification was found to predict self-objectification in heterosexual women. This finding adds incrementally to extant research that has found a link between varying forms of sexual objectification (e.g. pressure to be thin) and self-objectification (Calogero, 2004; Fredrickson, et al., 1998; Huebner & Fredrickson, 1999; Tiggemann & Slater, 2001; Tylka & Hill, 2004). The results indicated that 39% of the variance in self-objectification can be accounted for by perceptions of interpersonal sexual objectification. While this amount is significant, it is not enough to fully account for the presence of self-objectification. Future research should look closely at other forms of sexual objectification, such as exposure to messages in the media which contain overt (e.g. sexual harassment) and subtle (e.g. object-of-the-gaze) forms of sexual objectification.

5.22 Self-Objectification

The present study's finding that self-objectification predicts a significant portion of the unique variance in appearance anxiety is congruent with past research findings (Slater & Tiggemann, 2001; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). This finding is also supported by a principle of
objectification theory (Fredrickson & Roberts, 1997), which holds that women who self-objectify, or consistently view their body from a third-person perspective, are more likely to experience anxiety regarding their appearance. This consequence is theorized to arise partly by the inability of most women to meet cultural standards of appearance.

Further, in the model tested in the present study, self-objectification predicted a significant portion of the unique variance in body shame for heterosexual women. This is also supported by objectification theory (Fredrickson & Roberts, 1997), as well as extant research (Noll & Fredrickson, 1998; Slater & Tiggemann, 2001; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001; Tylka & Hill, 2004). This finding adds further support for the hypothesis that engaging in the process of self-objectification may lead women to feel ashamed of their body if it does not meet the cultural standards of beauty.

Contrary to expectations, the path from self-objectification to poor interoceptive awareness was found to be nonsignificant. This finding is in contradiction to Fredrickson and Roberts’ (1997) assertion that women who self-objectify will be left with fewer internal resources to monitor their bodily states and will thus have less awareness of their emotions, hunger and satiety. While, theoretically, the link between self-objectification and poor interoceptive awareness may appear tenable, this hypothesis has not received much empirical backing as most researchers (Greenleaf, 2005; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001) who have studied objectification theory have not examined this variable within their models.

Those studies that have examined this variable have yielded mixed results. For
instance, while Muehlenkamp and Saris-Baglama (2002) found the path between self-objectification and poor interoceptive awareness to be significant, they chose to measure the construct of interoceptive awareness using a combination of items from the 20-item Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994), the interoceptive awareness subscale of the EDI (Garner, et al., 1983) and the private body consciousness subscale of the Body Consciousness Questionnaire (Miller, et al., 1981). In contrast, Tylka and Hill (2004) only used the interoceptive subscale of the EDI (Garner, Olmsted & Policy, 1983) and found the path between self-objectification and poor interoceptive awareness to be nonsignificant.

Thus, given these findings, it is possible that the interoceptive awareness subscale of the EDI (Garner, et al., 1983) is not measuring the same construct of interoceptive awareness as described by Fredrickson and Roberts (1997) in objectification theory. However, it is also plausible that objectification theory (Fredrickson & Roberts, 1997) overpredicted the influence of self-objectification in predicting poor interoceptive awareness. In other words, in the context of the overall model, self-objectification may not be as strong a predictor of poor interoceptive awareness as appearance anxiety and body shame.

It is important to note that interpersonal sexual objectification is not directly related to any variable in the model except self-objectification. This is congruent with objectification theory, which predicts that sexual objectification will only facilitate body shame, appearance anxiety and eating disorders if it is internalized. Therefore, given the importance of self-objectification, it seems imperative that efforts be taken in society to reduce the amount of interpersonal sexual objectification that occurs (Tylka & Hill,
2004). This change may possibly be able to occur through child and adolescent programming that promotes media literacy. Also, efforts to lessen the media’s perpetuation of sexual objectification may also be helpful. In addition, it appears important to identify variables that moderate the relation between sexual objectification and self-objectification. Once these variables are identified, it may be possible to utilize these variables as protective factors.

5.23 Appearance Anxiety

Consistent with objectification theory (Fredrickson & Roberts, 1997), the present study indicated that appearance anxiety predicted a significant portion of the unique variance of body shame in heterosexual women. This finding is supported by Fredrickson and Roberts (1997), who propose that women that experience a greater amount of anxiety relating to the ability of their appearance to meet with societal standards will be more likely to feel ashamed if their body does meet this cultural ideal.

Further, the finding that appearance anxiety predicts a significant portion of the variance in poor interoceptive awareness in heterosexual women is also consistent with objectification theory (Fredrickson & Roberts, 1997). It is proposed that the experience of appearance anxiety will leave women with less mental resources to monitor their internal bodily states, such as hunger and satiety.

In addition, appearance anxiety predicted a significant portion of the unique variance of eating disorder symptomatology in the present study’s sample of heterosexual women. This finding is both consistent with past research (Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001) and is supported by a central tenet of objectification theory. In objectification theory, Fredrickson and Roberts (1997) argue that women who
experience anxiety related to their appearance will have an increased likelihood of exhibiting eating disorder symptomatology.

