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THE EFFECTS OF EXPOSURE TO FEMINIST
IDEOLOGY ON WOMEN'S BODY IMAGE

by

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B.A. Gustavus Adolphus College, 2001

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Science
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in the College of Arts and Sciences
at the University of Central Florida
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ABSTRACT

Body image disturbance has become an increasing problem among women (Cash & Henry, 1995). Thus researchers have begun to focus on methods of prevention and intervention. Programs utilizing psychoeducation and Festinger's cognitive dissonance theory, for example, have been found to reduce body image dissatisfaction and related symptomatology. The information provided and potential impact are limited, however, because the interventions do not offer women an adaptive method of interpreting the many appearance-related messages they experience. This study sought to determine if exposure to feminist theory of body image may act as a buffer – a filter through which cultural messages about thinness and beauty are challenged. This feminist schema may provide an alternative interpretation of cultural messages, thereby increasing body image satisfaction. Participants were exposed to one of three interventions (feminist, psychoeducational, control). Exposure to the feminist condition resulted in increased physical appearance satisfaction and likelihood to self-identify as a feminist when compared with the control group. While findings were not extensive, they are nonetheless promising due to the brevity of the intervention.

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INTRODUCTION

Currently, weight concerns and food restriction are so common for women that they have become the societal norm (Rodin, Silberstein, & Streigel-Moore, 1984). A national survey concluded that nearly 50% of women ages 18 to 70 evaluated their appearance negatively and were concerned about being or becoming overweight (Cash & Henry, 1995). Characteristics of negative body image such as body dissatisfaction, drive for thinness, and low self-esteem are strongly correlated with and predictors of eating disorder symptomatology (Fulkerson, Perry, & Cudeck, 1993; Stice, 1994). In addition to having poor body image, those suffering with eating disorders have low recovery rates, serious health problems, and the highest mortality rate of any mental illness (American Psychiatric Association, 2000; Fallon, Katzman, & Wooley, 1994). Due to the alarming increase in prevalence of eating disorders and their grave consequences, research efforts to focus on interventions for and the prevention of body image and eating disturbance are needed greatly (Fallon, Katzman, & Wooley, 1994; Stormer, 1999).

Many body image and eating disorder prevention and intervention methods have been researched (e.g., Baranowski & Hetherington, 2001; Dahlgren Daigneault, 2000; Glidden & Tracey, 1989; Irving & Berel, 2001; Killen et al., 1993; Springer, Winzelberg, Perkins, & Barr Taylor, 1999; Stice, Chase, Stormer, & Appel, 2001; Stice, Mazotti, Weibel, & Agras, 2000; Stice & Ragan, 2002; Stice, Trost, & Chase, 2003; Stormer, 1999; Tilgner, Wertheim, & Paxton, 2004; Withers & Wertheim, 2004; Zabinski et al., 2001). A recently published meta-analysis of 51 eating disorder prevention programs found small average effects sizes, Cohen's $d = .19$, $.13$, and $.12$, at termination for healthy

changes in thin-ideal internalization, body dissatisfaction, and eating pathology, respectively (Stice & Shaw, 2004).

Several studies have focused on psychoeducational techniques that involve informing participants of the sociocultural influences on body image (Springer et al., 1999; Stice & Ragan, 2002; Stormer, 1999). A recent intervention (Stormer, 1999) presented information to participants in video format and concentrated on topics such as the history of beauty ideals for women and the lengths to which women have gone to attain them (i.e. foot binding and corsets). The video also emphasized that today's media images represent an ideal that is not attainable even by the photographed model, since techniques such as airbrushing, plastic surgery, and computer altering are utilized regularly. The control group watched a video on nutrition and exercise. The experimental condition resulted in significantly lowered acceptance of sociocultural norms of beauty for women and men, increased the body size females felt would be most attractive to men, and increased the smallest acceptable dating figure for men as compared to the control group. There also was a nonsignificant trend towards reducing body image anxiety.

Another intervention study tested internally based (i.e., focused on potentially destructive cognitions regarding one's appearance that result from beauty norms and how to challenge the thoughts) versus externally based (i.e., educating women to question media imposed beauty norms and showing them ways to work towards societal changes) intervention programs (Irving & Berel, 2001). The two intervention groups were compared to a video-only intervention and a no-intervention control group. Three groups watched "Slim Hopes" (Kilbourn, 1995), a video about society's preoccupation with

thinness and harmful media messages. Following the video, the internal and external groups participated in structured discussions regarding sociocultural influences on body image specific to their intervention. This intervention resulted in increased media skepticism; however, there were no group differences in the post-test only measures of body image and media internalization (Irving & Berel, 2001).

Researchers have taken interventions one-step further by implementing college courses on the topic of body image (Springer et al., 1999; Stice & Ragan, 2002). Springer and colleagues (1999) found that class lectures on topics such as body image, culture, and obesity significantly reduced body image dissatisfaction and eating disorder symptomatology. Stice and Ragan (2002) found that an intensive psychoeducational college course focused on body image reduced body part dissatisfaction, dieting, and eating disorder symptomatology.

Although these intensive college classes significantly reduced body image disturbance, it is unlikely that most psychoeducational interventions will result in behavioral changes (Moskowitz, 1989). Therefore, Stice and colleagues (2000, 2001, 2003) tested interventions based on Festinger's cognitive dissonance theory. To investigate this theory, college women were recruited on the premise of helping researchers to evaluate body image programs for women. This required the women to take a stance against the thin ideal and in turn create cognitive dissonance. Both the pilot (Stice et al., 2000) and follow-up study (Stice et al., 2001) significantly decreased internalization of the thin ideal, body dissatisfaction, negative affect, and bulimic symptomatology. A further comparison (Stice et. al, 2003) led to similar results, with the exception of body dissatisfaction, which did not change significantly. These studies also

supported the hypothesis that intervention methods may be most beneficial to those with already high levels of symptomatology (Stice et al., 2000). Stice and colleagues (2001) emphasized the need for additional experimental studies to identify effective intervention methods.

Glidden and Tracey (1989) asked female participants to watch a video of a mock therapy session to assess women's preferences for different types of interventions. In one version, the therapist focused on the sociocultural theory of body image disturbance (e.g., unattainable expectations) and the other focused on personal responsibility (e.g., exercise, nutrition). The researchers hypothesized that nontraditional women would be more receptive to the sociocultural intervention and traditional women would prefer the personally based intervention. Contrary to their hypotheses, and only among women with high weight concern, the traditional women preferred the sociocultural approach, whereas the nontraditional women favored the personal responsibility method. Researchers theorized that the sociocultural intervention was a novel idea to the traditional women, whereas the nontraditional women already were aware of the cultural pressures and believed there would be no immediate changes in the unrealistic images and expectations of women's physical appearance. The researchers suggested that further assessment is needed to determine the effectiveness of different interventions for women with different cognitive schemas, such as traditional or feminist ideologies (Glidden & Tracey, 1989).

Glidden and Tracy (1989) are not the only researchers to propose differences between traditional and nontraditional women. Several studies have focused on body image, disordered eating, gender roles, and feminist ideology. Bem introduced the

concept of measuring gender roles in 1974, but how these roles relate to body image and eating symptomatology still is unclear. Jackson, Sullivan, and Rostker (1988) found that while masculine women may be unsatisfied with their appearance, it is unimportant to them, and androgynous women report that their appearance is important, but they rate it favorably. Unfortunately, not only are feminine women unhappy with their appearance, but they also rate appearance as inherently more important than other women do (Timko, Streigel-Moore, Silberstein, & Rodin, 1987). Davis, Dionne, and Lazarus (1996) found that as females' masculine characteristics increased so did body esteem. Similarly, Kimlicka, Cross, and Tarnai (1983) found that masculine and androgynous women had greater self-esteem, body satisfaction, and sexual satisfaction than feminine women. Interestingly, women who placed importance on or wished to possess more traditionally masculine characteristics reported the most disordered body shape concerns and eating disorder symptomatology of all the participants (Johnson & Petrie, 1995; Timko et al., 1987).

Studies examining the relationship between gender type and disordered eating have resulted in mixed outcomes. Katzman and Wolchik (1984) found no gender role differences among undergraduate females who met the criteria for bulimia or binge eating disorder, as compared to those who did not. A meta-analysis conducted by Murnen and Smolak (1997) found that women with eating disorder symptomatology scored lower on scales measuring characteristics of masculinity and higher on measures of femininity. Traditional femininity in women also is associated with increased conformity, low self-perception of personal appearance and greater importance placed on physical appearance, thinness, lower self-esteem, less life satisfaction, and increased dietary restraint as

compared to nontraditional women (Burger, 1987; Kleinplatz, McCarrey, & Kateb, 1992; Hawkins, Turell, & Jackson, 1983; Jackson et al., 1988; Streigel-Moore, Silberstein, & Rodin, 1986; Timko et al., 1987; Whiteley, 1983). Perhaps, feminine women recognize that masculine characteristics are socially advantageous, whereas their feminine characteristics generally are not. Discomfort between how they perceive themselves and the characteristics they would like to possess may lead to a lack of self-esteem and heightened sensitivity to negative body image.

Given that research findings suggest that nonfeminine gender typed women typically are physically and mentally healthier than feminine women, it is conceivable that “nontraditional” women who possess primarily masculine characteristics or traits of both genders (i.e., androgynous) may be feminists whose cognitive schemas regarding beauty and women’s roles lead to healthier body image and self-esteem. While some studies have found no relationship between a personal feminist ideology and disordered eating or negative body esteem (Mintz & Betz, 1986; Xinaris & Boland, 1990), others have found a significant relationship (Cash, Ancis, & Strachan, 1997; Dionne, Davis, Fox, & Gurevich, 1995; Snyder & Hasbrouck, 1996). Dionne and colleagues (1995) found that women’s feminist attitudes regarding physical attractiveness were correlated positively with body satisfaction, although overall feminist identification was not correlated with being more satisfied with one’s body. Snyder and Hasbrouck (1996) found that, although masculine personality characteristics were unrelated to body dissatisfaction, drive for thinness, or bulimic symptomatology, women who identified with feminist values had significantly greater body satisfaction and less drive for thinness than women who did not. Therefore, regardless of gender role identification, feminist

women reported better body image and less disordered eating than nonfeminists. In contrast, Cash and colleagues (1997) found no differences in body image between feminist and nonfeminist women. However, women with more stereotypical views of men and women, traditional beliefs regarding women's sexuality, a desire for traditional female and male interactions (i.e. aggressive male and submissive female), and harmful beliefs regarding the importance of one's appearance were more invested in their appearance and internalized the beauty ideal to a greater extent than women with less traditional views.

These findings suggest that women who adhere to feminist theories may experience less eating and body image disturbance and for a decade, researchers have emphasized the need to implement feminist theory in the treatment of body image and eating disorder disturbance (Fallon et al., 1994; Mason & Chaney, 1996; Piran, 1995; Thompson, et al., 1999). In general, there are three feminist theories regarding body image: Culture of Thinness, Weight as Power and Control, and Anxieties About Female Appearance –Achievement (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). The Culture of Thinness focuses on beauty ideals for women that are mostly communicated through the media (Thompson et al., 1999). The theory proposes that body image and eating disturbance are reactions to societal messages that women need to be thin in order to be accepted and loved (Thompson et al., 1999). This is supported by a great deal of research that shows prototypical beauty has become thinner, with average weights for women in Miss America pageants and Playboy magazine stabilizing around 13 to 19% below recommended height and weight ratios (Wiseman, Gray, Mosimann, & Ahrens, 1992). As these weights have decreased, rates of eating disorders have increased

(Wiseman et al., 1992). The notion of Weight as Power and Control asserts that historically women have had no jurisdiction over their bodies and possessions and consequently experience this needed control through dieting or overeating (Thompson et al., 1999). Although this theory has not been extensively empirically supported, the proposed relationship between sexual abuse and eating disturbance lends credence to the premise (Smolak & Murnen, 2002). Women who experience the ultimate loss of control over their bodies may be more likely to develop disordered eating. Lastly, Anxieties About Female Appearance –Achievement theorizes that body image and eating disturbance allows females to refute womanhood and success by returning to or keeping a prepubescent body that takes up less space, is nonthreatening, and is “sufficiently feminine” (Thompson et al., 1999, p. 221). This theory is twofold: First, eating disturbance allows women to be successful yet not threatening within typically masculine sects of professions (Thompson et. al., 1999). Second, the refutation of the female form may be viewed as a way to ensure safety from harassment and violation (Thompson et al., 1999). Evidence suggests that in periods of high stress, such as college graduation, women experience an increase in disordered eating (Perlick & Silverstein, 1994). This may be a way that women thwart their own chances of success. This assumption, however, has been called into question, due to confounding variables such as women attending college in increasing numbers (Gilbert & Thompson, 1996). An increase in the population of women in college may artificially enlarge the occurrence of disturbed eating.

