A TEST OF OBJECTIFICATION THEORY AND ITS RELATIONSHIP TO FEMINIST IDENTITY

A Dissertation

by

ALISA MARIE VANLANDINGHAM

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2006

Major Subject: Counseling Psychology

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ABSTRACT

A Test of Objectification Theory and Its Relationship to

Feminist Identity. (December 2006)

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The purpose of this study was to investigate the validity of a sociocultural theory of objectification with a population of older women. Specifically, the study sought to determine if level of self-objectification influenced psychological well-being, disordered eating, and sexual dysfunction. Additional goals of this study included determining if older women self-objectify like their younger counterparts and if level of self-objectification was influenced by one's feminist identity. Participants were 128 randomly selected women living in a small city in the southwest recruited through a local seniors fair and organizations. Participants completed a take-home survey which included a demographic questionnaire, the Feminist Identity Development Scale, the Objectified Body Consciousness Scale, the Scales of Psychological Well-Being Short Form, the Eating Attitudes Test, and the Brief Index of Sexual Functioning for Women. Participants returned surveys in postage pre-paid envelopes. The data was analyzed using structural equation modeling methods and the final model fit the data well. Results indicate that older women do self-objectify but this level of self-objectification is not influenced by their level of feminist identity. In addition, level of self-objectification

is negatively related to psychological well-being and positively related to disordered eating; however, no relationship exists between self-objectification and sexual dysfunction. Implications for clinical practice and further research are discussed.

DEDICATION

This dissertation is dedicated to the loving support and memory of my father, Richard VanLandingham, Jr. He lived his life well following a belief in family and enjoyment of life's simple pleasures. He faced his too early death bravely but, sadly, with very little awareness of the woman I was becoming. As a toddler I learned from him the single most useful lesson that has guided me in this graduate school process. Often with tears in his eyes he would help me perform the painful nightly physical therapy that has allowed me to walk normally today. He strongly believed that, even though it hurt and we often just didn't want to do it, the benefits would be worth it. Much like that nightly ritual, graduate school has often been painful, but absolutely worth it.

He lived his life as an example, not letting his early diagnosis stop him from enjoying his work, hobbies, my mother, and his children. His constant love, bravery and strength have kept me moving forward when I wanted to give up. I have no doubt how proud he would be of his "little one" today.

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me has never ceased. The accomplishments in your life are a daily inspiration to me. You are an incredible woman, friend, and sister.

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CHAPTER I

INTRODUCTION

Overview

For women in this culture, concerns about weight and appearance are so prevalent that women are said to have a "normative discontent" with their bodies and tend to be more preoccupied with weight, appearance, and dieting than men (Rodin, Silberstein, & Striegel-Moore, 1984). There are volumes of literature on body image and the experience women have with their bodies; however, most literature is focused on young and mid-life populations. Little is known about body image and the experience of older women, despite the aging of the baby boomer generation and resulting growth of this segment of the population. There is an established double standard of aging that posits that women's aging is more harshly judged than a man's aging and should reinforce the normative discontent that younger women experience (Sontag, 1972). One would, thus, expect elderly women would continue to struggle with these issues later in life but the scant literature is diffuse and not conclusive.

Although relatively little research has focused on elderly women's body image and experience of their bodies, some studies indicate that there are similarities between how older women and younger women experience their bodies. Evidence shows elderly women's experiences of body dissatisfaction and body size preferences are similar to those of middle aged women (Lewis & Cachelin, 2001). In addition, the study found that

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This dissertation follows the style of the *Journal of Counseling Psychology.*

drive for thinness and other eating-related concerns in elderly women were comparable to the normative levels of college aged women who are thought to suffer from constant preoccupation with their appearance.

In comparison with aging men, aging women tend to have higher levels of concern with eating, weight, and their appearance. This trend has been identified to exist across the lifespan (Pliner, Chaiken, & Flett, 1990). In addition, older women endorsed weight gain as the second greatest concern behind memory loss, whereas men endorsed no such concern (Rodin, 1984b as cited in Rodin, Silberstein, & Striegel-Moore, 1984). Furthermore, women tend to discuss their attitudes towards aging almost exclusively in terms of its negative effects on appearance, whereas men focus on both ability and appearance (Halliwell & Dittmar, 2003).

Given the trend of such research, it is surprising that, although many older women tend to evaluate their bodies negatively, they tend not to translate this into a negative evaluation of self and their identity. Instead, they endorse a general shift from emphasizing physical beauty to emphasizing health concerns (Hurd, 2000). Lewis & Cachelin (2001) also found that elderly women are less likely to take part in behaviors such as disordered eating to address their dissatisfaction with their bodies. Some older women admit to focusing less on their physical attractiveness and attributed the shift to less pressure from society to look good or to the increasing invisibility of older women in this society (Halliwell & Dittmar, 2003).

Objectification Theory

Objectification theory is one paradigm that may help shed light on how older women experience their bodies. Objectification theory posits that females in this culture are socialized to take an observer's view of their bodies or physical selves (Frederickson & Roberts, 1997). This acculturation process occurs as a result of being sexually objectified by others which occurs when a woman's body, body part, or sexual function is separated from her person and viewed as bodies that exist for the use and pleasure of others. Sexual objectification happens in social and interpersonal encounters and in the visual media, including advertising, mainstream films, pornography, visual arts, music videos, women's magazines, and television shows (Frederickson & Roberts, 1997). The constant barrage of objectifying images leads women to adopt a preoccupation with their own physical appearance and how closely they approximate the cultural standard portrayed in the media. In addition, it has been well documented that a woman's appearance to others can influence her social and economic success (Frederickson & Roberts, 1997). It is, therefore, beneficial for women to monitor their appearance constantly and anticipate other's evaluations of their appearance. Through a complex socialization process, women are taught to take an observer's view of their bodies or to "self-objectify."

Objectification theory suggests that shame, anxiety, and decreased awareness of one's inner experiences result from self-objectification (Frederickson & Roberts, 1997). Furthermore, objectification theory asserts that these ramifications leave women at risk for developing depression, eating disorders, and sexual dysfunction (Frederickson &

Roberts, 1997). Although Frederickson & Roberts (1997) are clear that self-objectification is not the sole explanation for depression in women, it can be a contributing factor. Self-objectification and objectification from the society at large can lead to increased shame and anxiety. In addition, women tend to eventually identify more with their body appearance rather than see themselves as an entire entity. Together these factors can contribute to depression in women.

Similarly, self-objectification leads to a decreased ability to monitor internal body states, including sexual arousal, and objectifying women tend to be very self-conscious about their bodies leading to increased shame and anxiety. An activity such as sex perpetuates a woman's appearance self-awareness and observer status of her own body, increasing shame and anxiety, thus preventing her from being fully in the moment and enjoying the encounter. The result is a reduction in sexual satisfaction.

The impact of self-objectification on women's eating habits is quite obvious. In this society, women are constantly comparing their physical selves to the ideals portrayed in the visual media and are also aware that others will evaluate their bodies against this ideal. Women often engage in eating behaviors that reduce the experience of shame and anxiety that result from a failure to achieve the standards set forth by society while actively continue to strive for these ideals (Frederickson & Roberts, 1997). In other words, the more they fail to meet the ideal, the more shame and anxiety they feel, the harder they try. This cycle often results in the development of an eating disorder or, at the least, habitual dieting.

Statement of the Problem

Research in the area of body image and older women is scant and inconclusive. A review of the literature reveals that, although many studies assert their results explain the experiences "across the lifespan," most studies do not include a large enough sample of older women to support such claims.

There is still much to be learned about older women and their relationship with their aging bodies. One important question is whether or not women continue to self-objectify as their younger counterparts do. There is some evidence that women continue to evaluate their physical selves harshly into late life (Lewis & Cachelin, 2001). However, there is an emerging body of literature that describes how older women are able to de-identify with their aging bodies and re-embrace other aspects of the self (Hurd, 2001). In summary, there is conflicting evidence regarding older women's tendency to evaluate their looks negatively and levels of concern about their appearance and weight. Furthermore, little is understood about the cognitive, psychological, or behavioral impact of these concerns for older women. Continued research will assist in providing clarity for clinical practice with older women, as well as younger populations.

Purpose of the Study

The purpose of this study is to investigate the applicability of the theory of objectification to the experience of older women. Specifically, does the assertion that self-objectification leads to depression, sexual dysfunction and disordered eating hold true for women as they move into a later stage of life? Furthermore, an additional aim of this study is to investigate the impact of feminist identity on self-objectification. By

understanding the experience women have with their aging bodies, psychologists may be able to better address presenting issues of older women in therapy. In addition, understanding the relationship between feminist identity and objectification may lead to means through which women may protect themselves from the ramifications of the western socialization process.

Research Questions

This study proposes to evaluate the following hypothesis:

1) Women over the age of 65 will evidence low levels of self-objectification.

2) In women over age 65, the level of self-objectification is negatively correlated with psychological well-being and positively correlated with sexual dysfunction and eating disorders.

3) Level of feminist identity is negatively correlated with self-objectification.

CHAPTER II

LITERATURE REVIEW

Introduction

A review of the literature on research pertaining to older women, women over the age of 50, and their relationship with their bodies reveals that there has been precious little work done in this area. Several areas of knowledge can be summarized from this literature. The first area consists of literature that addresses how older women differ from younger women in their experience of their bodies. The second area of knowledge involves the double standard of aging and the differences between how men and women experience their bodies as they age. Third, a very small body of literature exists that discusses the unique experiences of older women in relation to their bodies, including patterns of eating and psychological outcomes of a woman's aging body. Finally, the last area of literature involves an organizing theory, the theory of objectification, offered from the feminist literature as a possible theory on the socio-cultural context in the development of a woman's experience of her body. It is this theory that the current research aims to test quantitatively in a population of exclusively mature women (age 65+) in an effort to expand the knowledge base of the older woman's relationship with her body. These areas will be discussed in the following literature review.