5.24 Body Shame

Consistent with theory (Tribole & Resch, 1995) and past research (Garner, 1991; Muehlenkamp & Saris-Balgama, 2002; Tylka & Hill, 2004; Tylka & Subich, 2004), the present study’s findings indicate that body shame predicts the degree to which heterosexual women experience poor interoceptive awareness. This result is supported by a tenet of objectification theory which posits that women who feel ashamed of their bodies may attempt to suppress cues related to emotions, hunger and satiety (Fredrickson & Roberts, 1997).

This finding is especially significant since, contrary to the assertion of objectification theory, self-objectification did not predict poor interoceptive awareness. This type of relation was also found by Tylka and Hill (2004), who hypothesized that this finding may be evidence for body shame fully mediating the relation between self-objectification and poor interoceptive awareness. These findings may indicate that, in heterosexual women, the internalization of sexual objectification (i.e., self-objectification) predicts poor interoceptive awareness, only if the women feel ashamed of their bodies.

Further, we found that body shame predicts a significant portion of the unique variance in eating disorder symptomatology. This finding is consistent with extant research (e.g. Noll & Fredrickson, 1998; Tiggemann & Slater, 2001; Tylka & Hill, 2004) and the assertion in objectification theory (Fredrickson & Roberts, 1997) that women who experience body shame as a result of failing to meet cultural standards of beauty will
be more likely to actively attempt to meet those standards by engaging in dieting and other maladaptive eating behaviors.

5.25 *Poor Interoceptive Awareness*

As hypothesized, poor interoceptive awareness was found to predict a unique portion of the variance for eating disorder symptomatology. This finding is supported by previous research (Pike, 1995; Tylka & Hill, 2004) which has found the suppression of emotional, satiety and hunger cues to predict the occurrence of eating disorder symptomatology. In addition, it is important to note that, as hypothesized, eating disorder symptomatology is predicted by several variables (i.e. appearance anxiety, body shame and poor interoceptive awareness). This finding is consistent with the assertion of both objectification theory (Fredrickson & Roberts, 1997) and several other scholars (Kashubeck, West & Mintz, 2001; Leung, Geller, & Katzman, 1996) that eating disorder symptomatology is multidetermined.

5.26 *Summary*

There appears to be satisfactory evidence that the heterosexual sample in the present study may function as an adequate comparison group for the lesbian sample. According to an ANOVA, the ethnic composition and relationship status of the two samples are comparable. Additionally, all participants in both samples were currently enrolled in a college or university. While the ages of the two samples are significantly different, as illustrated by a t-test, the effect sizes elicited by age were small. Further, as outlined above, the present study’s analysis of the sample of heterosexual women is congruent with past research on objectification theory. For these reasons, it is reasonable to presume that direct comparisons may be made from the results garnered from the
lesbian and heterosexual samples.

5.3 Discussion of Findings for Lesbian Sample

The next major finding of the present study is that the model outlined by objectification theory (Fredrickson & Roberts, 1997) does not appear to be consistent with the experiences of lesbian women. The fit statistics of the original model (see Figure 1) indicate a poor fit of the model to the data. Indeed, several paths found to exist in heterosexual women were deleted and other paths were added by the use of modification indices. Once these alterations were made, our fit statistics indicated that our final model provided an excellent fit to the data and accounted for 54% of the variance in lesbian women’s eating disorder symptomatology. However, the addition of paths to the model created by Fredrickson and Roberts (1997) must be interpreted with caution, as scholars (e.g., Kelloway, 1998) have argued that alterations to models based on modification indices are not grounded in theory. These types of alterations may potentially be capitalizing on sample error by reflecting findings that are specific to a particular sample. The next section will review the implications of the findings of each variable in the sample of lesbian women.

5.3.1 Interpersonal Sexual Objectification

The present study’s results suggest that interpersonal sexual objectification functions somewhat differently in the model for lesbian women than in the model for heterosexual women. Sexual objectification was found to directly predict many variables not theorized in objectification theory (Fredrickson & Roberts, 1997) and not empirically supported by research with heterosexual women (Greenleaf, 2005; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2004).
2001; Tiggemann & Slater, 2001). Based on these findings, it appears as though sexual objectification has extremely pervasive effects on the body image experience of lesbian women.

Consistent with the present study’s heterosexual sample and supported by a principle of objectification theory (Fredrickson & Roberts, 1997), sexual objectification was found to directly predict self-objectification. However, contrary to the present study’s heterosexual sample and not supported by principles of objectification theory (Fredrickson & Roberts, 1997), interpersonal sexual objectification also directly predicted body shame, poor interoceptive awareness and, most notably, eating disorder symptomatology. These findings suggest that the frequency with which a lesbian woman has experienced interpersonal sexual objectification directly predicts the degree to which she will self-objectify, feel ashamed of her body, experiences diminished awareness of her bodily states and display eating disorder symptomatology. Thus, according to these findings, it is suggested that the experience of interpersonal sexual objectification may have a greater number of directly harmful implications for the body image experience and eating disorder symptomatology of lesbian women than heterosexual women. This finding unexpected finding may have several explanations.