These three feminist theories of body image have modest empirical and anecdotal support, but they never have been tested as an intervention or prevention method (Gilbert

& Thompson, 1996). The majority of previous body image and eating disorder interventions have been psychoeducational programs based on the sociocultural theory of body image disturbance (Stormer, 1999) that asserts body image and eating disturbance are the byproduct of an appearance-obsessed society. The three feminist theories of disturbance are similar to sociocultural theory in that all view the disorders as a result of external pressures, not personal psychopathology.

This external view is a key aspect of the feminist theories of eating disturbance. The way in which women perceive external appearance-related pressures and messages may alter the subsequent impact on their body image. Glidden and Tracey (1989) theorized that feminist women recognized that external pressures to achieve the thin-ideal are not going to change in the near future, thus one may need to change the way she views and interprets these messages. This is a key component in Cognitive Behavioral Therapy (CBT), an effective treatment approach to many disorders, including eating disorders (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Fairburn, Norman, Welch, & O'Connor, 1995). The theory of CBT is that people interpret messages in a way that contributes to the development of their disorders (Beck, 1995). CBT focuses on identifying each maladaptive thought, checking the evidence that either supports or refutes the thought, and replacing it with a healthier cognition (Beck, 1995). Each message is filtered through this type of reality check designed to interpret the world in a more realistic and healthy manner.

This reality check may be what feminists have been doing all along to deter body image disturbance. Feminist women are exposed to many of the same messages as their nonfeminist counterparts. Lull, Mulac, and Rosen (1983) found that feminist and

nonfeminists with “some” college education watched similar amounts of television, yet feminists had healthier self-esteem and body image. Similar to CBT, a feminist schema may work as a buffer – a filter through which cultural messages about thinness and beauty are challenged rather than passively accepted. A feminist schema may provide an alternative interpretation of cultural messages such that feminists may not perceive personal deficiencies because they do not resemble the women portrayed in the media. Unlike CBT, exposure to feminist theories of body image may offer individuals a healthier means to interpret all appearance-related messages, rather than focus on individual negative cognitions.

Interventions utilizing sociocultural theory have shown women that societal messages regarding beauty are unhealthy and unrealistic. The information provided and potential impact, however, are limited. The intervention informs participants that images presented are not accurate, but does not offer them an adaptive way of interpreting the plethora of messages about weight and shape that women experience everyday. A feminist schema may empower women to critically and accurately assess the onslaught of harmful messages. In fact, empirical evidence demonstrates that women with feminist schemas are less likely to experience body image dissatisfaction and disordered eating (Cash et al., 1997; Dionne et al., 1995; Snyder & Hasbrouck, 1996).

In summary, previous research has shown that long-term psychoeducational interventions (i.e., a semester length college class) focusing on the media and sociocultural theories of body image may work effectively to reduce symptomatology (Springer et al., 1999; Stice & Ragan, 2002). This type of intervention, however, may not provide women with a broader viewpoint through which to filter all of society’s

harmful appearance-related messages. Due to the serious consequences and wide spread nature of body image and eating disturbance, development and empirical validation of effective intervention methods is needed (Stice et al., 2001).

This study sought to determine if exposure to feminist theory may create or enhance a feminist schema, thereby enabling women to filter society's harmful and unrealistic messages regarding weight and shape. This schema is theorized to decrease body image and eating disturbance and increase empowerment and self-esteem when compared to a traditional psychoeducational intervention or control group. Based on previous research that demonstrated a relationship between disordered body image and eating symptomatology and factors such as sex role and feminist identification, these factors will be investigated within the context of the interventions (Glidden & Tracy, 1989). It was hypothesized that, regardless of these factors (i.e., sex role or pre-intervention feminist identification), that participants exposed to the feminist theory intervention would experience an increase in feminist schema and significant improvements in body image and eating symptomatology, empowerment, and self-esteem. Further, participants who report the greatest pre-intervention eating disturbance will benefit most from the feminist condition when compared to participants without elevated symptoms. Participants in the psychoeducational and control conditions were not hypothesized to experience significant changes in feminist schema, body image or eating disturbance, empowerment, or self-esteem.

METHOD

Participants

Based on the modest findings of intervention studies, the estimated effect size chosen was .50 and the suggested power was .80. For this, Cohen (2003) suggests a sample size of 156 (i.e., 52 participants in each of the intervention groups). Two hundred and ninety-seven women were recruited from undergraduate classes at a large southeastern university and offered extra credit for completing the study. Of the 297 that completed the first set of questionnaires, approximately 200 signed up for the second portion of the study (i.e., presented as a separate and unrelated study). Of those who agreed to participate, 161 completed both portions of the study. In total, 29 participants' data was excluded from the analyses (see Results section) resulting in a final sample size of 131 participants. Their mean age was 20.24 (SD = 1.88), and they were of the following ethnicities: Caucasian = 65.6 %, Hispanic/Latino = 17.6 %, African American = 9.2 %, Asian = 3.1 %, and 4.6 % identified as "Other." The majority of the participants identified themselves as heterosexual (98.5 %), 1 person reported being homosexual, and 1 person reported being bisexual (See Table 1 for further demographic breakdown).

Measures

Feminist Identity Composite (FIC; Fischer, Good, & Hill, 2000, see Appendix A).

This scale is a combination of the Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991) and the Feminist Identity Scale (FIS; Rickard, 1987). Using factor analyses, Fischer and colleagues (2000) utilized 14 items from the FIDS and 20 from the FIS to create the FIC. This measure was validated on female community and student samples. Participants are assessed on five theorized stages of feminist identity: Passive

Acceptance, Revelation, Embeddedness, Synthesis, and Active Commitment. Reported internal consistency estimates (Cronbach's alpha) were .74, .75, .86, .71, and .81, respectively.

Empowerment Scale (ES; Rogers, Chamberlin, Ellison, & Crean, 1997, see Appendix B). This is a 28-item scale that measures the construct of empowerment for consumers of mental health services. The measure consists of five factors: self-esteem/self-efficacy, power/powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger. Answers are based on a Likert scale. Cronbach's alpha was .86 and the measure correlated positively with measures of community involvement, quality of life, social support, and self-esteem.

Bem Sex Role Inventory (BSRI; Bem, 1974, see Appendix C). The BSRI is a measure of stereotypic gender personality characteristics. The measure contains 60-items that are answered on a Likert scale. The internal consistency of this measure is high with alphas of .86, .80, and .85 for the Masculinity, Femininity, and Androgyny scales respectively. Test-retest reliability ranged from .90-.93 after a four-week follow-up.

Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ; Heinberg, Thompson, & Stormer, 1995, see Appendix D). The SATAQ is a 14-item scale that assesses the extent to which women are aware of and believe in societal standards of beauty. Participants answer questions based on a 5-point Likert scale (i.e., completely disagree to completely agree). The SATAQ includes two subscales, Internalization (alpha = .88) and Awareness (alpha = .71). The SATAQ correlates significantly with many measures of eating symptomology (e.g. Eating Disorders Inventory; Heinberg et al., 1995).

Multidimensional Body Self-Relations Questionnaire (MBSRQ; Brown, Cash, & Mikulka, 1990, see Appendix E). The MBSRQ is a 69-item scale that measures multiple aspects of body image disturbance. Two subscales will be used in this study: Appearance Evaluation subscale (MBSRQ-AE) and the Body Areas Satisfaction subscale (MBSRQ-BAS). The AE is a seven-item scale that provides a personal evaluation of aspects of physical appearance such as “I am physically attractive.” The BAS, a nine-item scale, measures satisfaction with different body sites (e.g., face, mid torso, weight). Participants respond using a 5-point Likert scale (i.e., definitely disagree to definitely agree). Internal consistency for the AE is .88 and the BAS is .73. At a one-month follow-up, test retest reliability was .91 and .73, respectively.

Physical Appearance State and Trait Anxiety Scale (PASTAS; Reed, Thompson, Brannick, & Sacco, 1991, see Appendix F). The PASTAS is a self-report measure of state and trait anxiety for eight weight-related (e.g., thighs, hips) and eight non-weight-related (e.g., ears, lips) body sites. For this study the trait scale was used. Participants rate how often they generally experience tension or anxiety about their body sites on a 5-point Likert scale (i.e., never to almost always). Reported Cronbach’s alphas for both weight and non-weight scales ranged from .82 to .92, and test-retest reliability was .82.

Appearance Schema Inventory (ASI; Cash & Labarge, 1996, see Appendix G). This is a 14-item scale designed to assess core beliefs or assumptions about the importance, meaning, and effects of appearance in one’s life. The internal consistency is .84. Factor analysis suggested three moderately interrelated components of the ASI – body-image vulnerability, self-investment, and appearance stereotyping.

The Self-Esteem Inventory (SEI; Rosenberg, 1965, see Appendix H). This 10-item scale measures self-esteem. Rosenberg (1965) reported a reliability coefficient of .92, test-retest reliability of .85, and convergent validities were .56, .67, and .83, with three other measures of self-esteem. The SEI has been negatively correlated with body size overestimation (Thompson & Thompson 1986).

Eating Disorders Inventory - II (Garner, 1991, Appendix I). The EDI - II (Garner, Olmstead, & Polivy, 1983; Garner, 1991) is a self-report measure of attitudes, feelings, and behavior regarding disordered eating. For this study, the Body Dissatisfaction subscale will be used, which measures the overall dissatisfaction with size and shape of specific body parts (i.e., stomach, hips). Participants respond using a 6-point Likert scale (never to always). Internal consistency has been found to range from .91 to .93. Test-retest reliability was .95 at one week, .97 at three weeks, and .75 at one year.

Visual Analogue Scale (VAS, see Appendix J). The VAS is a self-report measure designed to assess changes in areas of body image satisfaction. They are comprised of lines (typically 10 centimeters in length), and at each endpoint is the opposite view for the construct being measured (e.g., “no dissatisfaction with appearance” to “dissatisfaction with appearance as bad as it could be,” Stormer, 1999). Participants make a vertical mark through the line to indicate their response (e.g., from “not at all invested” to “completely invested”) to statements such as “Investment in my physical appearance.” There were 6 VAS questions that asked participants to rate items such as “Satisfaction with my physical appearance” and “Sexual appeal of my physical appearance.” This measure is used as a supplement to traditional Likert scales that may

restrict the range of responses and may be more subject to testing effects. Heinberg and Thompson (1995) found several VAS measures to be correlated significantly with the EDI-Body Dissatisfaction Scale.

Contour Drawing Rating Scale (CDRS; Thompson & Gray, 1995, see Appendix K). The measure consists of drawings depicting women and men from a range of extremely underweight to obese. Test-retest reliability of self-ratings were within the acceptable range ($r = .87$). Validity was shown through a 97-98% accuracy rate in ordering the drawings from thinnest to heaviest. Additionally, the most anorexic and obese drawings were correctly identified 96 % (male-anorexic), 98% (female-anorexic), 88% (male-obese), and 90% (female-obese) of the time. The measure asks participants to choose their ideal body size.