Body Experience in Older Women Compared to Younger Women

Although relatively little research has focused on elderly women's body image and experience of their bodies, some studies indicate that there are similarities between how older women and younger women experience their bodies. There is evidence that

shows elderly women's experience of body dissatisfaction and body size preferences are similar to those of middle aged women (Lewis & Cachelin, 2001). This study found that drive for thinness and other eating-related concerns in elderly women were comparable to normative levels in college aged women, who are thought to suffer from constant preoccupation with their appearance. In addition, the authors found a positive relationship between fear of aging and disordered eating; women, regardless of age, with greater disordered eating, evidenced greater fear of aging. Elderly women, however, were shown to *do* less about their body dissatisfaction and drive for thinness than younger women, such as restricting intake of food, and they demonstrated less concern about their actual eating habits than younger women. This study, therefore, sheds little light on how these low levels of body satisfaction and eating-related concerns are manifested in elderly women.

The notion that women continue to be concerned with their appearance beyond the years during which sexual attractiveness and reproductive functioning are deemed important is supported by a variety of studies (Altabe & Thompson, 1993; Garner, 1997; Johnston, Reilly, & Kremer, 2004; McKinely, 1999). In a study using a large sample, incorporating a substantial number of subjects over the age of 60, Ben-Tovim and Walker (1994) found that attitudes towards one's body are consistent across the lifespan; levels of disparagement remained consistent across age and were unrelated to actual body size. In support of these findings, McKinely (1999) found that body-esteem held constant in a sample of mothers and daughters, as did beliefs about one's ability to control the look of one's body. While this study indicates an emerging trend in beliefs

regarding one's body across two generations, the study does not look at women who are significantly removed from these childbearing years and can, therefore, not claim to offer understanding of these factors across the lifespan. This predicament is similar in the variety of studies that stake claim to an understanding of body experience across the lifespan; they rarely include the use of subjects over the age of 50.

In order to gain insight into the unique experiences of women across a broad range of ages, Johnston, Reilly, and Kremer (2004) interviewed women ranging in ages from 16 to 77. Based on this lifespan study, similar dissatisfaction themes occurred consistently across all age groups. In some instances, women described an increasing concern for their appearance as they aged, especially after the effects of having children and the experience of menopausal weight gain. These results support the findings of a study in which women in their 60's and 70's were interviewed and consistent themes of body dissatisfaction emerged (Tunaley, Walsh, & Nicolson, 1999). Similarly, a 1992 study which interviewed subjects raging from 10 to 70 also concluded that women struggle with low appearance esteem and worry about eating, weight, and appearance similarly at all ages (Pliner, Chaiken, & Flett, 1992).

While research shows that women are generally preoccupied with their appearance and weight regardless of age, the effects of this preoccupation on women at various ages is unclear. The finding by Lewis and Cachelin (2001) that older women are less likely to engage in restrictive eating or other weight-related behaviors is supported by findings that up until the age of 59, women generally engage in similar attempts at losing and controlling weight, but those behaviors dramatically decrease after the ages of

59 (Serdula, Collins, Williamson, Anda, Pamuk, & Byers, 1993) and 65 (Rand & Kuldau, 1991). Consistent with these findings, Rizvi, Stice and Agras (1999) indicate that eating attitudes became more disturbed with age, but actual behaviors of disturbed eating decreased. Contradicting this information is the widely held assertion that eating disorders are prevalent among older women and are, in fact, under diagnosed (Beck, Casper, & Anderson, 1996; Gupta, 1990; Gupta, 1995; Hsu & Zimmer, 1988; Zerbe, 2003). While it thus seems to be likely that eating disorders are under diagnosed in older women, it is unlikely that the rates exist to the extent that they do in young adults and adolescent females. Why then, do women continue to struggle with such poor evaluation of their appearance into old age and what impact does this have on mature women? The next section will explore the notion of the double standard of aging in an attempt to gain more insight into the experience of older women in relation to their bodies.

Women and Men as They Age: A Double Standard of Aging?

One common theme regarding the aging of women involves the established double standard of aging, which posits that women's aging is more harshly judged than men's aging. Theoretically, this could reinforce the "normative discontent" with their bodies that younger women experience (Sontag, 1972) and explain why women continue to struggle with issues central to their bodies throughout their lives. However, the literature regarding the double standard of aging is diffuse and not conclusive.

The theory of the double standard of aging asserts that the most salient characteristic for women in our western culture is their physical appearance (Sontag, 1979). Men, on the other hand are thought to be defined by a broader range of

characteristics. One attribute essential to the definition of female beauty is that of youthfulness; as women age (e.g., appearance of grey hair, wrinkles, loss of muscle tone and firm skin), their physical beauty diminishes. Sontag (1979) argues that aging women are, therefore, judged more harshly than men. Women in this culture are valued as sexual objects and as they age, they lose their cultural value. In fact, as women age, cultural norms deem sexual desire inappropriate and often ignore the fact that it even exists (Deutsch, Zalenski, & Clark, 1986). Sontag (1979) depicts the opposite process occurs for men; salient culturally prescribed masculine characteristics such as competence, autonomy and self-control are not damaged by the effects of aging, as is physical beauty. The theory implies that as a result of the harsh evaluation of aging, older women may have increased difficulties remarrying, in gaining and maintaining employment, and in experiencing prejudice. In addition, women may, in turn, begin to negatively self-evaluate as they drift further from the culturally accepted female-ideal.

As has been the case in much of the review of literature regarding older adults and body concerns, little empirical data exists to make a clear determination regarding the validity of the assertions of the double standard of aging theory. In 2005, Kite, Stockdale, Whitely and Johnson undertook a meta-analytic review of such literature. Their work reveals that the topic of the double standard of aging is complex and has various categories with which to measure it. Their review used the following categories: evaluation (e.g., generous, friendly), competence (e.g., intelligent, good memory), attractiveness (e.g., pretty, wrinkled); and behavioral (e.g., the willingness to interact with). The results indicate that aging women were judged more harshly in the categories

of evaluation and behavioral intentions than were men; however, men were evaluated more negatively across the competence category. It was noted that competence is one of the characteristics more salient to the male stereotype. Interestingly, the researchers could not conduct analysis of the attractiveness dimension, citing that too few studies exist. Overall, the various studies used in this meta-analytic review support the notion of a double standard of aging when evaluating the dimensions of whether one is friendly/generous and whether a person seems willing to interact and be social. A double standard negatively evaluating men exists along the dimension of intelligence or competence.

Several studies exist that address the notion of a double standard of aging across the attractiveness dimension. In one of the earliest studies, subjects were shown photographs and asked to rate the individual along several dimension, including physical attractiveness (Deutsch, Zalenski, & Clark, 1986). Older women were evaluated more negatively than older men regarding physical attractiveness. In addition, levels of women's femininity were rated as decreasing with age, but ratings of men's masculinity were not. Contradicting these results, Canetto, Kaminski, & Felicio (1995) found no gender differences in ratings of attractiveness. In their study, participants were asked to simply think about typical older adults and rate them along various dimensions. The double standard of aging was supported when considering male and female stereotypes; older women were seen as more nurturing while men were viewed as more intelligent, competent and independent.

While the preceding studies lend minimal support for various aspects of the double standard of aging, none considers the older adult's self-perception. When men's and women's self-perception of physical attractiveness across a broad spectrum of adult age were evaluated, no support for the double standard of aging was found (Wilcox, 1997). This study suggests that as adults age, they continue to compare themselves to peers rather than comparing themselves with cultural ideal currently in vogue.

Wilcox (1997), however, did confirm that attitudes about one's body held earlier in life remain fairly consistent into old age. Previous research has shown that in comparison with aging men, aging women tend to have higher levels of concern with eating, weight, and their appearance across the adult lifespan (Pliner, Chaiken, & Flett, 1990) and that older women have levels of body dissatisfaction similar to that of younger counterparts; their younger counterparts have lower levels of body dissatisfaction than cohort males (Ben-Tovim & Walker, 1994; Johnston, Reilly, & Kremer, 2004; Tunaley, Walsh, & Nicolson, 1999).

Additional studies have shown interesting differences in older male and female relationships with their bodies. Older women endorsed weight gain as the second greatest concern behind memory loss, whereas men endorsed no such concern (Rodin, 1984b as cited in Rodin, Silberstein, & Striegel-Moore, 1984). Furthermore, women tend to discuss their attitudes towards aging almost exclusively in terms of its negative effects on appearance, whereas men focus on both ability and appearance (Halliwell & Dittmar, 2003). Interestingly, men did not feel the negative impact of changes in appearance as the women did, which lends further support for the double standard of

aging (Halliwell & Dittmar, 2003). Given the mixed results of studies aimed at directly measuring the validity of a double standard of aging and the host of information about the differences between older men's and women's concerns about body, eating, weight, one would begin to wonder what is really happening with women as they age? In the next section, the sparse literature that solely focuses on older women and their experience of their bodies and aging will be discussed.

Women, Aging, and Their Bodies

Given the vast amount of research on women's body image in adolescence and early adulthood, it is surprising how little research exists about older women and their bodies. The fact of limited research in this particular dimension of aging and, until more recently, gero-psychology in general, is reflective of a larger issue of ageism in social science and in the larger western culture. With respect to women, one could assert that since this culture is inherently sexist and ageist, literature in the arena of older women shows women to be at a double risk. This topic has been virtually ignored by researchers of both body image and of gerontology. This section will review the sparse literature that has recently emerged focused solely on the body experience of women in later life.