A potential explanation for this finding may be the presence of feminist identity. Indeed, many researchers have noted that the feminist identity is a discernable facet of the lesbian subculture (e.g. Brown, 1987; Szymanski, 2004; Szymanski & Chung, 2003). Research findings have demonstrated that a high frequency of lesbian women do not endorse sexist beliefs (Szymanski, 2004; Leavy & Adams, 1986) and self-identify as feminist (Szymanski & Chung, 2003). A study by Swim, Mallet and Stangor (2004)
found that women who do not endorse sexist beliefs (e.g. feminists) more easily and accurately identify events that may be classified as “sexist.” Therefore, it is possible that lesbian women may be more impacted by sexually objectifying events because, due to their feminist identification, they are more likely to notice and identify the sexist event.

Another potential explanation for the importance of sexual objectification in the model found for lesbian women may be the relative salience of sexuality to the overall body image experience of lesbian women. On the whole, American culture and institutions are typically not supportive of any sexuality that is not heterosexual (Brown, 1987), a phenomenon termed heteronormativity. In this way, the identification of “lesbian” directly defies gender and societal norms. Particularly, while lesbian women are in the early stages of their identity development, they may feel uncomfortable in any situation in which their sexuality is highlighted. Thus, it is possible that sexually objectifying events cause discomfort in a greater number of ways (e.g., directly increasing their body shame, poor interoceptive awareness, and disordered eating) for lesbian women.

In addition, while our measure for interpersonal sexual objectification, the Interpersonal Sexual Objectification Questionnaire (Kozee, et al., 2005), did not directly inquire into the gender of the perpetrators of the sexually objectifying events, extant research (Ford, Wentzel & Lorion, 2001; Landrine & Klonoff, 1995; Swim, Hyers, Cohen & Ferguson, 1997) has demonstrated that men are more likely to sexually objectify women than other women. It is possible that any sexual attention by a male may be perceived as more objectifying than that initiated by females, as it is more likely to be undesired. For this reason, interpersonal sexual objectification may more directly
affect the overall body image experience of lesbian women in comparison to heterosexual women.

This finding provides support for the importance of safe-spaces. As the degree to which a lesbian woman is in an environment which is sexually objectifying directly predicts the degree to which she will experience negative body-image variables (self-objectification, body shame, appearance anxiety and disorder eating), it seems important that efforts be taken to increase the amount of time that lesbian women spend in places where they feel safe from sexual objectification. These results support the promotion of trainings in which college faculty and staff are educated about how to be allies to lesbian women. Further, the use of cards and other placards that designate college offices as “safe-spaces” for lesbian women may be important in allaying their fears of sexual objectification. In addition, it seems important that college campuses and communities make efforts to create and support spaces specifically for GLBT students.

5.32 Self-Objectification

The present study’s findings suggest that self-objectification also functions slightly differently for lesbian women in the model proposed by objectification theory. It was noted that self-objectification predicts a significant portion of the unique variance for both appearance anxiety and body shame. These findings are consistent with the heterosexual sample and are supported by central tenets of objectification theory (Fredrickson & Roberts, 1997). This suggests that, similar to heterosexual women, lesbian women are more likely to experience shame and anxiety regarding their appearance if they engage in self-objectification. These findings support the harmfulness of the internalization of objectification for women of all sexualities.
Finally, this finding has direct implications for mental health professionals. Mental health professionals may wish to assess lesbian clients for the amount and effects of sexual objectification that they experience. Interventions may be aimed at lessening the degree to which lesbian women are physically located in environments that are sexually objectifying, or at finding ways to lessen the impact of sexual objectification on their client.

However, contrary to research findings for heterosexual women, self-objectification was also found to directly predict a significant portion of the unique variance in disordered eating. This finding is not supported by objectification theory, which proposes that the relation between self-objectification and eating disorder symptomatology is mediated by such variables as appearance anxiety, body shame and poor interoceptive awareness. This finding may indicate that the process of self-objectification is damaging in a greater number of ways for lesbian women, as it directly predicts the occurrence of their eating disorder symptomatology. Future research should investigate this assertion and examine the relation between self-objectification and eating disorder symptomatology more closely in lesbian women. A qualitative study may be helpful in determining potential factors that moderate these relationships.

In addition, the present study indicated that self-objectification negatively predicted poor interoceptive awareness in the sample of lesbian women. This finding is completely contrary to an assertion in objectification theory that women who engage in self-objectification are utilizing a larger portion of their attention in order to monitor their outside appearance, and will thus be less aware of their internal states, such as hunger, satiety and emotions. This particular tenet of objectification was not supported by our
findings for our heterosexual sample and past research (Muehlenkamp & Saris-Balgama, 2002; Tylka & Hill, 2004).

While this finding may simply be a result of sample error, it is possible that it is due, in part, to the high frequency of feminist identification within the lesbian subculture. The lesbian subculture has been described as having values which embrace the female body and cultivate acceptance of various body sizes (Brown, 1987). However, given the pervasiveness and strength of the media’s message of the thin-ideal (Kilbourne, 1994), it is likely that it is still extremely difficult for many lesbian women to fully counter these messages, despite the support provided by the lesbian subculture. These lesbian women who do self-objectify may experience a certain amount of guilt and anger, as they may feel as though they have failed to meet the ambitious standard of body acceptance set by the lesbian community. A strong, visceral experience of these types of emotions after self-objectification may result in an actual heightening of internal awareness. More research must be done to investigate this hypothesis and to provide more information regarding the implications of self-objectification for lesbian women.