Eating Attitudes Test (EAT; Garner & Garfinkel, 1979, see Appendix L). The EAT is a self-report measure designed to assess disordered eating habits. Participants respond to 40 items (i.e., “give too much time and thought to food”) on a 6-point Likert scale (i.e., never to always). This measure has adequate validity, reliability ($\alpha = .79$ and $.94$), and the ability to discriminate between clinical and nonclinical populations.

Procedure

Time 1

Female participants were asked to complete a packet of surveys containing measures of demographic information, body image and eating disturbance, empowerment, self-esteem, sex role orientation, and feminism. Upon completion, participants were offered the chance to sign up for another study. To decrease participant biases, the second part of the study was presented as a separate study from the first.

Time 2

Women were randomly assigned to one of three conditions. The two intervention conditions involved listening to one of two 15-minute audiotapes created for this study: feminist or psychoeducational. Each tape was recorded by a female narrator with a pleasant speaking voice and was accompanied by a packet of images that corresponded with the oral presentation. Audiotapes were chosen to eliminate the appearance of the presenter as a confounding variable. In groups of one to six, participants listened to the tapes through personal headsets, separated from each other with dividers to ensure privacy and confidentiality. The third condition served as a control and participants were not exposed to an intervention at Time 2.

Condition 1: Feminist Theory Intervention (FTI)

This audiotape focused on feminist theories of body image and eating disturbance (i.e. Culture of Thinness, Weight as Power and Control, and Anxieties About Female Appearance –Achievement). The FTI began with definitions and an explanation of feminism. Subsequently, each theory, its background, and corresponding empirical research was discussed in detail. For example, Mintz and Betz's (1986) findings that women who abide by society's ideals of beauty are more likely to experience disordered eating was presented. Pictures in the corresponding visual packet included images such as historical photos of the women's movement and art such as Degas' Bather (see Appendix M for transcript and N for example image).

Condition 2: Psychoeducational Intervention (PI)

To replicate past psychoeducational interventions and also to serve as a comparison to the FTI, participants listened to an audiotape that described the

sociocultural theory of body image and eating disorders. Topics included the unrealistic bodies of models and the use of airbrushing to change the appearance and shape of women in magazines. For example, the fact that the average woman is 5 foot 4 inches tall and weighs 142 pounds, whereas the average model is 5 foot 9 inches tall and weighs 110 pounds was presented. Pictures in the corresponding visual packet included examples of computer alteration of pictures and runway models (see Appendix O for transcript and P for example image).

Condition 3: Assessment Only Control (AOC)

This group served as a temporal control to determine if changes in symptomatology occurred naturally, without intervention. Participants in this group were not exposed to an intervention and completed the same post test packet of measures as the FTI and PI conditions.

Post Test

Following exposure, participants in the FTI and PI conditions were asked to complete a quiz that served as a manipulation check. Participants who answered more than one quiz question incorrectly were excluded from the analyses (Lavin & Cash, 2001). One question for the FTI was not included in this exclusion criterion because more than 50% of the participants answered it incorrectly. Participants rated the PI and FTI as equally interesting, providing new information, and influential on their attitudes and/or beliefs regarding body image and eating disturbance. The quiz for the FTI was rated as significantly harder, $F(1, 92) = 10.37, p = .002$, however, participants in the FTI and PI correctly answered the quiz questions at an average of 89.73% and 85.71%, respectively. Following the quiz, participants were asked to complete the same packet of

measures as completed at Time 1. Participants in the AOC completed the same packet with the exclusion of the quiz.

RESULTS

Of the 161 participants who participated in Time 1 and Time 2 (i.e., Feminist Condition = 57, Psychoeducational Condition = 53, Control Condition = 51), four participants' information was excluded from the analyses due to an unstandardized administration of the intervention (i.e., food was placed in the intervention room prior to administration and not taken out), 15 participants were excluded due to extreme outlier scores, and 11 participants were excluded because they answered more than one question wrong on the aforementioned quiz. The final sample size included 131 participants (i.e., Feminist Condition = 43, Psychoeducational Condition = 46, Control Condition = 42).

All variables were screened for skewness, kurtosis, outliers, normality using the Kolmogorov-Smirnov test, and homogeneity of variance using Levene's test. There were no variables in which both non-normality of distribution and unequal variance were a problem, suggesting no major violations in statistical assumptions underlying the parametric statistics used (Keppel & Zedeck, 1998, p. 108). Based on one-way ANOVAS and chi-square analyses, there were no significant differences on measures of demographics (see Table 1), Body Mass Index (BMI), self-esteem, feminism, empowerment, or disturbance among the FTI, PI, and AOC groups at Time 1, and there was no significant change in BMI from Time 1 to Time 2 across all groups.

Chi-square analyses were conducted on the Yes or No responses to the question, "Do you consider yourself a feminist?" While not significant at Time 1, there were significant differences among groups at Time 2. At Time 2, participants in the FTI were significantly more likely to identify themselves as a feminist when compared to the PI, χ^2

(1) = 4.53, $p = .021$ and AOC, $\chi^2(1) = 11.21, p = .001$. There were no significant differences between the PI and AOC, $\chi^2(1) = 1.44, p = .23$ (see Table 1).

Table 1: Participants' demographic information at Time 1

Measure	FTI	PI	AOC
Age $X(SD)$	20.02 (1.54)	20.24 (1.82)	20.45 (2.25)
Body Mass $X(SD)$	23.30 (5.95)	22.06 (3.45)	23.17 (5.04)
Ethnicity			
Caucasian	65.1%	63.0%	69.0%
Hispanic/Latino	18.6%	23.9%	9.5%
African American	9.3%	8.7%	9.5%
Asian	4.7%	0%	4.8%
Others	2.3%	4.3%	7.1%
Sexual Orientation			
Heterosexual	100.0%	100.0%	95.8%
Homosexual	0%	0%	2.4%
Bisexual	0%	0%	2.4%
Taken a women's studies class?			
Yes	25.6%	17.4%	14.3%
Consider yourself a feminist?			
Yes Time 1	52.4%	48.9%	39.5%
Time 2	69.0%	43.4%	31.6%

Repeated measures ANOVAS were conducted to examine changes in measures of body image and eating disturbance, empowerment, self-esteem, and feminism from Time 1 to Time 2 as a function of Condition (see Tables 2 – 7). A Bonferroni correction was used to decrease the chance of a Type 1 error. A starting alpha of .05 was divided by 5 (i.e., the number of variable categories) resulting in a modified alpha level of .01. There were significant main effects for time on the Active Commitment subscale of the FIC scale, $F(2, 128) = 13.21, p < .0005$, ideal female figure of the CDRS, $F(2, 128) = 20.66, p < .0005$, Appearance Evaluation subscale of the MBSRQ, $F(2, 126) = 7.166, p = .008$, and Righteous Anger subscale of the ES, $F(2, 123) = 7.33, p < .008$. These results indicate that significant changes occurred across all groups from Time 1 to Time 2.

There was a significant Condition by Time interaction on self-identification as a feminist, $F(2, 128) = 5.41, p = .006$ (see Table 6). Post-hoc pairwise comparisons were then conducted, with a new adjusted alpha level of .017 (i.e., corrected for 3 comparisons). Results indicate that participants in the FTI experienced significant increases in self-identification as a feminist from Time 1 to Time 2 when compared to the AOC, $F(1, 83) = 6.25, p = .014$ and PI, $F(1, 87) = 8.76, p = .004$. The FTI led to the following effect sizes when compared to the PI, Cohen's $d = .47$, and AOC, Cohen's $d = .56$. These effect sizes indicate that approximately 69% of the feminism scores for the FTI participants would be expected to fall above the mean score of the PI and 73% of the FTI scores would fall above the mean of the AOC (see Figure 1). There were no significant differences when comparing the PI to the AOC, $F(1, 86) = .71, p = .402$ (Cohen's $d = .09$; see Tables 8 – 9).

There was a Condition by Time trend for the VAS measure: “Satisfaction with my physical appearance,” $F(2, 125) = 3.99, p = .021$ (see Table 2). Due to the exploratory nature of this study, further post-hoc pairwise comparisons were conducted, with a new adjusted alpha level of .017 (i.e., corrected for 3 comparisons). Results indicate that participants in the FTI experienced significant increases in physical appearance satisfaction from Time to Time 2 when compared to the AOC, $F(1, 81) = 7.34, p = .008$ but not the PI, $F(1, 85) = 4.90, p = .030$. The FTI led to the following effect sizes when compared to the PI, Cohen’s $d = .23$, and AOC, Cohen’s $d = .19$. These effect sizes indicate that approximately 58% of the physical appearance scores for the FTI participants would be expected to fall above the mean score of the PI and 23% of the FTI scores would fall above the mean of the AOC (see Figure 2). There were no significant differences when comparing the PI to the AOC, $F(1, 84) = .192, p = .663$ (Cohen’s $d = .01$; see Tables 8 – 9).

Table 2: Time by condition repeated measures ANOVAS for the Visual Analogue Scale

Measure	FTI	PI	AOC	<i>F</i> (1,126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
Satisfaction with PA					
Time 1	5.27 (1.81)	5.59 (2.02)	5.74 (2.03)		
Time 2	6.11 (1.72)	5.76 (1.69)	5.77 (1.73)	3.994	.021
Investment in PA					
Time 1	5.30 (1.98)	5.40 (1.94)	5.01 (2.06)		
Time 2	5.60 (2.01)	5.36 (1.85)	5.39 (1.56)	.597	.552
The importance of PA					
Time 1	6.24 (1.76)	6.27 (1.67)	6.48 (1.68)		
Time 2	6.32 (1.31)	6.13 (1.32)	6.46 (1.78)	.226	.798
Anxiety regarding PA					
Time 1	4.66 (2.43)	4.49 (1.89)	4.27 (2.35)		
Time 2	4.82 (2.29)	4.70 (2.07)	4.53 (2.00)	.038	.962
LS is based on PA					
Time 1	4.09 (1.83)	3.78 (1.82)	3.80 (2.16)		
Time 2	4.07 (1.61)	3.84 (1.84)	4.43 (1.94)	1.900	.154
Sexual appeal of PA					
Time 1	5.23 (2.10)	5.31 (1.94)	5.78 (1.68)		
Time 2	5.43 (1.70)	5.60 (1.76)	6.01 (1.46)	.028	.972

Note. PA = Physical appearance. LS = Life Satisfaction.

Table 3: Time by condition repeated measures ANOVAS for measures of eating and body image disturbance

Measure	FTI	PI	AOC	<i>F</i> (1, 126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
EAT					
Time 1	54.98 (23.69)	61.13 (18.54)	52.46 (13.74)		
Time 2	54.72 (24.61)	58.22 (21.50)	52.17 (16.30)	1.531	.220
EDI					
Time 1	29.19 (8.44)	31.13 (8.86)	27.60 (9.31)		
Time 2	28.53 (9.60)	31.22 (9.210)	27.74 (9.80)	.379	.685
CDRS					
Time 1	3.65 (1.21)	3.86 (1.01)	4.13 (1.11)		
Time 2	3.94 (1.56)	4.34 (1.08)	4.36 (.91)	1.095	.338
PASTAS					
Weight related					
Time 1	14.61 (5.58)	15.64 (5.07)	13.92 (6.04)		
Time 2	14.00 (5.97)	14.96 (5.12)	13.67 (6.03)	.186	.831
Non-weight					
Time 1	3.81 (3.83)	3.47 (2.81)	4.07 (3.98)		
Time 2	3.37 (3.32)	3.27 (3.18)	3.34 (3.02)	.398	.672

Note. EAT = Eating Attitudes Test. CDRS = Contour Drawing Rating Scale. PASTAS = Physical Appearance State and Trait Anxiety Scale. EDI = Eating Disorders Inventory.