What happens with women's body concerns as they age? One of the first texts to address the issues of body image and a mature woman's well-being was written by a practitioner. The author notes that through her practice with older women she learned that "a woman's relationship to her body often makes the difference between acceptance and resistance in the process of aging" (Crose, 2002). She relates that many of the older

women she counsels feel less pressured about their body shapes, but, nonetheless still feel badly about their weight and have desire to lose weight. The motivation for this desired thinness seems to shift, however, from one of sexual attractiveness to one of health consideration. In addition, she asserts that body image concerns may be underlying many older women's problems with "depression, anxiety, fear, isolation, or in relationships" (Crose, p 38, 2002). Furthermore, the author contends that talking about body image with older women may lead to topics that the woman was previously unable to talk about, such as "sexuality, sexual abuse, incontinence, feelings of worthlessness, and fear of deterioration and death" (Crose, p 38, 2002).

Qualitative research methods have provided this field of study a rich body of knowledge that has yet to be qualitatively explored. The first of these studies provides the findings of in-depth interviews with 12 women ranging from 63 to 75 years old (Tunaley, Walsh, & Nicolson, 1999). Notably, similar to other quantitative studies comparing older women to men and older women to younger women, almost all the women in this study were dissatisfied with their bodies, felt too fat, and believed that physical attractiveness was equated to being thin. Many of them admitted to restricting foods they deemed unhealthy or fattening. However, despite the nagging desire to be thin, many of these same respondents rejected the notion that they needed to do anything about this, such as restrict food intake, and even seemed less concerned about sexual attractiveness than their younger counterparts. Furthermore, women in this study often described weight gain as normal, given their age, and felt as if they had less control over

it (Tunaley, Walsh, & Nicolson, 1999). These seemingly contradictory notions demonstrate that the complexity of body related issues persists into late adulthood.

In a slightly larger study, with similar data collection methods, Hurd (2001) describes the relationship most of the 22 interviewees with their bodies as "uneasy and conflicted" (p 441). Most of the women made clear distinctions between their outside selves and inside selves and felt tension between these two selves, often stating that they do not feel their chronological age. Many referred to their bodies "as 'shells,' 'casings,' 'containers,' or 'limiting' vessels" and that their true selves are "hidden inside." (p 445) The author conceptualized this disconnect between the body and the self into five different types based on themes that emerged from the interviews: youthful older adults, masked older adults, entrapped older adults, fighters, and realists. While these categories are not mutually exclusive, each has a predominant theme. Youthful older adults "feel like teenagers on the inside" even though some may be experiencing physical decline or illness. Masked older adults feel that their outward appearance hides their "true identities" on the inside. Entrapped older adults feel their bodies are prisons that prevent their youthful inner self from being expressed. Fighters "struggle against the implications of having to appear young" in order to avoid the negative social backlash of a "youth-oriented society" through engaging in behaviors that conceal physical signs of aging while wishing they no longer had to do so. Finally, the realists believe their external and internal selves are congruent. With the exception of the realists, all other categories were seen to evidence frustration and pain over the loss of a youthful physical self.

While these two studies successfully explore the meaning of a woman's aging body, they do little to shed light on why women have such a conflicted relationship with their bodies and the psychological outcomes of such contradictory relationships between one's inner self and outward self. One possible paradigm that may help organize this body of literature, the feminist theory of objectification, will be discussed next.

Theory of Objectification

Objectification theory is one paradigm that may help broaden our understanding on how older women experience their bodies. Objectification theory is focused on the impact of the sociocultural context on a woman's experience of her body (Fredrickson & Roberts, 1997). In addition, it defines how one can develop several psychological consequences of internalizing these sociocultural constructs, such as disordered eating, sexual dysfunction, and depression.

Objectification theory proposes that western culture constructs the female body as an object to be looked at, a sexual object (McKinely & Hyde, 1996; Fredrickson & Roberts, 1997). Women in this culture are objectified. Objectification is defined as "separating out a person's body parts or sexual functions from the rest of her identity and reducing them to the status of mere instruments or regarding them as if they were capable of representing her" (Bartky, 1990, p. 26). Females are "viewed *as* bodies which exist for the use and pleasure of others" (Fredrickson & Roberts, p. 175, 1997).

Sexual objectification occurs in social and interpersonal encounters and in the visual media, including advertising, mainstream films, pornography, visual arts, music videos, women's magazines, and television shows (Frederickson & Roberts, 1997).

Women's bodies, more often then men's are depicted as mere parts and, implicitly and explicitly, sexualized. Women are subjected to objectification in actual interpersonal and social encounters, as well (Frederickson & Roberts, 1997). These experiences of objectification "range along a continuum, from sexualized gazing or visual inspection of women's bodies (arguably the most subtle and pervasive form) to the extremes of sexual violence" (Sinclair, p. 51, 2006).

The main derogatory effect of the constant barrage of objectifying experiences is that women tend to then adopt a self-perception as an object (Frederickson & Roberts, 1997). Over time, experiencing objectification leads women to adopt a preoccupation with their own physical appearance and to continually monitor how closely they approximate the cultural standard portrayed in the media. This is indeed true for college-aged women whose endorsement of socio-cultural norms for appearance, specifically thinness, was related to higher levels of self-monitoring and body surveillance (Sinclair, 2006). Arguably, it is beneficial for women to monitor their appearance constantly and anticipate other's evaluations of their appearance because often a woman's appearance to others can influence her social and economic success (Frederickson & Roberts, 1997). Through this complex socialization process, women are taught to take an observer's view of their bodies or to "self-objectify." McKinely (1995) (as quoted in McKinely & Hyde, 1996) entitled this experience of body as object, Objectified Body Consciousness (OBC).

Self-objectification, or OBC, theoretically contributes to the well-documented negative experience many women have of their bodies and may help explain the

conflicted relationship they have with their external selves. Shame, anxiety, decreased peak motivational states, and decreased awareness of one's inner experiences are a result of self-objectification (Frederickson & Roberts, 1997). Shame occurs when women constantly compare themselves to the ideal female image portrayed in the visual media and repeatedly evaluate themselves as falling short of the ideal, because the ideal is virtually unattainable. Shame results from women placing blame on themselves for the shortcoming and from the realization that others will realize her shortfall as well. (Frederickson & Roberts, 1997).

Anxiety exists in two forms: appearance anxiety and safety anxiety (Frederickson & Roberts, 1997). Appearance anxiety stems directly from the ambiguity of not knowing how one will be evaluated at any given time regarding appearance. This reinforces the constant monitoring of one's appearance throughout the day in attempts to avoid possible negative evaluation and the resulting social and economic consequences. In addition, striving for beauty carries with it concerns for safety. Frederickson & Roberts (1997) note that objectification of women by the larger society is a major contributing factor in sexual assault and results in higher levels of anxiety in women because of the need to be vigilant regarding physical safety.

Peak motivational states are described as moments in which individuals are fully in the moment and truly enjoying the challenging mental or physical activity in which they are engaged (Frederickson & Roberts, 1997). For many women, the potential to be fully engaged in a particular activity is continually challenged because of the chronic appearance self-awareness and anticipation of how others are evaluating her. In

addition, when a woman may be able to engage fully in an activity, there are a myriad of instances that will quickly bring her appearance back into self-awareness.

Finally, objectification theory asserts that chronic monitoring of one's physical self reduces one's ability to be aware of internal states such as heart beat, stomach contractions, blood-glucose levels, sexual arousal, and other physiological cues (Frederickson & Roberts, 1997). One possible reason for this may be a consequence of most women's chronic dieting habits in which women actively ignore hunger cues and other physiological cues in efforts to resist the temptation to eat. In addition, objectification theory asserts that because women spent so much time and perceptual resources monitoring their physical appearance, there may be few resources left to monitor inner bodily states (Frederickson & Roberts, 1997).

Objectification theory has gained much empirical support in part, and as a whole, in several age categories of women. Slater and Tiggemann (2002) found that the theory is applicable in a sample of adolescent females. Self-objectification, self-monitoring, body shame, disordered eating, and appearance anxiety were all significantly linked. In college-aged women, objectification, body shame and eating behaviors were significantly related (Fredrickson, Noll, Roberts, Quinn, & Twenge, 1998; Noll & Frederickson, 1998; McKinely, 1998, 1999). Calogero (2004) studied the effect of anticipating the objectifying male gaze on the level of body shame and anxiety in a population of college women, finding that the male gaze induced a greater amount of anxiety and body shame than did a female gaze. The study found no relationship with the male or female gaze on dietary habits, however. In a further study with college

women, Muehlenkamp, Swanson, and Brausch (2005) anticipated that the depression and body dissatisfaction resulting from self-objectification may lead to increase risk-taking and self-harmful behaviors. Indeed, self-objectification was significantly related to negative body regard, which was in turn related to depression, which significantly increased one's tendency to self-harm.

Few studies explore the concept of self-objectification in older populations. The first of these looked at objectified body consciousness in a sample of mothers and daughters (McKinely, 1999). While mothers seemed to have less shame and monitored their bodies less than their daughters, appearance control beliefs, body esteem, and rates of restricted eating were the same between the two groups. Interestingly, mothers were shown to be less satisfied with their weight than their daughters were. This study indicates that the experience of an objectified body likely continues well into adult-life but that older women may not feel the need to conform to cultural ideals as much as their younger counter parts. Another of this study's important finding is that a mother's relationship with her body may influence the daughter's relationship with her body. While this study highlights subtle changes in a middle-aged woman's relationship to her body as she ages, it still sheds little light on the experience of older women.

Greenleaf (2005) also engaged in study of objectification in women across an age range of 18 through 64. Similar to the results of McKinley (1999), it was found that older women had less shame than younger counterparts did. However, similar to results of studies of younger populations (Frederickson, Noll, Roberts, Quinn, & Twenge, 1998; Noll & Frederickson, 1998; McKinley, 1998, 1999), Greenleaf (2005) found that older

women experienced less objectification and shame than did younger women. Contrary to McKinley (1999), Greenleaf found that older women also had lower rates of restrictive eating than younger women. Despite lower rates of restrictive eating and lower levels of self-objectification in older women, shame continues to mediate this relationship as it does in younger women.