5.33 Appearance Anxiety

The current study’s results suggest that appearance anxiety functions slightly differently in the model for lesbian women and heterosexual women. The current study’s findings that appearance anxiety predicts a significant portion of unique variance for both body shame and poor interoceptive awareness is consistent with our heterosexual sample and supported by assertions in objectification theory (Fredrickson & Roberts, 1997). In objectification theory, Fredrickson and Roberts (1997) theorize that women who experience a greater amount of anxiety regarding whether their appearance is consistent
with societal standards will experience an increased amount of shame if their body is unable to meet the societal ideals. Further, it is proposed that the experience of appearance anxiety will leave women with less mental resources to monitor their internal bodily states, such as hunger and satiety.

However, the current study’s finding that appearance anxiety does not directly predict eating disorder symptomatology is contrary to the assertion within objectification theory and is not supported by our heterosexual sample or past research with heterosexual women (e.g. Slater & Tiggemann, 2002; Tiggemann & Slater, 2001). However, despite this finding, appearance anxiety and eating disorder symptomatology are strongly correlated ($r=.55$) in the lesbian sample. Thus, this finding does not appear to indicate that appearance anxiety and eating disorder symptomatology are unrelated for lesbian women, but that the variables of sexual objectification, self-objectification and body shame more strongly predict eating disorder symptomatology. In other words, appearance anxiety does not predict a significant amount of the variance in eating disorder symptomatology above and beyond sexual objectification, self-objectification and body shame for lesbian women.

5.34 Body Shame

The present study’s results suggest that body shame functions similarly in the model for lesbian women and heterosexual women. The results indicated that body shame predicts a significant portion of the unique variance in both poor interoceptive awareness and eating disorder symptomatology. In fact, the results suggest that body shame was the strongest predictor of eating disorder symptomatology. These findings are consistent with both our heterosexual sample and extant research with heterosexual
women (e.g. Slater & Tiggemann, 2002; Tiggemann & Slater, 2001; Tylka & Hill, 2004).

It is important to note the importance of body shame in both the heterosexual and lesbian sample in predicting eating disorder symptomatology. Given these and past findings (e.g. Tylka & Hill, 2004) it appears essential that action be taken to counter media messages which create a culture of “normative discontent” (Rodin, Silberstein & Striegel-Moore, 1985) by endorsing impossibly thin-ideals for women’s bodies (Kilbourne, 1984). It is imperative that mental health professionals promote and encourage body acceptance and positive body image in all women, regardless of their sexual orientation. This may be accomplished through the creation of student groups in colleges and universities that encourage students to discuss and analyze their feelings towards their bodies.

5.35 Poor Interoceptive Awareness

Contrary to the present study’s findings with the heterosexual sample, poor interoceptive awareness did not predict a significant portion of the unique variance in eating disorder symptomatology. This finding is not consistent with past research (Muehlenkamp & Saris-Balgama, 2002; Tylka & Hill, 2004) using heterosexual women and is contrary to an assertion made in objectification theory (Fredrickson & Roberts, 1997) that women who have poor interoceptive awareness will have a greater likelihood of developing eating disorder symptomatology.

Despite this finding, the results indicated that poor interoceptive awareness and eating disorder symptomatology were moderately correlated for lesbian women ($r=.35$). Thus, it does appear as though poor interoceptive awareness and eating disorder symptomatology are related for both lesbian women and heterosexual women. However,
as with appearance anxiety, the results seem to indicate that sexual objectification, self-objectification and body shame are stronger predictors of eating disorder symptomatology with lesbian women than poor interoceptive awareness. In other words, poor interoceptive awareness did not predict a significant portion of the variance in eating disorder symptomatology above and beyond that of the other variables (i.e. sexual objectification, self-objectification, body shame).

5.4 Summary

In summation, there appear to be several noteworthy similarities and differences between the models for the lesbian and heterosexual sample which contribute incrementally to the extant literature. First, for heterosexual women, sexual objectification is indirectly related to body image-related variables, such as appearance anxiety, body shame and eating disorder symptomatology. However, in the lesbian sample, sexual objectification directly predicts all of these variables. This finding suggests that the experience of interpersonal sexual objectification is more directly linked to the overall quality of the body image experience of lesbian women. Due to the increased influence of interpersonal sexual objectification and self-objectification, variables such as appearance anxiety and poor interoceptive awareness appear to be less likely to directly predict eating disorder symptomatology for lesbian women than heterosexual women.

Despite these differences, there is an important commonality between the samples that is worthy of mention. Whether directly (i.e. for the lesbian sample) or indirectly (i.e. for the heterosexual sample), the experience of interpersonal sexual objectification predicts the occurrence of eating disorder symptomatology in both samples. These
findings may be interpreted as more evidence for the harmfulness of interpersonal sexual objectification in society for all women, regardless of sexual orientation. Indeed, it appears as though lesbian women’s body image experience is more directly impacted by these experiences. These findings may indicate that sexual objectification has direct and indirect implications on the body image experience of all women and impact their overall mental health. Women who experience such potentially debilitating psychological phenomena (i.e., self-objectification, appearance anxiety, body shame, poor interoceptive awareness and eating disorder symptomatology) may be mentally and physically less capable of performing everyday functions to their maximum capacity, as these phenomena may be expected to consume a large amount of mental capacity.