Table 4: Time by condition repeated measures ANOVAS for measures of body image disturbance

Measure	FTI	PI	AOC	<i>F</i> (1, 126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
ASI					
BIV					
Time 1	14.65 (4.46)	16.46 (4.59)	14.40 (4.24)		
Time 2	14.86 (4.28)	15.52 (4.13)	15.19 (4.55)	5.15	.007
SI					
Time 1	13.33 (3.62)	13.89 (3.03)	14.17 (3.2)		
Time 2	12.86 (3.06)	13.35 (3.27)	14.26 (3.36)	.796	.454
AS					
Time 1	6.09 (2.44)	6.26 (2.16)	6.41 (2.28)		
Time 2	6.42 (2.25)	6.32 (2.01)	6.63 (2.38)	.235	.791
MBSRQ					
AE					
Time 1	24.29 (5.57)	22.80 (6.04)	25.45 (4.95)		
Time 2	25.00 (5.35)	24.28 (5.79)	25.50 (4.99)	2.269	.108
BAS					
Time 1	30.53 (5.85)	30.00 (5.00)	32.24 (5.69)		
Time 2	31.41 (6.00)	31.00 (5.23)	32.49 (6.08)	.557	.575

Note. ASI = Appearance Stereotyping Inventory. BIV = Body-image vulnerability. SI = Self-investment. AS = Appearance stereotyping . MBSRQ = Multidimensional Body Self-Relations Questionnaire. AE = Appearance evaluation. BAS = Body areas satisfaction.

Table 5: Time by condition repeated measures ANOVAS for measures of body image disturbance and self-esteem

Measure	FTI	PI	AOC	<i>F</i> (1, 126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
SATAQ					
Internalization					
Time 1	23.16 (7.79)	25.76 (7.14)	24.34 (6.49)		
Time 2	24.24 (7.14)	26.31 (7.36)	23.44 (7.23)	2.53	.084
Awareness					
Time 1	19.39 (2.80)	19.80 (2.81)	19.74 (3.25)		
Time 2	19.72 (2.95)	19.60 (3.00)	20.38 (2.90)	.916	.403
SEI					
Time 1	32.99 (4.02)	33.21 (4.59)	33.68 (4.05)		
Time 2	33.29 (4.20)	34.26 (4.58)	33.98 (4.08)	.777	.462

Note. SATAQ = Sociocultural Attitudes Toward Appearance Questionnaire. SEI = Rosenberg Self Esteem Inventory.

Table 6: Time by condition repeated measures ANOVAS for measures of feminism

Measure	FTI	PI	AOC	<i>F</i> (1, 126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
Feminist self rating? ^a					
Time 1	2.67 (.87)	2.63 (.68)	2.82 (.79)		
Time 2	2.33 (.89)	2.74 (.77)	2.81 (.83)	5.41	.006
FIC					
Passive acceptance					
Time 1	19.84 (5.22)	19.77 (4.85)	19.93 (3.57)		
Time 2	19.65 (5.16)	19.82 (4.68)	19.88 (4.01)	.09	.912
Revelation					
Time 1	18.70 (6.00)	20.27 (4.95)	18.79 (4.72)		
Time 2	19.19 (5.45)	20.28 (5.32)	19.62 (5.36)	.39	.680
Embeddedness					
Time 1	12.72 (3.40)	12.87 (3.76)	12.67 (3.07)		
Time 2	12.90 (3.13)	12.30 (4.17)	12.31 (3.13)	.93	.399
Synthesis					
Time 1	23.28 (2.98)	22.82 (3.05)	23.19 (2.85)		
Time 2	23.56 (2.64)	23.13 (3.14)	22.76 (2.82)	1.25	.291
Active commitment					
Time 1	32.42 (5.50)	31.74 (5.59)	31.86 (3.78)		
Time 2	31.21 (5.59)	30.52 (5.49)	30.93 (4.81)	.09	.911

Note. FIC = Feminist Identity Composite . ^a = Participants rated their level of feminism on a Likert scale (i.e., 1 = very feminist to 5 = very traditional).

Table 7: Time by condition repeated measures ANOVAS for the empowerment scale

Measure	FTI	PI	AOC	<i>F</i> (1, 126)	<i>p</i>
	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)	<i>X</i> (<i>SD</i>)		
Empowerment Scale					
Self-esteem/efficacy					
Time 1	26.62 (3.57)	29.98 (3.43)	29.47 (3.30)		
Time 2	29.50 (3.19)	30.07 (3.42)	29.14 (3.33)	.278	.758
Powerlessness					
Time 1	16.14 (3.02)	15.73 (2.28)	16.46 (2.28)		
Time 2	15.60 (2.73)	15.58 (2.13)	16.51 (2.12)	.867	.423
Community activism					
Time 1	20.17 (2.19)	20.45 (1.82)	20.20 (2.03)		
Time 2	20.24 (2.15)	19.95 (2.14)	19.78 (2.02)	1.05	.353
Optimism					
Time 1	11.86 (1.66)	12.07 (1.56)	12.17 (1.67)		
Time 2	12.16 (1.54)	12.11 (1.65)	12.07 (1.57)	.718	.490
Righteous anger					
Time 1	8.93 (1.79)	8.93 (1.35)	8.92 (1.47)		
Time 2	8.45 (2.10)	8.55 (1.50)	8.75 (1.35)	.475	.623

Figure 1: Means and confidence intervals for feminist self-rating scores by condition.

Table 8: Reported effect sizes

	PI	AOC
FTI		
FEM	.47	.56
VAS1	.23	.19
BIV	.01	.07
PI		
FEM	-	.09
VAS1	-	.01
BIV	-	.08

Note. FEM = Feminist self-rating; VAS1 = physical appearance satisfaction rating; BIV = Body Image Vulnerability.

Table 9: Confidence intervals for reported effect sizes

	FTI	PI	AOC
	<i>X</i> (CI)	<i>X</i> (CI)	<i>X</i> (CI)
Feminist Rating	2.33 (2.05-2.60)	2.74 (2.51-2.97)	2.81 (2.55-3.07)
VAS 1	6.11 (5.57-6.65)	5.76 (5.25-6.27)	5.77 (5.23-6.32)
BIV	14.86 (13.54-16.18)	15.52 (14.29-16.75)	15.19 (13.77-16.61)

Note. CI = 95% confidence interval. VAS 1= measure of physical appearance satisfaction. BIV=Body Image Vulnerability Scale.

Figure 2: Mean and confidence intervals for physical appearance satisfaction scores by condition.

There was a significant Condition by Time interaction on the ASI-Body Image Vulnerability (BIV) subscale, $F(2, 128) = 5.15, p = .007$ (see Table 4). Post-hoc pairwise comparisons were then conducted, with a new adjusted alpha level of .017 (i.e., corrected for 3 comparisons). Results indicate that the PI significantly decreased BIV from Time 1 to Time 2 when compared to the AOC condition, $F(1, 86) = 11.32, p = .001$ (Cohen's $d = .08$) but not the FTI, $F(1, 87) = 3.93, p = .051$ (Cohen's $d = .11$; see Table 4). The effect size indicates that 54% of the BIV scores for the PI participants would be

expected to fall above the mean score of the AOC (see Figure 3). There were no significant changes when comparing the FTI to AOC, $F(1, 83) = 1.061, p = .306$ (Cohen's $d = .07$; see Tables 8 – 9). The FIT and PI led to no other significant changes in measures of body image, eating disturbance, empowerment, or self-esteem.

Figure 3: Mean and confidence intervals for body image vulnerability scores by condition.

Bonferroni-corrected repeated measures MANOVAS were utilized to examine the interactions between Condition and sex role, Condition and level of feminism, and Condition and level of pre-intervention eating disturbance. Only 65% of participants (i.e., N = 86) fully completed the BSRI leading to small sample sizes within each condition; therefore, the findings related to sex role must be interpreted with caution (see Table 10). There were no significant Condition by Time by variable (i.e., gender role, level of feminism, or eating disturbance) interactions.

Table 10: Bem sex role by condition

	Feminine	Masculine	Androgynous
FTI	11	1	14
PI	9	3	18
AOC	14	3	13
Total	34	7	45

DISCUSSION

Results indicated that participants who were exposed to a 15-minute feminist theory intervention experienced significant increases in their willingness to self-identify as a feminist and significant improvements in their body image satisfaction when compared with the control group. The effect sizes for change in feminist identification are considered “medium” and indicate participants in the FTI were more likely to increase their self-identification as a feminist when compared with the PI and AOC groups. While there were no changes in standardized measures of feminism, willingness to self-identify may be a more salient reflection of a change towards a feminist schema. Outwardly identifying as a feminist indicates a refusal to be complacent towards the current hegemony of society. Prior to the intervention, participants may have held beliefs in accordance with feminist ideologies but refrained from identifying themselves as feminist for many reasons. For example, believing that feminists are “man-haters” or being concerned about being perceived negatively by others may prevent some women from identifying as feminists, despite their beliefs about equality for women. The FTI may have helped to dispel negative stereotypes, allowing participants to see the connection between their belief systems with those of the feminist movement. Another possibility is that women were unaware of feminist ideologies and either recognized how their current belief system fits with feminism, or their beliefs were changed based on the information presented.

The importance of this particular result relates to the possibilities for change. Increased identification as a feminist may lead women to actively challenge the status quo and work towards the actual definition of feminism, equality for men and women.

Not only could this shift in schema lead women to challenge existing ideals of beauty, but it also may help buffer some of the well-documented negative effects (e.g., body dissatisfaction) of exposure to unrealistic societal ideals. Although the FTI did not lead to immediate widespread changes in disturbance, the potential shift in schema may lead some women to interpret appearance-related messages differently following the intervention. Since previous research has shown that women who identify as feminists exhibit less body image and eating disturbance than their nonfeminist counterparts (Cash et al., 1997; Dionne et al., 1995; Snyder & Hasbrouck, 1996), identifying more strongly as a feminist may lead to prevention of or decreases in body image and eating disturbance.

The effect sizes for increases in physical appearance satisfaction, while small, still are meaningful, particularly when compared with the findings of Stice and Shaw (2004; i.e., average body image dissatisfaction effect size of Cohen's $d = .13$). The effect sizes indicate that participants in the FTI were more likely to experience an improvement in their physical appearance satisfaction when compared with the PI and AOC groups. Importantly, participants experienced this change *without* decreases in BMI. Improvements in the FTI group, while significantly better than the AOC, were not significantly better than the PI after Bonferroni corrections; further, the PI did not lead to significant changes over the AOC. The results suggest that components of the FTI were more effective at creating significant positive changes when compared with participants receiving no intervention and may be indicative of the change toward a feminist schema.

It is of interest to note that the experimental effects occurred after only a 15-minute intervention. Previous psychoeducational interventions that were long-term (e.g.,

18 lessons), utilized sample sizes of several hundred, and included post intervention discussion groups found no evidence of change in body image disturbance (Irving & Berel, 2001; Killen et al., 1993; Stice et. al, 2003; Tilgner et al., 2004). Further, the original psychoeducational interventions (e.g., Stormer, 1999) began as small-scale interventions and led to significant decreases in internalization of the thin-ideal and only “trends” towards decreasing body image dissatisfaction. It was not until psychoeducational interventions moved to semester-long college courses that major changes in eating and body image disturbance were found (Stice & Ragan, 2002). The exposure needed to evoke significant changes using the psychoeducational approach compared with the results of a 15-minute FTI indicate the FTI may be a more efficient and effective means of change.

The PI led to significant improvements in participants’ Body Image Vulnerability when compared with the AOC. The PI was designed to serve as a valid intervention comparison for the FTI; therefore, while not predicted, body image improvements due to the PI are not surprising and speak to the legitimacy of its administration. The PI, however, did not lead to significant changes in feminist schema which may be a critical ingredient in reducing body dissatisfaction.