Contradicting much of the previous research that indicates women experience less shame about their bodies as they age (McKinely, 1999; Greenleaf, 2005), Tiggemann and Lynch (2001) found that shame did remain constant throughout the lifespan in their sample of women ranging in age from 20 to 84. They also found, as many other researchers have, that body dissatisfaction remains the same, as well (Tunaley, Walsh, & Nicolson, 1999; Pliner, Chaiken, & Flett, 1990). However, in this study, self-objectification completely mediated the relationship between age and disordered eating; that is, there was no direct relationship found between age and disordered eating. Rather, this finding indicated that some women were able to begin to distance themselves from the process of self-objectification and its impact on the need to control eating as they aged, but it shed no light on how some women were able to and others could not.

Objectification theory posits that the ramifications of high OBC on women's subjective experiences place women at risk for developing depression, eating disorders, and sexual dysfunction (Frederickson & Roberts, 1997). Although Frederickson & Roberts (1997) are clear that while self-objectification is not the sole explanation for depression in women, it can be a contributing factor.

As described earlier, self-objectification and objectification from society can lead to reduced peak motivational states and increased shame and anxiety. In addition, women tend to eventually identify more with their body appearance rather than see themselves as an entire entity (Frederickson & Roberts, 1997). Together these factors can contribute to depression in women. Early research on the role that body image plays in determining one's happiness has indicated that happiness, or psychological well-being, correlates directly with body esteem for older women (McKinley, 2004), specifically sexual attractiveness (Stokes & Frederick-Recascino, 2003). Muehlenkamp and Saris-Baglama (2002) found both a direct and indirect relationship between self-objectification and depression in a sample of college-aged women; internal awareness mediated the relationship between self-objectification and depression. In slight contradiction to these results, Tiggemann and Kuring (2004) found no direct relationship between self-objectification and depression, but did find, however, a mediated relationship through both body shame and appearance anxiety. Differences in the measurement tools used in the later two studies could account for the variance in results. However, it is clear that self-objectification, directly and indirectly, seems to contribute to a woman's level of happiness (lack of depression). To date, there are no studies that look at this relationship in older women.

Similarly, the impact of self-objectification on women's sexual functioning is based in the idea that women have decreased ability to monitor internal body states, including sexual arousal, and tend to be very self-conscious about their bodies, which leads to shame and anxiety (Frederickson & Roberts, 1997). An activity such as sex

perpetuates a woman's appearance self-awareness and observer status of her own body, increasing shame and anxiety, thus preventing her from being fully in the moment and enjoying the encounter. The result is a reduction in sexual satisfaction. No studies evaluate the merit of this hypothesis. However, in relation to older women, this is an important area of study. According to a recent worldwide study in the age range 40 to 80, 65% of women indicated they were sexually active in the last year, with 39% of these women endorsing having at least one sexual dysfunction (Nicolosi, Laumann, Glasser, Moreira, Paik, & Gingell, 2004). In women, inability to reach orgasm, lack of sexual interest, and lack of lubrication were the most commonly endorsed dysfunctions; these dysfunctions were seen to increase with age. These results echo the results of a study completed almost ten years prior, which indicated that of the 91 participant females age 50 to 91, 53% were sexually active, with 65% having sexual interest (von Sydow, 1992). Not only do these results challenge the erroneous notion that "sexual pleasure is seen as a prerogative of the young" (Mohan & Bhugra, 2005), they also highlight the need to investigate the possible psychological correlates of the various dysfunctions.

The impact of self-objectification on women's eating habits is quite obvious. In this society, women are constantly comparing their physical selves to the ideals portrayed in the visual media and are aware that others will evaluate their bodies against this ideal. Women continue to strive for this unattainable ideal often through engaging in various forms of disordered eating. In addition, shame and anxiety from failure to meet the ideal perpetuates the use of such restrictive patterns (Frederickson & Roberts,

1997). In other words, the more they fail to meet the ideal, the more shame and anxiety they feel, and the harder they try.

This cycle often results in the development of an eating disorder or, at the least, habitual dieting. Internalization of socio-cultural norms and body shame from failure to conform to those norms are the mechanisms through which sexual objectification translates into disordered eating practices (Moradi, Dirks, Matteson, 2005). OBC directly relates to body esteem and eating practices in young and middle aged women, with body esteem negatively related to eating behaviors (McKinley & Hyde, 1996). While this study included middle-aged women, it is unclear if women beyond middle-age engage in similar patterns. Similar results were found in various other studies supporting the claim that self-objectifying significantly predicted eating disorder scores in women (Piran & Cormier 2005; Prichard & Tiggemann, 2005). Self-objectification was found to be present in a population of women hospitalized for eating disorders and is a motivational factor in their drive for thinness (Calogero, Davis, & Thompson, 2005). While this body of research is conclusive regarding the important role self-objectifying plays in the development of eating disorders, it is unclear what role, if any, it may play in the etiology of disordered eating in late life. "Age by itself is no barrier to onset of eating disorders" (Beck, Casper, Anderson, 1996). In addition, these authors assert that late-life disordered eating may be influenced by unresolved body image issues.

Objectification theory has implied how the model may work for older women and it is the purpose of this present study to evaluate the validity of these hypotheses. As discussed earlier, as women age, it becomes more difficult for them to approximate

the physical ideals that society dictates, and women are judged more harshly as they age then men. It would be logical to conclude that women, then, have greater difficulties as they age and the mental health consequences posited by objectification theory would be rampant.

Objectification theory, however, has two competing hypotheses about how aging affects women's mental health. First, women may continue to self-objectify even into old age. However, this objectification may be adaptive, meaning that older women detach from their bodies in a healthy manner, allowing them to maintain positive self-concepts despite objectifying their bodies (Frederickson & Roberts, 1997). This scenario implies that as a woman's body ages and drifts further from the ideal appearance and the woman begins to encounter health issues related to an aging body, it is healthy for her to objectify her body. Objectification theory, however, also hypothesizes that as women age, they may be able to simply let go of the observer's view of their body, thus avoiding the negative mental health ramifications of the culture that objectifies her (Frederickson & Roberts, 1997). Both of these scenarios assume that some older women are able to escape the negative mental health consequences that have been posited by this theory.

Very little literature exists to support either of these possibilities. Only two studies have applied concepts of objectification theory to older populations. Tiggemann and Lynch (2001) found that body dissatisfaction remained constant across the lifespan, but self-objectification, habitual body monitoring, appearance anxiety, disordered eating, and dietary restraint all declined with age, lending support for the hypothesis that women

were able to relinquish the observer's perspective as they aged. However, this study examined a cross-sectional population raging from age 20 to 84, investigated only the mental health outcome of disordered eating, and did not evaluate the other two proposed consequences of depression and sexual dysfunction.

Tiggemann and Lynch's findings are supported by another study in which mothers and daughters were compared on the concepts of objectified body consciousness (McKinley, 1999). This study found that mothers did have lower levels of viewing themselves from the observer's perspective than their daughters. Further, objectified body consciousness (a measure of how much one views one's self from an outside observer's perspective) was found to be positively related to psychological well being. This last study, though, did not include any women over the age of 65. To date, no study explores the comprehensive model as outlined by Frederickson and Roberts (1997) in a significant sample of older women.

Feminist Identity

In addition to the specific hypothesis about older women, objectification theory notes that the extent to which a woman self-objectifies may depend on how closely she identifies with the feminine ideals prescribed by this culture (Frederickson & Roberts, 1997). Empirical research is not conclusive about the notion that one's feminist identity impacts one's body image. However, it has been shown that women who identified with feminist values tend to have less body dissatisfaction, less of a focus on being thin, and fewer eating disorders that those women who identified with traditional gender-role values (Snyder & Hadbrouk, 1996). These findings are supported by another study that

found that masculinity, as measured by the Bem Sex-Role Inventory, was related to positive body image in women (Davis, Dionne, & Lazarus, 1996). Furthermore, Tiggemann and Stevens (1999) found that not only do overall weight concerns decrease slightly as women surpass age 40, strong feminist attitudes related to decreased weight concerns for women age 40 to 49. An early study by Beck, Ward-Hull, & McLear (1976) demonstrated that women who adhere to nontraditional gender roles and support greater options for women associate larger, more ample female bodies with traditional roles such as wife and mother. In fact, professional, high achieving women prefer thinner, smaller female bodies and tend to be quite dissatisfied with their own bodies and reported weight (Rodin & Striegle-Moore, 1984).

Confusing the results of the previous studies, Tiggemann and Stevens (1999) noted that feminist attitudes were not related to decreased weight concerns for women aged 50 to 59, nor women who under were 39. Cash, Ancis and Strachan (1997), who found no relationship between body image satisfaction and adherence to traditional gender beliefs or feminist identity in college women, confirmed these results. They hypothesized that the social expectations and pressures to approximate the ideal are so great in younger groups, specifically those under the age of 39, that even a strong feminist identity cannot mediate the consequences. In the same vein as these findings, Fingeret and Gleaves (2004) showed that feminist ideology did not protect college women from internalization of sociocultural appearance standards. Similarly, Dionne, Davis, Fox, and Gurevich (1995) found no relationship between feminist identification

and body satisfaction. Most notably, none of the previous studies included women over the age of 60, so little is known about what role feminist identity plays for older women.