The potential damage that is done to the mental health of young women through interpersonal sexual objectification may be seen as an additional barrier in life that prohibits women from achieving self-actualization. Given these implications, interpersonal sexual objectification should be regarded as a subtle variety of cultural oppression for both heterosexual and lesbian women. It seems imperative that action be taken to educate both men and women about the implications of sexual objectification, in an attempt to lessen the amount that occurs.

5.5 Limitations

Despite the contributions that the present study has made to the literature, there are several limitations that must be addressed. First, the data for the lesbian sample was collected through the Internet. This particular method of data collection is especially prone to duplicate surveys, random answering, and inattentiveness. While several strategies were used in order to minimize these issues, these approaches may not have
controlled for all fallacious data.

Next, two different formats of data collection were used for each sample; the lesbian sample was collection through the Internet, whereas the heterosexual sample was collected in a college classroom through paper and pencil. It may be reasonable to expect that there are differences in response styles for each particular set of circumstances. For instance, a participant who is answering items at their residence (i.e. on the Internet) may be more likely to admit having experienced eating disorder symptomatology than a respondent who is in a public setting (i.e. in a college classroom). It is possible that this confound added to sample error.

Another potential limitation is the use of self-identification as a means to categorize the sexual orientation of the participants. Sexuality is composed of several dimensions (e.g. behavior, attraction, identification). The single dimension of identification was utilized for convenience and because self-identification may be the most useful in determining the extent to which one is involved in the GLBT community. In addition, sexuality is fluid in nature.

Also, two different recruitment tactics were used for the sample; the heterosexual sample was recruited through an introductory psychology class at a major midwestern university, whereas the lesbian sample was recruited through gay, lesbian, bisexual and transgender Listservs and student organizations at universities and colleges throughout the country. It is likely that important differences beyond sexual orientation exist between the groups that may impact their body image. It is possible that this potential difference may have contributed to sample bias.

Further, both samples utilized came from a young adult, college background.
Thus, it would be inappropriate to generalize the findings in this study to lesbian and heterosexual women from older and non-college backgrounds. There is adequate reason to believe that lesbian and heterosexual women from different backgrounds may have experiences that differ dramatically from those in the samples used in the present study. Future research should seek to examine the experiences of lesbian women who are not enrolled in college, as well as lesbian women who are older.

Another limitation of the present study was that data were collected at only one point in time and therefore cannot be used to imply causality. In addition, other potential models containing other variables may have fit the model equally well. The excellent fit of the model that was found for the lesbian sample does not imply that the model has been “proven” true. Further research should attempt to cross-validate the lesbian model of objectification theory and subject it to latent variable structural equation modeling.

Lastly, as with any self-report study, the validity of the data in this study relies on the respondents reporting their experiences accurately. In order to minimize the effects of social desirability, all respondents were reminded that their responses would be kept completely anonymous. Despite this strategy, some respondents may have potentially given either intentionally or unintentionally inaccurate responses. This particular issue may have also resulted in response error. Due to constraints caused by the software used to administer the study online, no measure of social desirability was administered. Thus, it is possible that one or more of the measures administered in the study correlated highly with social desirability for one or both of the samples. Due to this limitation, the findings of the present study should be interpreted with caution.
5.6 Future Research

In addition to the ideas for future research presented previously, researchers may want to examine potential moderators of the relationship between sexual objectification and self-objectification. Moderators of this relationship (e.g., feminist consciousness, lesbian identity development, ethnic identity development) may serve as buffers that may minimize the internalization of interpersonal sexual objectification. Identification of these protective factors may prove useful to mental health or social service professionals who are seeking to diminish the pervasive effects of sexual objectification.

In addition, future research should examine the effects of sexual objectification on lesbian women more closely. More research must be done in order to confirm or disconfirm the hypotheses generated in this study. In particular, it may be useful to qualify the effects of sexual objectification on lesbian women perpetrated by different genders. For instance, it is plausible that sexual objectification by men is more psychologically damaging to lesbian women than that committed by women. In an elective email correspondence with the researcher, one of the respondents raised the following concern:

The way I experience being "viewed" varies TREMENDOUSLY according to the gender of the viewer. I found myself coming up with very different answers depending on whether I pictured the comment or action in question being committed by a man or a woman (as well as by a queer woman as opposed to straight woman).

Due to this reaction, it may be important for future research to examine the impact that gender has on the effects of sexual objectification.
Finally, several respondents in the lesbian sample electively contacted the researcher via email to describe their difficulty in answering some of the items. The participants described their responses and overall body image as being often context-specific. As an oppressed minority, lesbian women's body image may likely be influenced by their immediate sense of safety, comfort and belonging. In a correspondence, one respondent stated:

My image of myself varies greatly according to my environment, and many straight women do not have access to the queer/women's community in which many queer women find (inconsistent) refuge. [sic] myself find my body-image in constant flux, and constantly reacting to the tension between a "lesbian aesthetic" and the aesthetic of larger society.