Although the current study addressed several methodological (e.g., random assignment) and statistical (e.g., lack of controlling for initial disturbance levels with repeated measures ANOVAS, excluding effect size estimates) limitations of previous prevention literature (Stice & Shaw, 2004), it is important to consider the potential reasons why changes in body image and eating disturbance were not more extensive. One issue relates to the familiarity participants already had with the information

presented. Today's extensive media coverage of topics including eating disorders, plastic surgery, and negative effects of advertising has led to widespread dissemination of much of the information presented in the PI and some of the information in the FTI. In 1989, Glidden and Tracy stated that their psychoeducational intervention may have worked better for traditional women because the sociocultural theory presented was novel information for them, whereas nontraditional women were already aware of social pressures to be thin. Fifteen years later, the information theorized to be novel only to traditional women may now be familiar to both traditional and nontraditional women. This is evidenced by the fact that most participants in both the FTI and PI groups rated the intervention information as "a little new" on a scale that included the options of "None," "A little," "Most," or "All" new. Frequent exposure to the intervention information prior to participation may have diminished its potential experimental effects.

Another possible limitation was that the FTI may have been lacking in focus on personal empowerment and action. Emphasizing personal initiatives is an important aspect of feminist therapy, but much of the FTI focused on feminist theories and related research. Only a short portion of the intervention provided women with ideas about how to take action with their new information (e.g., vote, discontinue buying fashion magazines). Perhaps participants gained a newfound feminist identity, however, they were left feeling unsure of how to proceed. This uncertainty may have been related to unchanged empowerment and disturbance scores. Had the "action" portion been extended, participants may have felt more secure in what role they can play in changing external pressures to be beautiful.

Another possible explanation for the limited findings is that the credentials of the speaker on the tapes were not disclosed. Based on the social psychology theory of the “sleeper effect,” information presented by a source viewed as non-credible still may lead to opinion changes but in a delayed manner (Hovland, Lumsdaine, & Sheffield, 1949). The post-test assessments were completed immediately after presentation of the information. If, in fact, the participants doubted the information presented due to a lack of established credentials by the presenter, significant and extensive changes in disturbance may not occur immediately after the presentation.

As in all studies, the number of statistical comparisons and possibility of spurious findings must be considered. Multiple comparisons were chosen due to the fact there are so few documented successful intervention studies that it is not only important to explore which interventions may work, but also to ascertain which interventions work for whom. Previously, interventions have resulted in significant changes for specific subpopulations (e.g., traditional or highly disturbed women), thereby limiting the possibility of extensive intervention implementation (Glidden & Tracey, 1989; Stice et al., 2000). In contrast, the FTI had a more universal impact in that there were no significant interactions between the intervention and other variables. In other words, all participants exposed to the FTI experienced similar changes in feminist schema and physical appearance satisfaction, regardless of sex role, previous feminist identification, or level of eating disturbance. Therefore, the FTI may be a promising approach for reaching the broad spectrum of women subjected to a culture of thinness.

Another limitation to the present study was the relatively small sample size. Much of the body image and eating disturbance literature to date has not reported effect

sizes, but a recently published meta-analysis of prevention studies reported small effect sizes (i.e., Cohen's $d = .13$) for changes in body image disturbance (Stice & Shaw, 2004). Based on a power analysis using a small effect size (i.e., Cohen's $d = .2$) and power of .80, a total sample size of 966 (i.e., 322 per condition) would have been needed to detect significant changes (Cohen, 2003; Stice & Shaw, 2004). Another possible explanation for the limited results of this study is that the intervention was brief and did not include active participant involvement. It may be helpful for future interventions to increase the length of a feminist-based intervention and include active participation since interactive prevention programs were found to be more effective at reducing disturbance when compared to didactic programs (Stice & Shaw, 2004). Adding the "action" component of facilitating a discussion of how women can participate in societal change may foster further feelings of empowerment, increase the success of a feminist intervention, and therefore enhance body image and decrease disordered eating.

In summary, exposure to feminist theory was shown to increase participants' feminist schema and physical appearance satisfaction. This shift in feminist identification holds many possibilities for positive change such as increasing the number of women who are willing to work toward changing society's current ideals of beauty. Further, the increased appearance satisfaction occurred without changes in participants' weight. Even more extensive psychoeducational interventions did not result in positive appearance evaluation changes. In light of previous findings, the potential impact of feminist ideology as an effective intervention component merits continued investigation. Empowering women with information and encouraging active participation in shaping sociocultural standards may not only decrease their personal body image and eating

disturbance, but also may change the current unrealistic ideals to standards that are healthier and more representative of the average woman.

APPENDIX A: FEMINIST IDENTITY COMPOSITE

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

	1-----	2-----	3-----	4-----	5
	Strongly Disagree	Mostly Disagree	Neither Disagree nor Agree	Mostly Agree	Strongly Agree
1. I am very committed to a cause that I believe contributes to a more fair and just world for all people.	1	2	3	4	5
2. I want to work to improve women's status.	1	2	3	4	5
3. I am willing to make certain sacrifices to effect change in this society in order to create a nonsexist, peaceful place where all people have equal opportunities.	1	2	3	4	5
4. It is very satisfying to me to be able to use my talents and skills in my work in the women's movement.	1	2	3	4	5
5. I care very deeply about men and women having equal opportunities in all respects.	1	2	3	4	5
6. I choose my "causes" carefully to work for greater equality of all people.	1	2	3	4	5
7. I feel that I am a very powerful and effective spokesperson for the women's issues I am very concerned with right now.	1	2	3	4	5
8. On some level, my motivation for almost every activity I engage in is my desire for an egalitarian world.	1	2	3	4	5
9. I owe it not only to women but to all people to work for greater opportunity and equality for all.	1	2	3	4	5
10. I feel like I have blended my female attributes with my unique personal qualities.	1	2	3	4	5
11. I am proud to be competent woman.	1	2	3	4	5
12. I have incorporated what is female and feminine into my own unique personality.	1	2	3	4	5
13. I enjoy the pride and self-assurance that comes from being a strong female.	1	2	3	4	5
14. As I have grown in my beliefs I have realized that it is more important to value women as individuals than as members of a larger group of women.	1	2	3	4	5
15. If I were to paint a picture or write a poem, it would probably be about women or women's issues.	1	2	3	4	5

16. Gradually, I am beginning to see just how sexist society really is.	1	2	3	4	5
17. I feel angry when I think about the way I am treated by men and boys.	1	2	3	4	5
18. Men receive many advantages in society and because of this are against equality for women.	1	2	3	4	5
19. I never realized until recently that I have experienced presson and discrimination as a woman in society.	1	2	3	4	5
20. I feel like I've been duped into believing society's perceptions of me as a woman.	1	2	3	4	5
21. My female friends are like me in that we are all angry at men and the ways we have been treated as women.	1	2	3	4	5
23. In my interactions with men, I am always looking for ways I may be discriminated against because I am female.	1	2	3	4	5
24. Regretfully, I can see ways in which I have perpetuated sexist attitudes in the past.	1	2	3	4	5
25. I am very interested in women writers.	1	2	3	4	5
26. I am very interested in women musicians.	1	2	3	4	5
27. I am very interested in women artists.	1	2	3	4	5
28. I am very interested in women's studies.	1	2	3	4	5
29. I don't see much point in questioning the general population that men should be more masculine and women should be more feminine.	1	2	3	4	5
30. One thing I especially like about being a woman is that men will offer me their seat on a crowded bus or open doors for me because I am a woman.	1	2	3	4	5
31. I like being a traditional female.	1	2	3	4	5
32. I think that men and women had it better in the 1950's when married women were housewives and their husbands supported them.	1	2	3	4	5

33. If I were married to a man and my husband was offered a job in another state, it would be my obligation to move in support of his career.	1	2	3	4	5
34. I think that most women will feel most fulfilled by being a wife and a mother.	1	2	3	4	5
35. I think it's lucky that women aren't expected to do some of the more dangerous jobs that men are expected to do, like construction work or race car driving.	1	2	3	4	5
36. I do not want to have equal status with men.	1	2	3	4	5
37. I evaluate men as individuals, not as members of a group of oppressors.	1	2	3	4	5
38. I just feel like I need to be around women who share my point of view right now.	1	2	3	4	5
39. I feel that some men are sensitive to women's issues.	1	2	3	4	5
40. I share most of my social time with a few close women friends who share my feminist values.	1	2	3	4	5

APPENDIX B: EMPOWERMENT SCALE

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

1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree

1. I generally accomplish what I set out to do.	1	2	3	4
2. I have a positive attitude about myself.	1	2	3	4
3. When I make plans, I am almost certain to make them work.	1	2	3	4
4. I am usually confident about the decisions I make.	1	2	3	4
5. I am often able to overcome barriers	1	2	3	4
6. I feel I am a person of worth, at least on an equal basis with others.	1	2	3	4
7. I see myself as a capable person.	1	2	3	4
8. I am able to do things as well as most other people.	1	2	3	4
9. I feel I have a number of good qualities.	1	2	3	4
10. I feel powerless most of the time.	1	2	3	4
11. Making waves never gets you anywhere.	1	2	3	4
12. You can't fight city hall.	1	2	3	4
13. When I am unsure about something, I usually go along with the group.	1	2	3	4
14. Experts are in the best position to decide what people should do or learn	1	2	3	4

15. Most of the misfortunes in my life were due to bad luck.	1	2	3	4
16. Usually, I feel alone.	1	2	3	4
17. People have no right to get angry just because they don't like something.	1	2	3	4
18. People have a right to make their own decisions, even if they are bad ones.	1	2	3	4
19. People should try to live their lives the way they want to.	1	2	3	4
20. People working together can have an effect on their community.	1	2	3	4
21. People have more power if they join together as a group.	1	2	3	4
22. Working with others in my community can help to change things for the better.	1	2	3	4
23. Very often a problem can be solved by taking action.	1	2	3	4
24. People are limited only by what they think possible.	1	2	3	4
25. I can pretty much determine what will happen in my life.	1	2	3	4
26. I am generally optimistic about the future.	1	2	3	4
27. Very often a problem can be solved by taking action.	1	2	3	4
28. Getting angry about something is often the first step toward changing it.	1	2	3	4

29. People have no right to get angry just because they don't like something.	1	2	3	4
30. Getting angry about something never helps.	1	2	3	4
31. Making waves never gets you anywhere.	1	2	3	4

APPENDIX C: BEM SEX ROLE INVENTORY

Please indicate on the 7-point scale how well each of the sixty attributes listed below describes you (1 = I seldom exhibit this attribute, and 7 = almost always exhibit this attribute).