Summary

In conclusion, there is sparse literature that investigates the role that body image concerns and the sociocultural pressures of appearance standards have on an aging woman's mental health. The preceding literature review does, however, make several things clear. First, there are parallels between the way older women and younger women experience their bodies. Specifically, older women evidence similar levels of body concerns, body dissatisfaction, body size preferences, drive for thinness and general eating concerns as their younger counterparts (Altabe & Thompson, 1993; Garner, 1997; McKinely, 1999; Lewis & Cachelin, 2001; Johnston, Reilly, & Kremer, 2004). Older women do engage in disordered eating practices (Beck, Casper & Anderson, 1996; Gupta, 1990, 1995; Hsu & Zimmer, 1988; Zerbe, 2003); however, the rates appear to be lower than in their younger counterparts (Serdeula, et al, 1993; Lewis & Cachelin, 2001).

Secondly, as women age, they are confronted by the double standard of aging in which evidences of aging in women are judged more harshly than in men (Sotag, 1972) and older men are seen as more competent than older women (Canetto, Kaminski, & Felicio, 1995). Further, research has shown that women's femininity is rated as decreasing with age, while men's masculinity is not (Deutsch, Zalenski, & Clark, 1986). In addition, it appears that there are differences in self-perceptions of aging in men and women as well. Aging women tend to have higher levels of concern with body

appearance, eating, and weight than aging men (Pliner, Chaiken, & Flett, 1990). Women also are generally more concerned with the effects of aging on one's appearance than are men (Halliwell & Dittmar, 2003). There are obvious differences in the effects of aging on men and women.

Finally, there has been little research done exclusively in the area of older women and their bodies. Crose (2002) reflects on her practice with older women and posits that a woman relationship with her body greatly impacts how smoothly she transitions into late life. Interviews with older women generally show that mature women do hold strong feelings of dissatisfaction with their bodies and continue to equate thinness with attractiveness (Tunaley, Walsh, & Nicolson, 1999). Furthermore, Hurd (2002) found themes of distancing from one's body and conflict between outer selves and inner selves. Women in this study continued to voice frustration and pain over the loss of their previously youthful selves. It is unclear how these conflicting feelings regarding one's body are manifested in older women.

The major aim of this present study was to investigate the proposed link between objectification and the three particular psychological disorders proposed by the objectification theory (unipolar depression, sexual dysfunction, and eating disorders) exclusively in an older population. For the purpose of this study, instead of measuring unipolar depression, the opposite construct of psychological well-being, or absence of depression, was measured. The construct of psychological well-being has six sub-scales, yielding a more complete picture of one's psychological health or absence of psychological health. These scales also yielded more data than a single measure of

depression, which was used in post-hoc analysis. A subsidiary aim of this study was to examine the relationship between feminist identity and objectified body consciousness, as suggested by objectification theory, in older women, as well as explore the levels of self-objectification in elderly women. Three main hypotheses were developed to examine the aims of this study:

1) Women over the age of 65 will evidence low levels of self-objectification, as measured by the Objectified Body Consciousness Scale (OBC; McKinely & Hyde, 1996).

2) In women over age 65, the level of self-objectification, as measured by the Objectified Body Consciousness Scale (OBC; McKinely & Hyde, 1996), is negatively correlated with psychological well-being and positively correlated with sexual dysfunction and eating disorders, as measured by The Scales of Psychological Well-Being (Ryff, 1989), the Brief Index of Sexual Functioning in Women (BISF-W; Taylor, Rosen, Leiblum, 1994)), and The Eating Attitude Test (Garner & Garfinkel, 1979), respectively.

3) Level of feminist identity, as measured by the Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991), is negatively correlated with self-objectification, as measured by the Objectified Body Consciousness Scale (OBC; McKinely & Hyde, 1996); specifically, those who endorse later-stage feminist identity will evidence less self-objectification.

CHAPTER III

METHOD

The purpose of the current study was to investigate the validity of the socio-cultural theory of objectification with a population of older women. Specifically, the aim was to determine if one's feminist identity influenced the level of self-objectification in older women. Additionally, the study sought to determine if level of self-objectification influenced psychological well-being, disordered eating, and sexual dysfunction. All instruments utilized in the current study were submitted to the IRB and approval to complete this study was granted. This chapter will discuss the selection of participants, the demographics of participants, the instruments used, and a description of the procedure for conducting the research.

Participants

Participants were 128 women living in a small city in the southwest. The subject pool consisted of any female aged 65 and older in the community. These subjects were accessed through the city's recreation department who organized a senior's information fair. The city allowed the researcher to set up a table from which to distribute the survey to interested subjects. The researcher distributed additional surveys at two assisted living/nursing home facilities in the area and one quilting group located by networking with faculty members in the researcher's department of study and members of the dissertation committee. Three hundred and twenty-five surveys were handed out and 130 were returned for a return rate of 39.4%. Two subjects were removed from the study because they did not fall in 65 and older age range established for this study. The

average age of the sample was 73.6 with a range of 26 years from 65 to 91. Approximately 91% of the sample was Caucasian, followed by 6% Native Americans, 1% each for African Americans, 1% Asian American/Pacific Islander and 1% Hispanic Americans. As for marital status, 50% reported they were married, 2% reported they were single and never married, 40% reported they were divorced, and 8% reported they were widowed.

Instruments

Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991) is a 39-item, self-report measure that operationalized Downing and Roush's (1985) five-stage feminist identity development model. The five subscales are names to reflect the five stages of the feminist identity model: Passive Acceptance, Revelation, Embeddedness-Emanation, Synthesis, and Active Commitment. Items are rated on a 5-point Likert-type scale ranging from (1) strongly disagree to (5) strongly agree, with higher mean subscale scores indicating a level of feminist identity more consistent with that particular scale (See Appendix D). Reliability coefficients are as follows: .80 - passive acceptance, .78 – revelation, .67 – embeddedness, .78 – synthesis/active commitment. For conceptual and psychometric reasons, Bargad and Hyde (1991) recommend combining the fourth and fifth subscales. That recommendation was followed in this study.

Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996) is a 24-item, self-report measure based on feminist theory about the social construction of the female body. Three scales represent the salient aspects of objectified body consciousness: surveillance (i.e., viewing the body as an outside observer), body shame

(i.e., feeling shame when the body does not conform to accepted societal standards), and appearance control beliefs (i.e., the amount of perceived control a woman believes she has over her appearance). Items are rated on a 6-point Likert-type scale ranging from (1) strongly disagree to (6) strongly agree (See Appendix E). Reliability coefficients are .62 for the surveillance scale, .67 for the body shame scale, and .69 for the control scale. The authors of the Objectified Body Consciousness have used the measure to distinguish those with high OBC subscales from those with low OBC subscales. However, the authors do not operationally define high and low OBC. Each of the subscales have a possible score between 8 and 56. For the purposes of this study low will be defined as scores between 8 and 24, moderate will be defined as scores between 25 and 41, high scores will be defined as scores between 42 and 56.

Scales of Psychological Well-Being- Short Form (PWB-SF; Ryff, 1989) is a 54-item, self-report measure of six dimensions of psychological well-being: autonomy, environmental mastery, personal growth, purpose in life, self-acceptance, and positive relations with others. Items are rated on a 6-point Likert-type scale ranging from (1) strongly disagree to (6) strongly agree (See Appendix F). The short form is a derivation of the longer 20-item per subscale version. The scales on the shorter version are highly correlated with the longer version; reliability coefficients are as follows: autonomy (.73), environmental mastery (.75), personal growth (.67), purpose in life (.39), self-acceptance (.82), and positive relations with others (.84).

Eating Attitudes Test (EAT-26, Garner, Olmsteadm, Bohr, & Garfinkel, 1982) is a 26-item screening questionnaire used to detect symptoms consistent with an eating

disorder. Respondents rated whether each statement applied to them “always”, “usually”, “often”, “sometimes”, “rarely”, or “never”. Answers were scored as follows: (3) always, (2) usually, (1) often, (0) sometimes, rarely and never (See Appendix G). A total score of 20 or more indicates significant eating concerns or weight preoccupations (Garner, Olmsteadm, Bohr, & Garfinkel, 1982). The EAT-26 has an accuracy rate of at least 90% when used to discriminate individuals with and without DSM-IV eating disorder diagnosis and is a reliable and valid measure (Mintz & O’Halloran, 2000). Reliability of the EAT-26 is .83.

Brief Index of Sexual Functioning for Women (BISF-W, Taylor, Rosen, & Leiblum, 1994) is a 22-item, self-report measure for the assessment of current levels of female sexual functioning and satisfaction (See Appendix H). The BISF-W consists of seven dimensions: (D1) thought/desire, (D2) arousal, (D3) frequency of sexual activity, D4) receptivity/initiation, (D5) pleasure/orgasm, (D6) relationship satisfaction, and (D7) problems affecting sexual functioning. Reliability coefficients are as follows: .77 for D1, .78 for D2, .72 for D3, .87 for D4, .86 for D5, .94 for D6 and .82 for D7. Low correlations between social desirability scores and the BISF-W subscales indicated responses were not influenced by social desirability (Taylor, Rosen, & Leiblum, 1994).

Procedure

The first step in the development of the survey used in the current study involved the creation of a Demographic Questionnaire (see Appendix A). All participants in the study completed the form. Subjects were asked to provide their age, ethnicity, marital

status, level of education, occupation information, brief health rating, weight and height information, and type and area of residence.

In addition to the Demographic Questionnaire, each packet contained a 2-page information sheet. The first of the two pages was an informal introduction to the study and letter from the researcher (See Appendix B). A quarter, which served as an incentive, was attached to this first page of each survey. The second page of each survey consisted of a more formal information sheet, which provided the subject on mental health resources in the area, should participation in the study cause any emotional distress (See Appendix C).

At the various dissemination locations, the researcher sat at a table with a sign that announced a "study on body image in women age 65+". Participants were handed a survey if they agreed to participate in the study. Each survey was provided in a self-addressed, postage paid envelope. Participants were told they could either fill the survey out immediately and drop in the provided box, or take the survey home and mail it back in. All surveys were anonymous.