Considering these reactions, it seems especially crucial for future research to more fully examine the impact of context on lesbian women's body image experience, in order to gain a fuller understanding.
LIST OF REFERENCES


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APPENDIX A

INTERPERSONAL SEXUAL OBJECTIFICATION QUESTIONNAIRE
Please indicate the relative frequency with which each of these events has occurred during your lifetime.

How often have you...

1.) ...been whistled at you when you walk down a street.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

2.) ...noticed someone staring at your breasts when you are talking to them.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

3.) ...felt like or known that someone was evaluating your physical appearance.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

4.) ...been called a name that is sexist, like whore, bitch, etc.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

5.) ...felt that someone was staring at your body.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

6.) ...heard someone make negative comments about your body or a body part.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

7.) ...had a romantic partner that seemed to be more interested in your body than in you as a person.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always

8.) ...seen someone leer at your body.
   Almost Never    Rarely    Occasionally    Frequently    Almost Always
9.) …heard a sexual remark made about your body that was rude.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

10.) …been praised for having a nice body or a body part.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

11.) …been touched or fondled against your will.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

12.) …been the victim of sexual harassment.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

13.) …been honked at when you walk down the street.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

14.) …seen someone stare at a body part.

Almost Never  Rarely  Occasionally  Frequently  Almost Always

15.) …overheard inappropriate sexual comments.

Almost Never  Rarely  Occasionally  Frequently  Almost Always
APPENDIX B

APPEARANCE ANXIETY SCALE
Indicate to what extent the statement is true or characteristic of you, using the following response scale:

1. I feel nervous about aspects of my physical appearance

<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>sometimes</th>
<th>often</th>
<th>very often</th>
<th>almost always</th>
</tr>
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</table>

2. I worry about how others are evaluating how I look

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<th></th>
<th>never</th>
<th>sometimes</th>
<th>often</th>
<th>very often</th>
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</table>

3. I am comfortable with my appearance.

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<th></th>
<th>never</th>
<th>sometimes</th>
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<th>very often</th>
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4. I like how I look (reverse scored)

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<th>never</th>
<th>sometimes</th>
<th>often</th>
<th>very often</th>
<th>almost always</th>
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</table>

5. I would like to change the way I look

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<th></th>
<th>never</th>
<th>sometimes</th>
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6. I am satisfied with my body's build or shape (reverse scored)

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<th>never</th>
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7. I feel uncomfortable with certain aspects of my physical appearance

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8. I feel that most of my friends are more physically attractive than myself

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<th>very often</th>
<th>almost always</th>
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</table>
9. I wish I were better looking

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always

10. I am concerned about my ability to attract romantic partners

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always

11. I feel comfortable with my facial attractiveness (reverse scored)

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always
always

12. I am satisfied with my body weight (reverse scored)

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always

13. I get nervous when others comment on my appearance

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always

14. I am confident that others see me as physically appealing (reverse scored)

____ never  ____ sometimes  ____ often  ____ very often  ____ almost always
always
APPENDIX C

OBJECTIFIED BODY CONSCIOUSNESS SCALE:
BODY SHAME SUBSCALE
1.) When I can’t control, my weight, I feel like something must be wrong with me.

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<tbody>
<tr>
<td>NA</td>
<td>Strongly Disagree</td>
<td>Neither Agree Nor Disagree</td>
<td>Strongly Agree</td>
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2.) I feel ashamed of myself when I haven’t made the effort to look my best.

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<td>Strongly Disagree</td>
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<td>Strongly Agree</td>
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3.) I feel like I must be a bad person when I don’t look as good as I could.

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<td>Strongly Disagree</td>
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4.) I would be ashamed for people to know what I really weigh.

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5.) I never worry that something is wrong with me when I am not exercising as much as I should.

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6.) When I’m not exercising enough, I question whether I am good.

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<td>Strongly Disagree</td>
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7.) Even when I can’t control my weight, I think I’m an okay person.

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8.) When I’m not the size I think I should be, I feel ashamed.
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<td>NA</td>
<td>Strongly Disagree</td>
<td>Neither Agree Nor Disagree</td>
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APPENDIX D

OBJECTIFIED BODY CONSCIOUSNESS SCALE:
BODY SURVEILLANCE SUBSCALE
1.) I rarely think about how I look

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

2.) I think it is more important that my clothes are comfortable than whether they look good on me. (R)

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

3.) I think more about how my body feels than how my body looks. (R)

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

4.) I rarely compare how I look with how other people look. (R)

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

5.) During the day, I think about how I look many times.

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

6.) When I’m not exercising enough, I question whether I am good.

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

7.) I often worry about whether the clothes I am wearing make me look good.

1  2  3  4  5  6  7
NA
Strongly Disagree  Neither Agree Nor Disagree  Strongly Agree

8.) I rarely worry about how I look to other people.

1  2  3  4  5  6  7
APPENDIX E

EATING DISORDER INVENTORY 2-
INTEROCEPTIVE AWARENESS SUBSCALE
1.) I get frightened when my feelings are too strong.
   