Attribute	Seldom-----Always						
1. Self-reliant	1	2	3	4	5	6	7
2. Yielding	1	2	3	4	5	6	7
3. Helpful	1	2	3	4	5	6	7
4. Defend own beliefs	1	2	3	4	5	6	7
5. Cheerful	1	2	3	4	5	6	7
6. Moody	1	2	3	4	5	6	7
7. Independent	1	2	3	4	5	6	7
8. Shy	1	2	3	4	5	6	7
9. Conscientious	1	2	3	4	5	6	7
10. Athletic	1	2	3	4	5	6	7
11. Affectionate	1	2	3	4	5	6	7
12. Theatrical	1	2	3	4	5	6	7
13. Assertive	1	2	3	4	5	6	7
14. Flatterable	1	2	3	4	5	6	7
15. Happy	1	2	3	4	5	6	7
16. Strong personality	1	2	3	4	5	6	7
17. Loyal	1	2	3	4	5	6	7
18. Unpredictable	1	2	3	4	5	6	7
19. Forceful	1	2	3	4	5	6	7
20. Feminine	1	2	3	4	5	6	7

21. Reliable	1	2	3	4	5	6	7
22. Analytical	1	2	3	4	5	6	7
23. Sympathetic	1	2	3	4	5	6	7
24. Jealous	1	2	3	4	5	6	7
25. Has leadership abilities	1	2	3	4	5	6	7
26. Sensitive to the needs of others	1	2	3	4	5	6	7
27. Truthful	1	2	3	4	5	6	7
28. Willing to take risks	1	2	3	4	5	6	7
29. Understanding	1	2	3	4	5	6	7
30. Secretive	1	2	3	4	5	6	7
31. Makes decisions easily	1	2	3	4	5	6	7
32. Compassionate	1	2	3	4	5	6	7
33. Sincere	1	2	3	4	5	6	7
34. Self-sufficient	1	2	3	4	5	6	7
35. Eager to soothe hurt feelings	1	2	3	4	5	6	7
36. Conceited	1	2	3	4	5	6	7
37. Dominant	1	2	3	4	5	6	7
38. Soft spoken	1	2	3	4	5	6	7
39. Likable	1	2	3	4	5	6	7
40. Masculine	1	2	3	4	5	6	7
41. Warm	1	2	3	4	5	6	7
42. Solemn	1	2	3	4	5	6	7
43. Willing to take a stand	1	2	3	4	5	6	7

44. Tender	1	2	3	4	5	6	7
45. Friendly	1	2	3	4	5	6	7
46. Aggressive	1	2	3	4	5	6	7
47. Gullible	1	2	3	4	5	6	7
48. Inefficient	1	2	3	4	5	6	7
49. Acts as a leader	1	2	3	4	5	6	7
50. Childlike	1	2	3	4	5	6	7
51. Adaptable	1	2	3	4	5	6	7
52. Individualistic	1	2	3	4	5	6	7
53. Does not use harsh language	1	2	3	4	5	6	7
54. Unsystematic	1	2	3	4	5	6	7
55. Competitive	1	2	3	4	5	6	7
56. Loves children	1	2	3	4	5	6	7
57. Tactful	1	2	3	4	5	6	7
58. Ambitious	1	2	3	4	5	6	7
59. Gentle	1	2	3	4	5	6	7
60. Conventional	1	2	3	4	5	6	7

**APPENDIX D: SOCIOCULTURAL ATTITUDES TOWARD
APPEARANCE QUESTIONNAIRE**

SATAQ

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

	1-----2-----3-----4-----5	
Completely
Disagree	Neither agree
nor disagree	Completely
Agree
-
1. Women who appear in TV shows and movies project the type of appearance that I see as my goal.

1
2
3
4
5

 2. I believe clothes look better on thin models.

1
2
3
4
5

 3. Music videos that show thin women make me wish that I were thin.

1
2
3
4
5

 4. I do not wish to look like the models in the magazines.

1
2
3
4
5

 5. I tend to compare my body to people in magazines and on TV.

1
2
3
4
5

 6. In our society, fat people are not regarded as unattractive.

1
2
3
4
5

 7. Photographs of thin women make me wish that I were thin.

1
2
3
4
5

 8. Attractiveness is very important if you want to get ahead in our culture.

1
2
3
4
5

 9. It is important for people to work hard on their figures/physiques if they want to succeed in today's culture.

1
2
3
4
5

 10. Most people do not believe that the thinner you are, the better you look in clothes.

1
2
3
4
5

 11. People think the thinner you are, the better you look in clothes.

1
2
3
4
5

**APPENDIX E: MULTIDIMENSIONAL BODY SELF-RELATIONS
QUESTIONNAIRE**

PART I:

Please read each statement and **CIRCLE** the number that best indicates the extent to which you agree or disagree with each statement.

1 = DEFINITELY AGREE 2 = MOSTLY AGREE 3 = NEITHER DISAGREE NOR AGREE 4 = MOSTLY AGREE 5 = DEFINITELY AGREE

1.	My body is sexually appealing.	1	2	3	4	5
2.	I like my looks just the way they are.	1	2	3	4	5
3.	Most people would consider me good-looking.	1	2	3	4	5
4.	I like the way I look without my clothes.	1	2	3	4	5
5.	I like the way my clothes fit me.	1	2	3	4	5
6.	I dislike my physique.	1	2	3	4	5
7.	I am physically attractive.	1	2	3	4	5

PART II:

Please read each statement and **CIRCLE** the letter that best indicates the extent to which you are satisfied or dissatisfied with various parts of your body.

1 = VERY DISSATISFIED 2 = MOSTLY DISSATISFIED 3 = NEITHER SATISFIED NOR DISSATISFIED 4 = MOSTLY SATISFIED 5 = VERY SATISFIED

8.	Face (facial features, complexion)	1	2	3	4	5
9.	Hair (color, thickness, texture)	1	2	3	4	5
10.	Lower torso (buttocks, hips, thighs, legs, etc.)	1	2	3	4	5
11.	Mid torso (waist, stomach)	1	2	3	4	5
12.	Upper torso (chest or breasts, shoulders, arms)	1	2	3	4	5
13.	Muscle tone	1	2	3	4	5
14.	Weight	1	2	3	4	5
15.	Height	1	2	3	4	5
16.	Overall appearance	1	2	3	4	5

**APPENDIX F: PHYSICAL APPEARANCE STATE AND TRAIT
ANXIETY SCALE**

PASTAS

The statements listed below are to be used to describe how often IN GENERAL (that is, usually), you feel anxious, tense, or nervous about your body or specific parts of your body. Please read each statement and CIRCLE the number that best indicates the extent to which each statement holds true IN GENERAL. Remember, there are no right or wrong answers.

0 = NEVER 1 = RARELY 2 = SOMETIMES 3 = OFTEN 4 = ALMOST ALWAYS

IN GENERAL, I feel anxious, tense, concerned, or nervous about:

	Never	Rarely	Sometimes	Often	Always
1. the extent to which I look overweight.	0	1	2	3	4
2. my thighs.	0	1	2	3	4
3. my buttocks.	0	1	2	3	4
4. my hips.	0	1	2	3	4
5. my stomach (abdomen).	0	1	2	3	4
6. my legs.	0	1	2	3	4
7. my waist.	0	1	2	3	4
8. my muscle tone.	0	1	2	3	4
9. my ears.	0	1	2	3	4
10. my lips.	0	1	2	3	4
11. my wrists.	0	1	2	3	4
12. my hands.	0	1	2	3	4
13. my forehead.	0	1	2	3	4
14. my neck.	0	1	2	3	4
15. my chin.	0	1	2	3	4
16. my feet.	0	1	2	3	4

APPENDIX G: APPEARANCE SCHEMA INVENTORY

ASI

Indicate your beliefs about these items using the 1 to 5 scale below.

1 = Strongly Disagree 2 = Mostly Disagree 3 = Neither Disagree nor Agree 4 = Mostly Agree 5 = Strongly Agree

1. What I look like is an important part of who I am.	1	2	3	4	5
2. What's wrong with my appearance is one of the first things that people will notice about me.	1	2	3	4	5
3. One's outward physical appearance is a sign of the character of the inner person	1	2	3	4	5
4. If I could look just as I wish, my life would be much happier.	1	2	3	4	5
5. If people know how I <i>really</i> look, they would like me less.	1	2	3	4	5
6. By controlling my appearance, I can control many of the social and emotional events in my life.	1	2	3	4	5
7. My appearance is responsible for much of what has happened to me in my life.	1	2	3	4	5
8. I should do whatever I can to always look my best.	1	2	3	4	5
9. Aging will make me less attractive.	1	2	3	4	5
10. For women: To be feminine, a woman must be as pretty as possible. For men: To be masculine, a man must be as handsome as possible.	1	2	3	4	5
11. The media's messages in our society make it impossible for me to be satisfied with my appearance.	1	2	3	4	5
12. The only way I could ever like my looks would be to change what I look like.	1	2	3	4	5
13. Attractive people have it all.	1	2	3	4	5

APPENDIX H: THE SELF-ESTEEM INVENTORY

BELOW IS A LIST OF STATEMENTS DEALING WITH YOUR GENERAL FEELINGS ABOUT YOURSELF. IF YOU **STRONGLY AGREE**, CIRCLE **SA**. IF YOU **AGREE** WITH THE STATEMENT, CIRCLE **A**. IF YOU **DISAGREE**, CIRCLE **D**. IF YOU **STRONGLY DISAGREE**, CIRCLE **SD**.

	1 Strongly Agree	2 Agree	3 Disagree	4 Strongly Disagree
1. I feel that I am a person of worth, at least on an equal plane with others.	SA	A	D	SD
2. I feel that I have a number of good qualities.	SA	A	D	SD
3. All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
4. I am able to do things as well as most other people.	SA	A	D	SD
5. I feel I do not have much to be proud of.	SA	A	D	SD
6. I take a positive attitude toward myself.	SA	A	D	SD
7. On the whole, I am satisfied with myself.	SA	A	D	SD
8. I wish I could have more respect for myself.	SA	A	D	SD
9. I certainly feel useless at times.	SA	A	D	SD
10. At times I think I am no good at all.	SA	A	D	SD

APPENDIX I: EATING DISORDERS INVENTORY-II

Please read each statement and **CIRCLE** the number that best indicates how often you agree with the following statements:

1 = NEVER 2 = RARELY 3 = SOMETIMES 4 = OFTEN 5 = USUALLY
6 = ALWAYS

1.	I think my stomach is too big.	1	2	3	4	5	6
2.	I think that my thighs are too large.	1	2	3	4	5	6
3.	I think my stomach is just the right size.	1	2	3	4	5	6
4.	I feel satisfied with the shape of my body.	1	2	3	4	5	6
5.	I like the shape of my buttocks.	1	2	3	4	5	6
6.	I think my hips are too big.	1	2	3	4	5	6
7.	I think that my thighs are just the right size.	1	2	3	4	5	6
8.	I think my buttocks are too large.	1	2	3	4	5	6
9.	I think my hips are just the right size.	1	2	3	4	5	6

APPENDIX J: VISUAL ANALOGUE SCALES

VAS

The items listed below are used to describe how you feel right now. Use the following scale by drawing a **vertical slash** (/) through the line to indicate the degree to which you feel **right now** about what is asked:

1. Satisfaction with my physical appearance

Not at all satisfied

Completely satisfied

2. Investment in my physical appearance

Not at all invested

Completely invested

3. Importance of my physical appearance

Not at all important

Completely important

4. Anxiety about my physical appearance

Not at all anxious

Completely anxious

5. The degree to which my life satisfaction is based on my physical appearance

Not at all based

Completely based

6. Sexual appeal of my physical appearance

Not at all appealing

Completely appealing

APPENDIX K: CONTOUR DRAWING RATING SCALE

CDRS

1. Choose your ideal male figure
2. Choose your ideal female figure
3. Choose the female figure that you think men find the most attractive

Now choose the range of opposite-sex figures which you would find acceptable for a potential romantic partner.

4. Smallest acceptable figure I would consider dating
5. Largest acceptable figure I would consider dating

APPENDIX L: EATING ATTITUDES TEST

Please indicate on the line at the left the answer which applies best to each of the numbered statements. All of the results will be strictly confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

0 = Never

1 = Rarely

2 = Sometimes

3 = Often

4 = Very Often

5 = Always

- ___ 1. Like eating with other people.
- ___ 2. Prepare foods for others but do not eat what I cook.
- ___ 3. Become anxious prior to eating.
- ___ 4. Am terrified of being overweight.
- ___ 5. Avoid eating when I am hungry.
- ___ 6. Find myself preoccupied with food.
- ___ 7. Have gone on eating binges where I feel that I may not be able to stop.
- ___ 8. Cut my food into small pieces.
- ___ 9. Aware of the calorie content of foods that I eat.
- ___ 10. Particularly avoid foods with a high carbohydrate content (eg, bread, potatoes, rice, etc.).
- ___ 11. Feel bloated after meals.
- ___ 12. Feel that others would prefer if I ate more.
- ___ 13. Vomit after I have eaten.
- ___ 14. Feel extremely guilty after eating.
- ___ 15. Am preoccupied with a desire to be thinner.
- ___ 16. Exercise strenuously to burn off calories.
- ___ 17. Weigh myself several times a day.
- ___ 18. Like my clothes to fit tightly.
- ___ 19. Enjoy eating meat.
- ___ 20. Wake up early in the morning.
- ___ 21. Eat the same foods day after day.
- ___ 22. Think about burning my calories when I exercise.
- ___ 23. Have regular menstrual periods.
- ___ 24. Other people think that I am too thin.
- ___ 25. Am preoccupied with the thought of having fat on my body.
- ___ 26. Take longer than others to eat my meals.
- ___ 27. Enjoy eating at restaurants.
- ___ 28. Take laxatives.
- ___ 29. Avoid foods with sugar in them.
- ___ 30. Eat diet foods.
- ___ 31. Feel that food controls my life.
- ___ 32. Display self control around food.
- ___ 33. Feel that others pressure me to eat.
- ___ 34. Give too much time and thought to food.
- ___ 35. Suffer from constipation.
- ___ 36. Feel uncomfortable after eating sweets.
- ___ 37. Engage in dieting behavior.
- ___ 38. Like my stomach empty.
- ___ 39. Enjoy trying new rich foods.
- ___ 40. Have the impulse to vomit after meals.