CHAPTER IV

RESULTS

Preliminary Analyses

Descriptive statistics on the demographic data obtained during the research study were conducted. The mean age of the sample was 73.59 years with 32.0% of the sample age 65 to 69, 47.7% of the sample age 70 to 79 and 20.3% age 80 and above (see Table 1).

The largest number of participants, 90.6%, labeled their ethnicity as white. Native Americans were the next largest group with 6.3%, followed by .8% each for African Americans, Asian/Pacific Islander and Hispanics (see Table 2). Half of the participants were married and 39.8% were widowed (see Table 3). In addition, 60% of participants reported having current sexual partners, while only 25% reported having sexual activity in the past month. Finally, as can be seen in Table 4, the greatest number of participants, 31.3%, endorsed having attended some college. The second largest group, 21.1%, was those participants who have a high school diploma or equivalent. Those with bachelors, masters, doctorate, or professional degrees equaled 33.7% combined. The total sample consisted of 128 participants which is an adequate sample size for conducting SEM (Loehlin, 1992).

Table 1

Age Characteristics of the Participants

Age	Frequency	Percent	Valid Percent	Cum. Percent
65	19	14.8	14.8	14.8
66	6	4.7	4.7	19.5
67	3	2.3	2.3	21.9
68	12	9.4	9.4	31.3
69	1	.8	.8	32.0
70	7	5.5	5.5	37.5
71	5	3.9	3.9	41.4
72	5	3.9	3.9	45.3
73	12	9.4	9.4	54.7
74	7	5.5	5.5	60.2
75	7	5.5	5.5	65.6
76	4	3.1	3.1	68.8
77	7	5.5	5.5	74.2
78	5	3.9	3.9	78.1
79	2	1.6	1.6	79.7
80	3	2.3	2.3	82.0
81	3	2.3	2.3	84.4
82	3	2.3	2.3	86.7
83	2	1.6	1.6	88.3
84	5	3.9	3.9	92.2
85	3	2.3	2.3	94.5
86	2	1.6	1.6	96.1
87	1	.8	.8	96.9
88	1	.8	.8	97.7
89	1	.8	.8	98.4
90	1	.8	.8	99.2
91	1	.8	.8	100.0
Total	128	100.0	100.0	

Table 2

Ethnicity of Participants

Ethnicity	Frequency	Percent	Valid Percent	Cumulative Percent
African American	1	.8	.8	.8
Asian/Pacific Islander	1	.8	.8	1.6
Hispanic	1	.8	.8	2.4
native American	8	6.3	6.3	8.7
White	116	90.6	91.3	100.0
Total	127	99.2	100.0	
Missing	1	.8		
	128	100.0		

Table 3

Marital Status of Participants

Marital Status	Frequency	Percent	Valid Percent	Cumulative Percent
married	64	50.0	50.0	50.0
single, never married	2	1.6	1.6	51.6
widowed	51	39.8	39.8	91.4
divorced	11	8.6	8.6	100.0
Total	128	100.0	100.0	

Table 4

Education Level of Participants

Education Level	Frequency	Percent	Valid Percent	Cumulative Percent
less than 12th grade	4	3.1	3.1	3.1
high school or equivalent	27	21.1	21.3	24.4
vocational/technical school	7	5.5	5.5	29.9
some college	40	31.3	31.5	61.4
associate's degree or trade school	5	3.9	3.9	65.4
bachelor's degree	22	17.2	17.3	82.7
master's degree	13	10.2	10.2	92.9
doctoral degree	6	4.7	4.7	97.6
professional degree	2	1.6	1.6	99.2
other	1	.8	.8	100.0
Total	127	99.2	100.0	
System	1	.8		
	128	100.0		

Descriptive statistics for the central variables are presented in Table 5. The first hypothesis of this study can be answered looking at this descriptive data. It was hypothesized that women in this study would have fairly low levels of objectification; however, the mean levels of the three subscales indicate women in this study carry moderately high levels of objectification. Women in this study have a mean score of 32 on the Surveillance Scale (obsc1) indicating a tendency to watch one's body frequently

and a tendency to think about how one's body looks, rather than how it feels (McKinely & Hyde, 1996). Women in this study have a mean score of 25 on the Body Shame scale (obsc2), indicating a moderate level of feeling as if she is a bad person for not fulfilling cultural expectations of her body (McKinely & Hyde, 1996). In addition, women in this study have a mean score of 31 on the Control Beliefs Scale (obsc3) indicating a moderately tendency to believe that a woman can control her weight and appearance if she works hard enough (McKinely & Hyde, 1996). In summary, the first hypothesis of this current study that women over the age of 65 will evidence low levels of self-objectification, as measured by the Objectified Body Consciousness Scale was not supported.

Descriptive data also shows that endorsement of disordered eating in this sample was fairly low; mean score on the Eating Attitudes Test (eattot) was a 7. There were, however, 3 individuals who score above the acceptable cut-off of 20 indicating possible disordered eating. Scores on that various scales of the Scales of Psychological Well-being indicate that the women in this study, on average, positively endorsed ratings of high autonomy (pwba), environmental mastery (pwbem), personal growth (pwbpg), self-acceptance (pwbsa), and positive relationships with others (pwbpr). Scores on the Feminist Identity scales indicate little variance between the levels of feminist identity. Finally, mean scores on the Brief Index of Sexual Functioning for Women are fairly low indicating low levels of sexual thoughts/desires (sexd1), arousal (sexd2), frequency of sexual activity (sexd3) and pleasure (sexd5). However, they indicate slightly higher

levels of receptivity (sexd4), relationship satisfaction (sexd6) and problems effecting sexual functioning (sexd7).

Table 5

Descriptive Statistics of Independent and Dependent Variables

Scales	Minimum	Maximum	Mean	Std. Deviation
Sexual Dysfunction				
sexd1	.00	7.71	1.4110	1.70222
sexd2	.00	7.43	1.6195	2.32425
sexd3	.00	5.00	1.0423	1.33966
sexd4	.0	13.0	2.969	4.2684
sexd5	.00	8.75	1.1806	1.76415
sexd6	.0	12.0	3.547	4.2070
sexd7	.00	10.28	2.5845	2.03021
Feminist Identity				
afem1	1.25	4.33	3.0337	.60743
afem2	1.20	4.80	3.0313	.64744
afem3	1.86	4.57	3.1523	.53895
afem45	2.62	4.69	3.5056	.42838
Objectified Body Consciousness				
obcs1	11.0	56.0	31.578	7.6761
obcs2	8.0	44.0	25.508	7.4464
obcs3	15.0	50.0	30.852	7.7745
Psychological Well-being				
pwba	23.0	56.0	40.461	6.8768
pwbem	19.0	51.0	39.383	6.1415
pwbpg	24.0	54.0	40.344	5.8423
pwbpl	21.0	104.0	41.789	9.7518
pwbsa	17.0	59.0	42.445	7.7732
pwbpr	12.0	66.0	43.992	8.2981
Disordered Eating				
eattot	.0	38.0	7.117	6.3514

Structural Equation Modeling

The purpose of structural models is to determine the regression structure among latent variables, thus addressing the second two hypothesis of this study. In this case, the model is derived from Objectification Theory (Frederickson & Roberts, 1997). Structural equation modeling was used to determine whether self-objectification leads to sexual dysfunction, disordered eating, and depression. In addition, whether or not this relationship is mediated by feminist identity was also analyzed. The latent construct feminist identity has 4 subscales— Passive Acceptance (afem1), Revelation (afem2), Embeddedness-Emanation (afem3), and Synthesis-Active Commitment (afem45). The latent construct Objectified Body Consciousness is measured by three subscales—Surveillance (obcs1), Body Shame (obcs2) and Appearance Control Beliefs (obcs3). The latent construct Sexual Dysfunction was measured by seven subscales—Thoughts/Desires (sexd1), Arousal (sexd2), Frequency of Sexual Activity (sexd3), Receptivity/Initiation (sexd4), Pleasure/Orgasm (sexd5), Relationship Satisfaction (sexd6) and Problems Affecting Sexual Arousal (sexd7). The latent construct Psychological Well-Being was measured by six subscales—Self-Acceptance (pwbsa), Autonomy (pwba), Environmental Mastery (pwbem), Personal Growth (pwbpg), Positive Relations with Others (pwbpr) and Purpose in Life (pwbpl). Disordered Eating is measured by only one scale and is therefore included in the model as a manifest variable (eattot). As hypothesized, in this model there are direct relationships between Feminist Identity and Objectified Body Consciousness and between Objectified Body Consciousness and Sexual Dysfunction, Disordered Eating, and Psychological Well-

Being. There are no predicted direct relationships between Feminist Identity and Sexual Dysfunction, Disordered Eating and Psychological Well-Being nor between Sexual Dysfunction, Disordered Eating and Psychological Well-being. The theoretical model is shown in Figure 1.

The model was evaluated using AMOS 6.0 (Arbuckle, 1999). Missing data were imputed using the NORM program (Schafer, 2000). Structural equation modeling operates under the assumption of normality and the data set was examined for outliers and violations to the assumptions of multivariate normality. Violation of this assumption often inflates the Chi-square statistic (Kline, 1998). As can be seen in Table 6, the kurtosis value for the disordered eating variable (eatot) and the purpose in life subscale of the Scales of Psychological Well-Being (pwbpl) and the skewness value for pwbpl are slightly elevated indicating non-normality which may result in an elevated chi-square. More comprehensive normality characteristics are available in Table 6.