   Always  Usually  Often  Sometimes  Rarely  Never

2.) I get confused about what emotion I am feeling.
   
   Always  Usually  Often  Sometimes  Rarely  Never

3.) I can clearly identify what emotion I am feeling.
   
   Always  Usually  Often  Sometimes  Rarely  Never

4.) I don't know what's going on inside me.
   
   Always  Usually  Often  Sometimes  Rarely  Never

5.) I get confused as to whether or not I am hungry.
   
   Always  Usually  Often  Sometimes  Rarely  Never

6.) I worry that my feelings will get out of control.
   
   Always  Usually  Often  Sometimes  Rarely  Never

7.) I feel bloated after eating a small meal.
   
   Always  Usually  Often  Sometimes  Rarely  Never

8.) When I am upset, I don't know if I am sad, frightened, or angry.
   
   Always  Usually  Often  Sometimes  Rarely  Never

9.) I have feelings I can't quite identify.
   
   Always  Usually  Often  Sometimes  Rarely  Never

10.) When I am upset, I worry that I will start eating.
    
   Always  Usually  Often  Sometimes  Rarely  Never

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APPENDIX F

EATING ATTITUDES TEST-26
1. I am terrified about being overweight.
   Always  Usually  Often  Sometimes  Rarely  Never

2. I avoid eating when I am hungry.
   Always  Usually  Often  Sometimes  Rarely  Never

3. I find myself preoccupied with food.
   Always  Usually  Often  Sometimes  Rarely  Never

4. I have gone on eating binges where I feel that I may not be able to stop.
   Always  Usually  Often  Sometimes  Rarely  Never

5. I cut my food into small pieces.
   Always  Usually  Often  Sometimes  Rarely  Never

6. I am aware of the calorie content of foods that I eat.
   Always  Usually  Often  Sometimes  Rarely  Never

7. I particularly avoid food with a high carbohydrate content.
   Always  Usually  Often  Sometimes  Rarely  Never

8. I feel that others would prefer if I ate more.
   Always  Usually  Often  Sometimes  Rarely  Never

9. I vomit after I have eaten.
   Always  Usually  Often  Sometimes  Rarely  Never

10. I feel extremely guilty after eating.
    Always  Usually  Often  Sometimes  Rarely  Never

11. I am preoccupied with a desire to be thinner.
    Always  Usually  Often  Sometimes  Rarely  Never

12. I think about burning up calories when I exercise.
    Always  Usually  Often  Sometimes  Rarely  Never

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13. Other people think that I am too thin.
   Always    Usually    Often    Sometimes    Rarely    Never

14. I am preoccupied with the thought of having fat on my body.
   Always    Usually    Often    Sometimes    Rarely    Never

15. I take longer than others to eat my meals.
   Always    Usually    Often    Sometimes    Rarely    Never

16. I avoid foods with sugar in them.
   Always    Usually    Often    Sometimes    Rarely    Never

17. I eat diet foods.
   Always    Usually    Often    Sometimes    Rarely    Never

18. I feel that food controls my life.
   Always    Usually    Often    Sometimes    Rarely    Never

19. I display self-control around food.
   Always    Usually    Often    Sometimes    Rarely    Never

20. I feel that others pressure me to eat.
   Always    Usually    Often    Sometimes    Rarely    Never

21. I give too much time and thought to food.
   Always    Usually    Often    Sometimes    Rarely    Never

22. I feel uncomfortable after eating sweets.
   Always    Usually    Often    Sometimes    Rarely    Never

23. I engage in dieting behavior.
   Always    Usually    Often    Sometimes    Rarely    Never

24. I like my stomach to be empty.
   Always    Usually    Often    Sometimes    Rarely    Never
25. I enjoy trying new rich foods.

| Always | Usually | Often | Sometimes | Rarely | Never |

26. I have the impulse to vomit after meals.

| Always | Usually | Often | Sometimes | Rarely | Never |
APPENDIX G

DEMOGRAPHIC INFORMATION
Age: ____

Ethnic Identification

_____ African American    _____ Asian American
_____ Caucasian/White    _____ Native American
_____ Latino
_____ Other: please specify: ____________________________

Relationship status:

_____ Single
_____ Long term relationship
_____ Other: please specify: ______

_____ Divorced

Year in School:

_____ Freshman-or- high school senior
_____ Sophomore
_____ Junior
_____ Senior

_____ Post-bac
_____ Graduate student
_____ Other

Socio-Economic Identification

_____ Upper class
_____ Upper-middle class

_____ Middle class
_____ Working class

Sexual Orientation:

_____ Heterosexual
_____ Lesbian
_____ Bisexual
_____ Gay

Gender:

_____ Female
_____ Male
_____ Transgender
APPENDIX H

ADVERTISEMENT USED TO RECRUIT LESBIAN SAMPLE
To date, there has been little research done on the body image concerns of lesbian women. You can help to change this by participating in a brief online study that is currently being conducted by researchers at Ohio State University. The survey takes about 30 minutes to complete and is completely anonymous. If you are interested, please go to www.surveymonkey.com/XXX.
Participant Information Page

Thank you for your interest in this study. Before beginning, I would like to provide you with some information regarding this study. Please read this carefully.