APPENDIX M: FEMINIST THEORY INTERVENTION
TRANSCRIPT

There is a disease spreading. It taps on the shoulder of America's firstborn sons, its best and brightest. At its touch, they turn away from food. Their bones well out from receding flesh. First tens, then hundreds, then thousands, until, among the most affluent families, one young son in five is stricken. Many are hospitalized, many die.

These boys are the golden ones to whom the reins of the world are to be lightly tossed: the captain of the Princeton football team, the head of the Berkley debating club.

They have grown thin and still more thin. They lose their libido, and can no longer make the effort to joke or argue. There is no medical reason.

The disease mutates again. It becomes apparent that for every well-born living skeleton there are at least three other young men, also bright lights, who do something just as strange. (Please turn to page 2) Once they have swallowed their steaks and wine, they hide away, to thrust their fingers down their throats and spew out all the nourishment in them. They arrange their lives so they can spend hours each day hunched over like that, their highly trained minds telescoped around two shameful holes: mouth, toilet; toilet, mouth.

Meanwhile, people are waiting for them to take up their places: assistantships at the New York Times, seats on the stock exchange. What is happening to the fine young men? It hurts to look at them. (Please turn to page 3)

This excerpt from Naomi Wolf's dramatic essay illustrates the dire situation of eating and body image disturbance among women today and how the gender of the afflicted can influence society's reaction to the crisis. If men really were afflicted by eating disorders, how would society react? With funding, research, and mandates? The reality is that we *are* losing people to these diseases -- we are losing girls and women. Ninety to ninety-five percent of people suffering from an eating disorder are females.

Sex discrimination in health research has existed throughout the centuries. Historically, health researchers studied diseases in men and then applied their findings to women. (Please turn to page 4) It was not until the late 1980s that the National Institute of Health began insisting that women be included in health research. Alarming, the number of individuals with anorexia who will die is approximately 12 times higher than

the annual mortality due to all causes of death among females ages 15 to 24. Some of the “best and brightest” females are being lost to self-starvation.

The problem does not just exist for those diagnosed with an eating disorder. Average, everyday women report serious body image disturbance and risky dieting behaviors. In 1995, over 60% of women sampled reported being unsatisfied with their current weight, muscle tone, and mid and lower torso. Sadly, girls as young as 5 years old report dieting and believe they are “fat.” (Please turn to page 5) Who will fight on our behalf? What, if anything, will be done to stop the epidemic proportions of females who hate their bodies?

Feminists have long fought for equal rights for women. Historically, battles have focused on the right to be educated, to own property, to vote, to be included in medical research, and so on. Feminism and the women’s movement resulted in many of the opportunities and equalities that so many of us take for granted today. But, for many people, the terms “feminism” and “feminist” conjure up ideas of angry, unshaven man-haters. (Please turn to page 6) Many individuals don’t really understand what feminism is. Well, contrary to any stereotypes, feminism is defined as a belief in the social, political, and economic equality of the sexes. Using that definition, many of us may be more feminist than we ever realized.

Recently, feminists’ attention has been drawn to the battle to preserve women’s minds and bodies, as rates of body image and eating disturbance grow at an alarming pace. In understanding this battle, we must first ask, “Why do body image and eating disorders affect so many more women than men?” The answer may relate to the vastly different socialization of the genders. (Please turn to page 7) Traditionally, western

cultures have believed in a division between the mind and the body: men have been viewed as the mind and therefore the logic, whereas women have been viewed as the body, or the object. This division has resulted in the objectification of women's bodies throughout history. Subsequently, men typically have been evaluated on their career and monetary success, and women more often are judged on their physical appearance. As a result of all of this emphasis and value placed on women's attractiveness, women's self worth often is dependent on their physical appearance, leading to a great deal of energy, both mental and physical, spent on altering their appearance to look more attractive.

(Please turn to page 8)

Women spend countless hours and billions of dollars every year to prune, pluck, shape, and shave their bodies. Some feminists view this obsession as a form of subversive sexism. Women's focus has become centered on their bodies that they view as fat and inadequate. As a result, some girls and women become apathetic -- they don't feed their bodies and minds. Rather than fight to challenge the destructive emphasis on their appearance, women sometimes find themselves sucked into the pursuit of staying beautiful and defying their age with the dozens of face creams, cosmetic surgery procedures, diets, and exercise programs marketed to them every time they turn on the tv or open a magazine. (Please turn to page 9)

Feminists, however, are trying to fight this battle that afflicts us, our mothers, our sisters, and our friends. Many of the current theories view eating disorders as diseases that affect individuals, but feminists view disturbance as the logical result of a society obsessed with appearance and thinness. It is *not* women who are disturbed, but society. Feminist researchers have developed three theories to explain disturbance, and all of

them focus on disturbance as a natural consequence of external pressures to be unrealistically thin.

One feminist theory of body image disturbance, Culture of Thinness, concentrates on society's obsession with thinness. This obsession suppresses women by setting forth unrealistic physical standards that are made to appear attainable. (Please turn to page 10) Unable to achieve this standard, women may develop body image and eating disturbance. In fact, researchers have found that frequently reading fashion magazines is related to greater body image dissatisfaction, investment in being thin, use of more weight management techniques, and more eating disturbance.

Historically, curvy, voluptuous women were the epitome of attractiveness and sexuality. This shapely ideal was visible in art, such as Botticelli's Venus and Degas's Bather. Women's round, ample hips and breasts were not hidden behind loose clothing, but glorified as the signature of beauty. The curvaceous ideal was documented as recently as the Victorian age, when women fondly referred to fat as their "silken layer." (Please turn to page 11)

For centuries women have attempted to alter their appearance to fit within societal standards. Previous standards of curvaceousness were a more natural and attainable shape for women. Recently, the ideal shape has become thin and angular. The current ideal can be traced back to Twiggy, a popular model of the 1960s who was 5' 7" and weighed 98 pounds, well below her healthy weight range. The heroin chic of the 1990s with models such as Kate Moss also exemplified the ultra-thin ideal. The super-slender physiques on the runways and in magazines have been described as gawky, bare-boned, and adolescent. Current ideals are devoid of the secondary sex characteristics of women

(like breasts and hips) and represent a shape that only 5 to 10% of women possess naturally. (Please turn to page 12) Ninety to ninety-five percent of women are left striving dangerously for a shape they could never obtain, even with proper diet and exercise. The current weights of Playboy models and Miss America contestants are, on average, 13 to 19% below a healthy recommended weight for their height. This is alarming since one major symptom of anorexia nervosa is a body weight 15 % below recommended standards. Women are spending an astronomical amount of time and money on dieting, and feeling hungry has become part of life for many.

A second feminist theory of body image disturbance, Weight as Power and Control, asserts that, historically, women have had a lack of control over their lives, with limited access to education, government, choice of spouse, or independently owning possessions. (Please turn to page 13) In response to this, women began to focus on their physical appearance and controlling their weight. Not only does weight control allow women a sense of control in their lives, but also weight serves as a protective factor. Women may lose weight in order to shed their feminine sexuality, reducing their breasts and hips. Feminist theorists hypothesize that the emaciated, boyish body type is a rejection of society's objectification of women's bodies. Alternatively, some women may gain weight to hide curves and femininity to avoid being seen as a sex object, to take up as much physical space as men, and to be taken more seriously. Both extreme weight loss and weight gain may allow women to escape sexual harassment and assault. (Please turn to page 14) Extreme weight gains and losses also are viewed as "posttraumatic responses" to sexual abuse. In addition, women may attempt to erase reminders of sexual abuse by minimizing their sexuality. In support of this posttraumatic response theory,

research shows small but consistent relationships between the experience of sexual abuse and body image and eating disturbance.

A third feminist theory of body image disturbance relates to Anxieties about Female Appearance and Achievement. Researchers theorize that women today are faced with a difficult task of balancing achievement within professions that historically have been male-dominated while remaining “sufficiently feminine.” (Please turn to page 15) If women do not manage this balance, they may face discrimination. In response to the pressure, women may attempt to appear less threatening by losing weight. A woman shaped like a prepubescent girl may appear meek and incapable which, ironically, may allow her to continue working alongside men within her chosen profession. Research generally supports this hypothesis. Thinner women are more likely to be hired and promoted. Additional support for this theory comes from studies that show eating disorder symptoms increase during periods of high achievement stress, such as college graduation. (Please turn to page 16)

In conclusion, body image and eating disturbance are widespread problems facing girls and women. Feminists theorize that disturbance is a result of societal pressures and unattainable goals, not personal deficiencies. Naomi Wolf has stated that chronic dieting leads to passivity, anxiety, emotionality, and low self-esteem. Women need to pull together to challenge the beauty myth, both individually and as a group. Working together to rid ourselves of paralyzing anxieties about our weight and shape could bring about phenomenal achievements. Basing our self-esteem on things other than our outward appearance, like our intellect and creativity, would re-open the door for women

to thrive personally, professionally, and socially. We have the ability to empower ourselves to make desperately needed and long lasting societal changes.

So how can we empower ourselves, our mothers, sisters, and friends? (Please turn to page 17) First, you can define what being a feminist means to you. Perhaps stop buying fashion magazines that have been shown to decrease self-esteem and body image satisfaction. Why should you pay to feel badly about yourself? Defy stereotypes: wear pink ruffles to your women's studies classes or fix the engine in your car. Compliment women on positive internal characteristics, not their appearance. Do not laugh politely at offensive jokes. Educate yourself and others on the current state of women's health nationally and globally, and determine how you can help. (Please turn to page 18) Volunteer at a shelter, turn off the television, join a campus group, hold workshops, share your knowledge, vote, use your voice and be heard.

Most importantly, nourish yourself and revel in your own beauty. (Please turn to page 19) Embrace your shape and appreciate the amazing things your body can do. Through self-acceptance and rejection of socially prescribed notions of how we should look, we can change the world for ourselves and for our daughters.

APPENDIX N: FEMINIST THEORY INTERVENTION IMAGE

EXAMPLE

APPENDIX O: PSYCHOEDUCATIONAL INTERVENTION
TRANSCRIPT

Throughout history, there have been ideals of beauty, especially for women. Recently, the ideal feminine shape is one that most women cannot attain. The disparity between the ideals represented in the media and the average American woman's appearance often leads to body image dissatisfaction. Women are reminded everyday through television, magazines, billboards, and other forms of media that they don't measure up to the ideal. Sociocultural theory of body image disturbance asserts that society's obsession with thinness and women's continual exposure to images of ultra-thin women leads to undue and unrealistic pressure on women to become the ideal. (Please turn to page 2) Women are lead to believe that their bodies are "infinitely malleable." Realistically, bodies are not responsive to continual alterations; most women will never attain the shape publicized by the media. The media make promises that when women finally reach the appearance goals set forth for them, they will truly have happiness, health, and self-esteem. In pursuit of these visions of happiness, women spend billions of dollars struggling to acquire the ideal.