Table 6

Assessment of Normality

Variable	min	max	skew	c.r.	kurtosis	c.r.
eattot	-1.000	38.000	1.923	8.882	5.816	13.431
sexd7	-.870	10.280	1.226	5.663	1.623	3.748
obcs3	15.000	50.000	.185	.854	-.233	-.539
obcs2	8.000	44.000	.144	.667	-.528	-1.219
obcs1	11.000	56.000	.231	1.065	.463	1.069
afem45	2.620	4.690	.387	1.789	-.369	-.853
afem3	1.860	4.570	.174	.804	-.298	-.689
afem2	1.200	4.800	-.163	-.755	.219	.506
afem1	1.250	4.330	-.369	-1.704	-.103	-.238
pwbpl	23.000	104.000	2.357	10.885	12.995	30.011
pwbpr	24.000	61.000	-.671	-3.100	-.312	-.721
pwbpg	18.000	54.000	-.568	-2.625	.730	1.685
pwbem	19.000	56.000	-.619	-2.860	.666	1.539
pwba	24.000	54.000	-.073	-.337	-.500	-1.156
pwbsa	17.000	56.000	-.758	-3.502	.540	1.246
sexd6	-5.000	12.000	.755	3.485	-.710	-1.639
sexd5	-3.490	8.750	1.170	5.404	1.344	3.104
sexd4	-8.000	13.000	.785	3.627	-.588	-1.358
sexd3	-2.300	5.000	.989	4.570	.379	.875
sexd2	-2.440	7.430	.981	4.532	-.475	-1.096
sexd1	-3.230	7.710	1.229	5.675	1.930	4.458
Multivariate					82.290	14.977

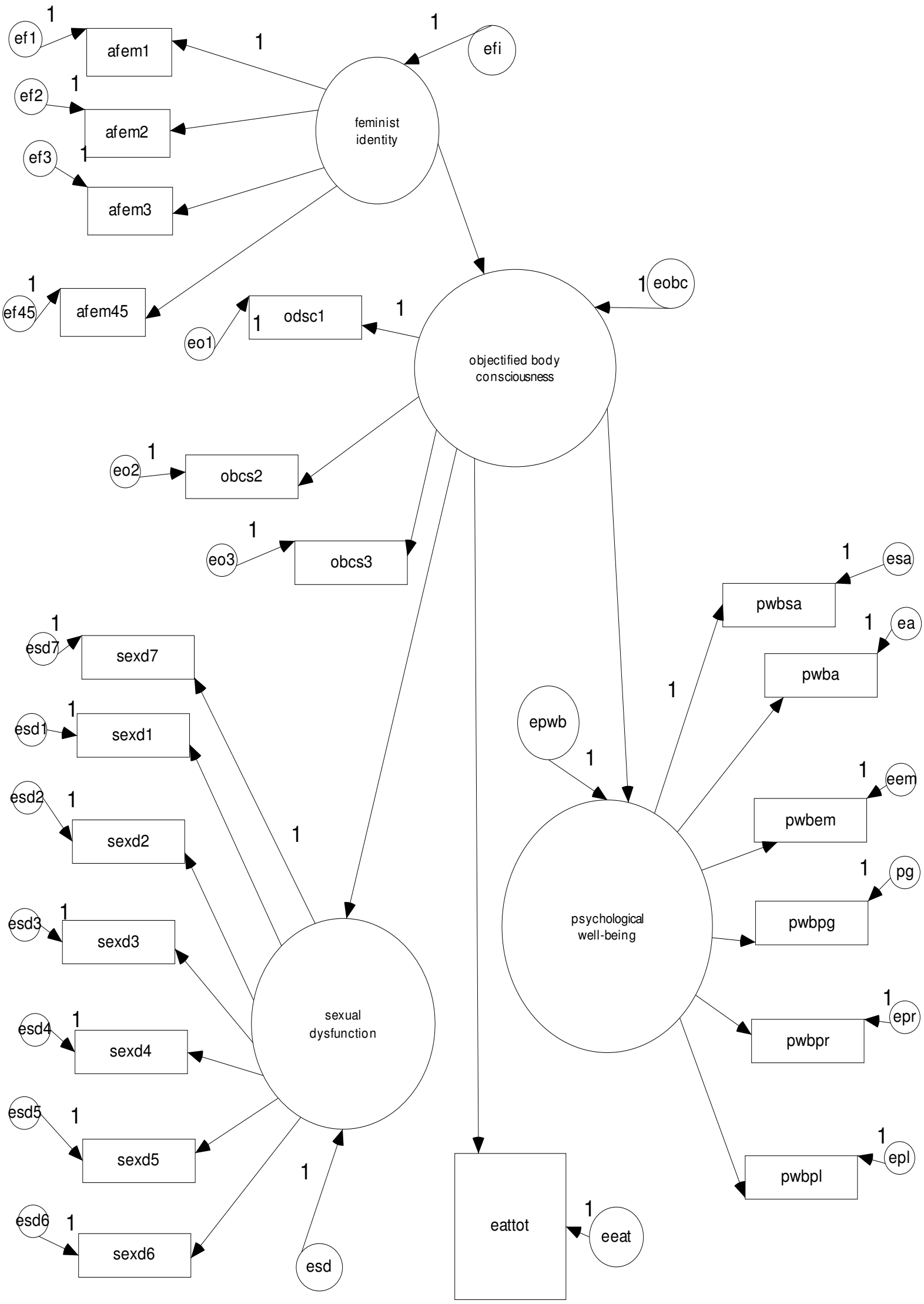

Figure 1: Input Path Model

As goodness of fit measures, chi-square statistic, comparative fit index (CFI), root-mean-square error of approximation (RMSEA) and Tucker-Lewis Index (TLI) were included. A model that fits the data will have a non-significant Chi-Square statistic, CFI and TLI over .95, and a RMSEA less than .06 (Hu & Bentler, 1999). The model tested in this study did not fit the data well, comparative fit index (CFI) = .822, root-mean-square error of approximation (RMSEA) = .104, Tucker-Lewis Index (TLI) = .799 (see Table 7). In addition, the chi-square statistic was significant; χ^2 (df =186) = 440.410, p = .000.

Table 7

Goodness of Fit Measures

Model	TLI rho2	CFI	RMSEA	LO 90	HI 90	PCLOSE
Default model	.799	.822	.104	.091	.116	.000

In evaluating this first model, modifying indices indicate possible paths to be added in order to achieve better model fit. After considering whether or not it made theoretical sense to add the paths, they were added to the model one at a time and the model was re-estimated each time. In addition, covariances were added one at a time as indicated by the modifying indices for covariances. The added covariance estimates can be seen in Table 8.

Table 8

Covariance Estimates

Variables			Estimate	S.E.	C.R.	P
epwb	<-->	esd	1.636	.642	2.550	.011
esd3	<-->	esd1	.496	.104	4.782	***
esd6	<-->	esd1	.811	.287	2.821	.005
esd2	<-->	esd5	.186	.103	1.812	.070
esd3	<-->	esd6	.638	.167	3.831	***
esd2	<-->	esd3	.297	.067	4.417	***
esd4	<-->	esd7	.837	.356	2.351	.019
esd3	<-->	esd7	.225	.099	2.281	.023
ea	<-->	epr	-6.916	2.780	-2.487	.013
esd7	<-->	esd1	.734	.230	3.187	.001
esd5	<-->	eeat	1.651	.469	3.521	***
ef1	<-->	eobc	.594	.253	2.348	.019
esd3	<-->	ea	-1.024	.320	-3.196	.001

The resulting final model fit the data well. The chi-square statistic was not significant; χ^2 (df =34) = 193.103, p = .081; comparative fit index (CFI) = .982, root-mean-square error of approximation (RMSEA) = .035, Tucker-Lewis Index (TLI) = .977 (see Table 9).

Table 9

Goodness of Fit Measures Modified Model

Model	TLI rho2	CFI	RMSEA	LO 90	HI 90	PCLOSE
Default model	.977	.982	.035	.000	.055	.878

In the final model, paths between objectified body consciousness and both disordered eating (standardized regression weight =.285) and psychological well-being (standardized regression weight = -.406) are significant at the $p < .05$ level indicating support for the first portion on hypothesis number 2. The path between objectified body consciousness and sexual dysfunction was not significant (standardized regression weight = -.181, $p = .174$) indicating lack of support for the remaining portion of hypothesis number 2. The path between feminist identity and objectified body consciousness was likewise not significant (standardized regression weight = .287, $p = .666$) indicating lack of support for hypothesis number 3. Standardized regression weights are shown in Table 10. Unstandardized regression weights for the final model are shown in Figure 2.

Table 10

Standardized Regression Weights

Variables			Estimate
objectified body_consciousness	<---	feminist_identity	-.162
sexual_dysfuntion	<---	objectified body_consciousness	-.080
sexd1	<---	sexual_dysfuntion	.506
psychological_well-being	<---	objectified body_consciousness	-.503
psychological_well-being	<---	feminist_identity	-.494
sexd2	<---	sexual_dysfuntion	.921
sexd3	<---	sexual_dysfuntion	.812
sexd4	<---	sexual_dysfuntion	.913
sexd5	<---	sexual_dysfuntion	.918
sexd6	<---	sexual_dysfuntion	.910
pwbsa	<---	psychological_well-being	.862
pwba	<---	psychological_well-being	.563
pwbem	<---	psychological_well-being	.726
pwbpg	<---	psychological_well-being	.685
pwbpr	<---	psychological_well-being	.767
pwbpl	<---	psychological_well-being	.601
afem1	<---	feminist_identity	.049
sexd7	<---	sexual_dysfuntion	.452
afem3	<---	feminist_identity	-.755
afem45	<---	feminist_identity	-.749
afem2	<---	feminist_identity	-.623
obcs1	<---	objectified body_consciousness	.303
obcs3	<---	objectified body_consciousness	.535
obcs2	<---	objectified body_consciousness	.771
eattot	<---	objectified body_consciousness	.344
sexd7	<---	psychological_well-being	-.393
afem2	<---	psychological_well-being	-.476
obcs1	<---	feminist_identity	-.315
afem3	<---	sexual_dysfuntion	-.312
afem1	<---	sexd1	-.348