What is the purpose of this study?
The following study focuses on exploring female body image. The purpose of the study is to explore whether factors related to body image differ for women of different sexualities.

What will this study involve?
This study contains several questionnaires that ask a variety of questions regarding one’s thoughts, feelings, experiences and behaviors. The study contains approximately 150 one-sentence items to respond to, which altogether should take around 30 to 45 minutes of your time.

Who can participate in this study?
This study is designed only for heterosexual and lesbian women in the 18 to 30 age range. If you are not a heterosexual or lesbian female or do not fall within this age range, please do not complete this study.

What are possible disadvantages of taking part in this study?
Given that this study will take about 30 to 45 minutes of your time, you may find this inconvenient. Please take this into account before beginning, and choose a convenient time for yourself to complete it if you wish to do so. Also this study may ask some questions that you find personal, or may make you feel uncomfortable. If this happens, you can simply leave any question blank if you do not wish to answer it. Furthermore, you can end the study at any time simply by closing your web browser. Also, as some of the questions may ask the participant to divulge personal information, participants are discouraged from completing this study at work.

What are the possible benefits of taking part in this study?
The main benefits of participating in this study lie in the contribution you would make towards further understanding of female body image. There are likely no direct benefits you would receive.

Will my taking part in this study be kept confidential?
Yes. This study will not request any identifying information from you, such as your name or address. Therefore, your responses are anonymous.

What if I decide to withdraw while taking the study?
If you decide to withdraw while in the middle of taking the study, your answers will be erased. If you choose to retake the study at a later time, you will have to start from the beginning.
What if I am interested in the results of this study?
You may contact the researchers for this study, listed at the bottom of this page, for more information.

Who has reviewed this study?
The procedures for this study have been reviewed by the Behavioral and Social Sciences Institutional Review Board at The Ohio State University.
Thank you. If you have any other questions, you may contact:

**Dr. Tracy Tylka, Ph.D.**  
Tylka.2@osu.edu  
237B Morrill Hall  
1465 Mt. Vernon Avenue  
Marion, OH 43302  
(740) 389-6786

**Holly Kozee, B.S.**  
kozee.1@osu.edu  
109 Townshend Hall  
1885 Neil Avenue  
Columbus, OH 43231  
(614) 475-0721

**Office of Responsible Research Practices (ORRP)**  
Phone: (614)688-8457  
Address:  
The Ohio State University  
Third Floor Research Foundation Building  
1960 Kenny Road  
Columbus, Ohio  
43210-1063

To continue with this study, you will be presented with a brief informed consent form, which describes that you understand several points discussed in this information. To go to the informed consent form and continue with this study, please click here: ___.

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APPENDIX J

INFORMED CONSENT PAGE
Informed Consent

By clicking to continue, I indicate that I understand the procedures involved in this study.

I am aware that I have the right to ask questions and receive answers related to this study by contacting the investigators: Dr. Tracy Tylka, tylka.2@osu.edu, (740) 389-6786; Holly Kozee, B.S., kozee.1@osu.edu, (614) 475-0721. Furthermore, if I have questions about my rights as a research participant, I can call the Office of Research Risks Protection at (614) 688-4792.

I am aware that I have the right to refuse to participate and may withdraw at any time without any penalty, simply by closing my web browser. Furthermore, I know I do not have to answer any question that I do not wish to, and can merely skip such questions. I understand that my participation is voluntary.

Click here to indicate your consent and continue with this study: ___
APPENDIX K

DEBRIEFING STATEMENT
Sexual Objectification and Body Image

The study you just participated in assessed the relationships between one’s personal experience with sexual objectification, self-objectification, anxiety over one’s appearance, feelings of body shame, level of awareness of one’s internal bodily states and disordered eating. Overall, this study focuses on the relationship between sexual objectification and eating disorders in women. Sexual objectification is any situation any which one’s body is removed from their identity, as if their body is capable of representing them. It is has been hypothesized that the existence of sexual objectification within our society may indirectly lead to disordered eating. An increase in exposure to or experiences in which one is sexually objectified may lead to an increase in self-objectification, body shame, appearance anxiety, and awareness of one’s internal bodily states, such as hunger. All of these factors have been linked to disordered eating.

There has been a great deal of research supporting this hypothesis. However, as of yet, all of the research has been done with heterosexual women. The goal of this study was to determine whether these same relationships exist for lesbian women. Thus, this survey was given to both lesbian and heterosexual women to determine whether they respond similarly.

Please feel free to ask any questions about the study or the concepts presented. If you have any questions or want to hear about the results, you can contact the Principal Investigator, Dr. Tracy Tylka, at 740-389-6786 or tylka.2@osu.edu; or the Co-Investigator, Holly Kozee, at 614-475-0721 or kozee.1@osu.edu. Furthermore, if the content of this study brought up questions or issues that you would like to explore with someone, an option is to consider pursuing counseling to discuss these issues. You can do so by looking in the yellow pages under counseling, therapy, and psychology, for example. Another option is to contact your state board of mental health, which often provides referral services.

Thank you very much for your participation.