The societal ideal has changed greatly over the course of human existence. Previously, the standards for beauty were more congruent with reproduction and a natural female shape, such as wide hips. Between the 14th and 17th centuries, a round, curvaceous body was the epitome of sexual desire. (Please turn to page 3) Following this trend, during the Victorian age the "corseted figure" was the ideal. Corsets were designed to "cinch" in the waist. This beauty trend led to the use of "fainting" furniture. Couches and chairs actually were placed at the tops and bottoms of stairs because women were unable to breathe well enough while wearing corsets and would often faint after walking up or down stairs!

During the 1920s in America, the fashion trend described as a "flapper" emerged. This flat-chested, boyish shaped ideal led American women to restrict their eating severely to achieve the "flapper" look. That's when doctors noted the emergence of disordered eating. (Please turn to page 4) Later, in the 1950s, there was a resurgence of the voluptuous woman, exemplified by Marilyn Monroe, but soon after, the 1960s introduced a new icon -- an ultrathin model by the name of Twiggy who was 5 feet 7 inches and weighed a mere 98 pounds.

Since the 1960s, American culture has witnessed an enormous increase in the variety of cosmetic surgery procedures and the number of people electing to have them. In addition, there are many nonsurgical procedures that have become popular, like chemical peels and even Botox injections that decrease wrinkles. Despite the fact that the Botox bacteria in larger amounts can cause Botulism which can result in paralysis and death, "Botox parties" have become commonplace. (Please turn to page 5) Plastic surgery and the growing number of non-surgical appearance-altering techniques all take people further away from their original and biologically driven physical appearance. Extremely thin women now can have large breasts, and 60 year-old women can have virtually wrinkle-free faces. Cultural standards of beauty have begun to outweigh biological influences. Not only are many cosmetic alterations such as nose jobs not biologically beneficial, but many are in direct opposition to health, such as crash dieting, and breast implants.

Studies of body shape trends throughout the last century in America have supported the sociocultural hypothesis. (Please turn to page 6) Over time, average weights for highly visible women, such as Playboy models and Miss America Pageant

winners, have dropped. Not only have the models become thinner, but also their shape has changed from the natural curvaceous figure of a woman to a more "tubular" shape, with smaller breasts and hips. This is in direct contrast to the average American woman who has become heavier. Weights of idealized women like Miss America and Playboy Models have "stabilized" around 13 to 19% below recommended weight ranges. This is alarming because one criterion for the diagnosis of anorexia nervosa is a weight 15% below weight standards. So, a majority of the women in the media may be classified as having one of the major symptoms of an eating disorder. (Please turn to page 7)

The media is said to obscure the line between truth and fiction through many different techniques. For example, in response to viewing photos of herself, supermodel Cindy Crawford was quoted as saying that she wished she looked as good as the woman in the pictures. This exemplifies the fact that models do not even look like the photographs or films of themselves and they certainly are not representative of the average woman. The average model is 5 feet 10 inches tall and 110-pounds, whereas the average American woman is 5 feet 4 inches tall and 145-pounds. What media images do not explain is that the tall, emaciated look of models is a shape naturally attained by only 5 to 10% of the population. This leaves 90-95% of women striving to meet a biologically impossible shape. (Please turn to page 8) What's more, those achieving supermodel status still aren't good enough...their appearance is altered in a variety of ways. Most of us don't realize the amount of work that goes into each photograph or commercial. Before being signed to a modeling agency, many models have already had cosmetic surgery, whether it be on her nose, breasts, or lips. Before the "shoot," models spend hours with hair, make-up, and clothing professionals to make them look the best that they

can. Once the photos are taken, they can be digitally enhanced in case the 5 feet 10 inch, 110-pound woman is still too heavy, or has a bulge or dimple. Legs often are lengthened, leading models to appear even taller and thinner. (Please turn to page 9) If the makeup artist did not cover every tiny skin "imperfection," it can be airbrushed out. Even if self-starvation, plastic surgery, hours of attention by beauty care professionals, computer enhancement, and airbrushing are not enough to attain the perfect ideal, body parts from other models can be combined to create an illusion of an "ideal" woman. Ironically, these "perfect" female body parts are sometimes the legs, arms, or torso of an adolescent boy! What the average 5 feet 4 inch, 145-pound American woman sees is the picture of a model who may not resemble herself or who may not exist at all. (Please turn to page 10) The irony is that we see models promoting beauty products, weight loss products, and exercise products, promising that if we just try hard enough and spend enough money, we too can attain their looks...the looks that even they don't really have!

Fed up with the unrealistic ideals portrayed in the media, a very courageous actor Jamie Lee Curtis, nicknamed "the bod" and known for her perfect physique, shocked the world when she decided she wanted to do something to help average women rather than contribute to the unrealistic ideas about how women can and should look. In a 2002 photo shoot with More magazine, Jamie Lee decided to show the world what a real 43-year-old woman looks like. (Please turn to page 11) She posed with no make-up or professional hairstyling in a sports bra and bike shorts to reveal what she really looks like. She candidly shared that she is "soft" in the middle and has a bit of a tummy that is usually well-hidden. Then Jamie Lee posed for a traditional magazine photo that was taken after

three hours of work by 13 different people. The contrast between the photos was striking, making a powerful statement for all women (as well as for men) to hear.

The advertising industry is an incredibly powerful machine. Advertisers spend an estimated \$130 BILLION dollars every year. (Please turn to page 12) Much of this is funneled towards making women feel badly enough about themselves to spend over \$33 billion dollars on diet products, \$20 billion dollars on cosmetics, and \$300 million dollars on cosmetic surgery to attain the impossible ideal. It is estimated that each day the average American is exposed to 1500 advertisements. An estimated 1 in every 11 commercials sends *direct* messages about beauty, and this estimation does not include the indirect messages of every commercial that features beautiful people.

Avoiding the influences of unattainable ideals is virtually impossible. In the average American household, the television is on over seven hours a day and people spend a year and a half of their lives watching commercials. (Please turn to page 13) All of this television reminds viewers, particularly women, of the discrepancy between their actual body shapes and those portrayed as the ideal. For those who avoid television, it is estimated that as many as 83% of girls and women read fashion magazines. In magazines, women receive 63 messages to be slim and stay in shape for every one such message targeted to men.

Although effective for selling products, we know that exposure to advertisements featuring unrealistic body ideals can increase body dissatisfaction. Women shown pictures of "ultra-thin" models report increases in depression, insecurity, and body dissatisfaction as compared to women exposed to average sized models. (Please turn to page 14) Another striking example of this occurred on the sheltered Island of Figi where

the traditional female ideal was round and voluptuous. In 1995, islanders were introduced to television and western standards of beauty. Only three years later, researchers documented a dramatic increase in body image and eating disturbance, with girls reporting that they felt "too big or fat" which led them to begin dieting. Most women in America are dissatisfied with their bodies, which is a strong predictor of the development of an eating disorder. As the weights of models have decreased, rates of eating disorders have astronomically increased. (Please turn to page 15)

In addition to impossible weight standards, all non-Caucasian women are faced with an ideal that does not include their skin tone, eye and hair color, or body shape. This lack of representation leads to a larger discrepancy between the way they look and the blond-haired, blue-eyed models in the magazines. Therefore, it is unfortunate but not surprising that body image and eating disturbance are also on the rise among minorities in the U.S.

Sadly, sociocultural pressures are not reserved for adult women. A study found that five-year-old girls' body shape ideals were significantly thinner than their current body shape. The "perfect girl" as reported by Caucasian girls is described as 5 feet 7 inches tall, 100-pounds, a size five, with long blond hair, and big blue eyes. (Please turn to page 16) This "perfect girl" bares a striking resemblance to an American icon named "Barbie." Ninety percent of girls 3 to 11 own one or more Barbie dolls. Little do people know that if Barbie were a real person she would be 7 feet tall, her legs would take up 75% of her body, her head would be bigger around than her waist, and her chest would be so large that she would not be able to walk upright and she would have to crawl on her hands and knees.

In conclusion, ideal shapes of women have existed throughout history. Recently, the ideal has changed from a more natural curvaceous shape to a thin and angular shape, much in contradiction to evolution, biology, and how women's natural bodies are supposed to look. (Please turn to page 17) The sociocultural theory asserts that our society is obsessed with the thin ideal that is advocated in some form or another to women everyday through the media. Moreover, this ideal, which only 5% of the population is able to attain, is made to appear as the norm that is within reach to all women who are disciplined enough. Many of the female icons in the media, like Playboy centerfolds and Miss America winners, are so underweight that they meet at least one criterion for a potentially deadly eating disorder.

It is important for women to realize that the images they see often do not realistically represent the models in the photos. (Please turn to page 18) Digitally altering images of female models is commonplace within the advertising world, and unhealthy weight loss methods like dieting, purging, and over-exercising, are popular among those in the modeling industry. Therefore, the unrealistic ideal is even impossible for the supermodels who set the cultural standards for attractiveness. Women need to be made aware that the ideals they are exposed to are unrealistic and unhealthy to pursue. (Please turn to page 19) The hope is that increased awareness will lead to shifting our focus to self-acceptance and healthy living in place of obsessive dieting and body dissatisfaction.

APPENDIX P: PSYCHOEDUCATIONAL INTERVENTION IMAGE

EXAMPLE

APPENDIX Q: IRB HUMAN SUBJECTS APPROVAL LETTER

Office of Research

October 22, 2003

Rachel Peterson
University of Central Florida
Department of Psychology
P.O. Box 161390
Orlando, FL 32816-1390

Dear Ms. Peterson:

With reference to your protocol entitled, "The Effects of Exposure to Feminist Ideology on Women's Body Image," I am enclosing for your records the approved, executed document of the UCFIRB Form you had submitted to our office.

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur. Further, should there be a need to extend this protocol, a renewal form must be submitted for approval at least one month prior to the anniversary date of the most recent approval and is the responsibility of the investigator (UCF).

Should you have any questions, please do not hesitate to call me at 823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

A handwritten signature in black ink, appearing to read "Chris Grayson".

Chris Grayson
Institutional Review Board (IRB)

Copies: Stacey Tantleff-Dunn, Ph.D.
IRB File

Office of Research
12443 Research Parkway Suite 207 • Orlando, FL 32826-3252
407-823-3778 • FAX 407-823-3299
An Equal Opportunity and Affirmative Action Institution

**IRB COMMITTEE APPROVAL FORM
FOR UCF/OOR/IRB USE ONLY**

PI(s) Name: Rachel Peterson

Title: The Effects of Exposure to Feminist Ideology on Women's Body Image.

Check as applicable (optional):

- ☐ Yes ☐ No Have sufficient assurances been given to the committee to establish that the potential value of this research exceeds the risks involved?
- ☐ Yes ☐ No Written and oral presentations must be given to participating subjects (parents or guardians, if minors) informing them of the protocol, possible risks involved, the value of the research, and the right to withdraw at any time.
- ☐ Yes ☐ No A signed written consent must be obtained for each human subject participant.
- ☐ Yes ☐ No Are cooperating institutions involved? If yes, was there a sheet attached providing the name of the institutions, the number and status of participants, name of the involved official of the institution, telephone, and other pertinent information?

Committee Members:

Dr. Theodore Angelopoulos: _____
Ms. Sandra Browdy: _____
Dr. Jacqui Byers: _____
Dr. Ratna Chakrabarti: _____
Dr. Karen Dennis: _____
Dr. Barbara Fritzsche: _____
Dr. Robert Kennedy: _____
Dr. Gene Lee: _____
Ms. Gail McKinney: _____
Dr. Debra Reinhart: _____
Dr. Valerie Sims: _____

☐ Contingent Approval
Dated: _____

☐ Final Approval
Dated: _____

☒ Expedited
Dated: 21 OCT 2003

☐ Exempt
Dated: _____

Chair, IRB

Signed:
Dr. Sophia Dziegielewska

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