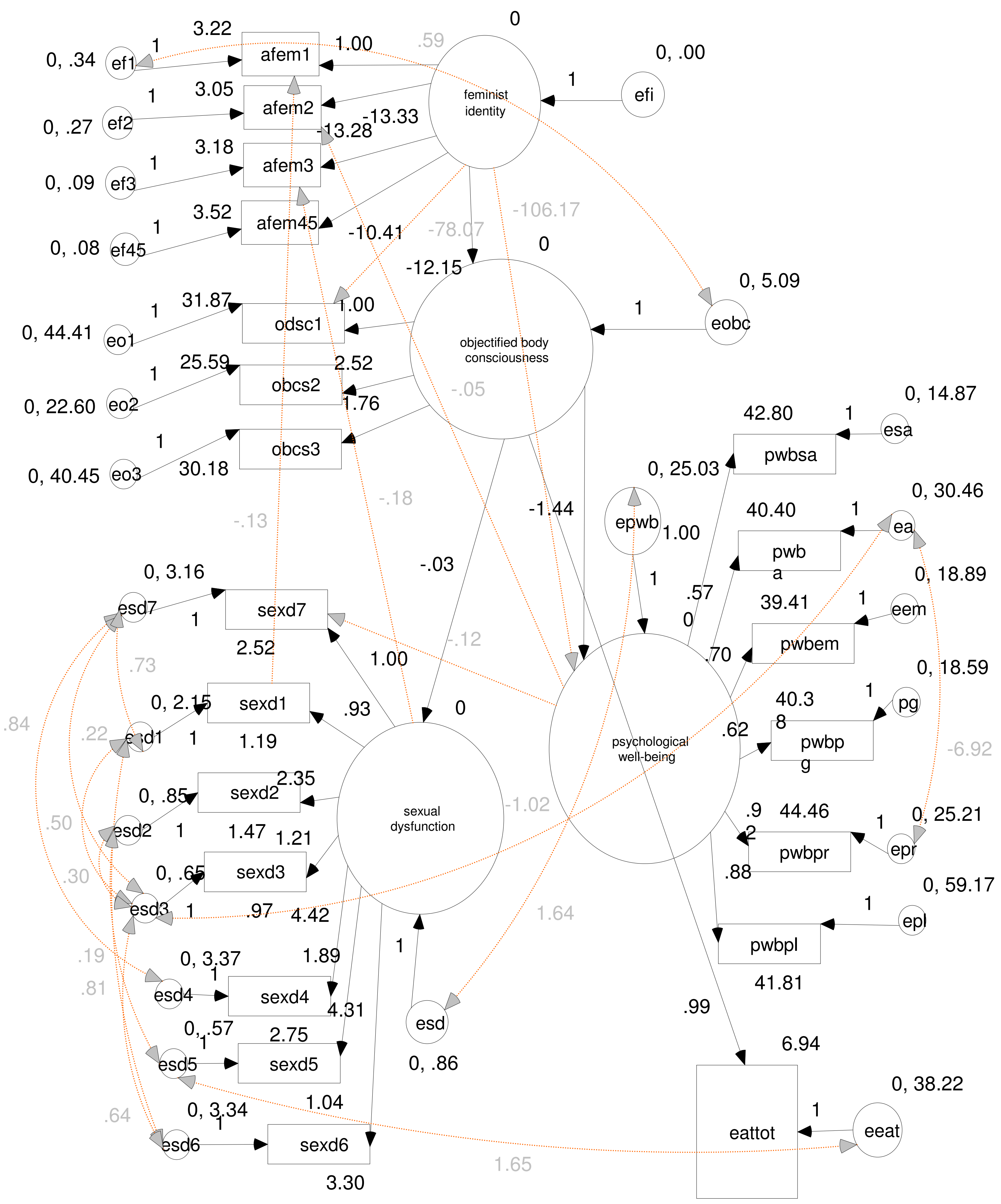

Figure 2: Path Model with Unstandardized Regression Weights and Variances. Note: Dark lines represent original path model; red lines represent modified model

CHAPTER V

SUMMARY AND DISCUSSION

This chapter will focus on the results of the analysis of each of the three hypotheses of this study. Generalizability and limitations of this research will be addressed, as will clinical implications and suggestions for future research.

Hypothesis One

The first hypothesis of this study was as follows: Women over the age of 65 will evidence low levels of self-objectification. Results from this study do not support this hypothesis. In fact, women in this study had moderate to high levels on each of the three scales comprising Objectified Body Consciousness contradicting the finding by Tiggemann and Lynch (2001) that self-objectification decreases with age.

The literature on the Theory of Self Objectification does not assert whether or not older women will have high or low levels of self-objectification, but does present two competing hypothesis. This result does, in part, support the Objectification Theory hypothesis that, as women age, they may continue to self-objectify, but that the self-objectification may be adaptive. In other words, women begin to detach from their bodies in a protective manner allowing them to preserve their self-concepts. The findings of this study lends support only to the first part of the theory's hypothesis about older women, but does not shed light on whether or not this is adaptive. In fact, as will be seen in the discussion of this study's other hypotheses, objectification is negatively correlated with psychological well-being and positively correlated with disordered eating in this sample of older women. Therefore, it does not appear that self-objectification is

any more adaptive in older women than it is in younger women. However, the second possibility described by the original Objectification Theory is that women cease to objectify all together and avoid the negative mental health ramifications. This, too, is not supported by the findings of this study. In this sample of older women, older women do self-objectify.

Hypothesis Two

The second hypothesis of this study was as follows: In women over age 65, the level of self-objectification is negatively correlated with psychological well-being and positively correlated with sexual dysfunction and disordered eating. Results from this study indicate that self-objectification has no relationship with sexual dysfunction. However, results also indicate that self-objectification is negatively correlated psychological well-being and positively correlated with disordered eating.

There are several possible reasons why this study may have produced a lack of a relationship between self-objectification and sexual dysfunction. First, it is possible that there was no relationship between self-objectification and sexual dysfunction because only 25% of the sample endorsed having any sexual activity in the past month; therefore, rates of sexual dysfunction were quite low. Women also endorsed normal rates of receptivity, arousal and relationship satisfaction, further indicating lack of generalized sexual dysfunction for this sample.

Another possible reason for this result was generated by comments written on two of the surveys. One comment stated, “These questions are none of your business,” referring to the sexual dysfunction scale questions. Another statement said, “Wow, such

private questions!" It is possible that women in this study were less than truthful when answering questions about sex since they were so detailed and personal. This mindset may have led to a reduction in the truthful reporting of sexual dysfunction.

Reasons for this result may also be found in the preceding literature review. This result supported the notion discussed by Hurd (2001) that, as women age, focus on the body may shift from one of sexual attractiveness to health considerations. The result of this may be a reduction in the shame and anxiety regarding the body that is often provoked in the vulnerable act of a sexual encounter. This may allow the woman to more fully engage in the activity, thus enjoying it more and receiving more satisfaction from the sexual encounter. In other words, perhaps, as women age, they are able to throw caution to the wind in terms of body image and are able to sexually enjoy themselves more than their younger counterparts. This may occur even though the experience of an objectified body consciousness continues into late adulthood, as asserted in the literature and supported by the results of this study, because older women don't feel the need to conform to cultural ideals, including that of the sexual cultural ideal, as do younger women (Hurd, 2001).

Notable tenants of Objectification Theory that were supported in this current study included the relationship between self-objectification and psychological well-being and eating disorders. McKinley (2004) found that psychological well-being was correlated with body-esteem and this study supports this notion and furthers our understanding with the knowledge that the act of self-objectifying is correlated with psychological well-being. This finding is also consistent with the finding by

Muehlendkamp and Saris-Baglama (2002) that self-objectification was directly related to depression in a college-aged sample. This result has been expanded to a population of older women through the findings of this study.

Finally, it was also found that self-objectification is directly related to disordered eating in older women. A similar result was found by McKinley and Hyde (1996) in a sample of young and middle aged women, but included no older women. This current result expands the understanding of the role self-objectification plays in the development of eating disorders across the lifespan and lends support for the notion that across the lifespan, women who fall victim to the socio-cultural pressures to self-objectify have higher rates of disordered eating.

Hypothesis Three

The third hypothesis of this study was as follows: Level of feminist identity is negatively correlated with self-objectification; specifically, those who endorse later-stage feminist identity will evidence less self-objectification. Results indicate there was no relationship between feminist identity and level of self-objectification. This result seems to support findings in the preceding literature review that there is no relationship between adherence to a traditional gender role and body image in college students (Cash, Ancis, & Strachan, 1997) or body satisfaction (Dionne, Davis, Fox, & Gurevich, 1995). In addition, this finding is in contradiction with findings in younger age ranges that women who identify with feminist values tend to have less body dissatisfaction than women who do not identify with feminist values (Davis, Dionne, & Lazurus, 1996). However, these studies lacks insight into the experience of older women with no

significant representation of older women in their studies; this current study extends the knowledge base through its exclusive study of women 65 and older.

Limitations

This study was conducted in a fairly small southwest city where it may not always be acceptable to discuss matters such as sex or feminist attitudes. Despite the anonymity of the survey, some women may have been reluctant to be honest about sexual practices or women's/feminist ideas. In addition, the reliability estimates for the sexual dysfunction scales were significantly low, especially for the D7 (problems effecting sexual arousal), D2 (arousal), and D4 (receptivity/initiation) subscales. These reliability estimates for these subscales may have affected the overall results for that particular portion of hypothesis number two.

As for generalizability, these results are only applicable to women aged 65 and older living in small cities in the southwest. The results should not be seen as applicable to women in general or in any age range except 65 and older. In addition, the majority of this sample were Caucasian; therefore, the generalizability of these results do not extend beyond this ethnicity.

Implications for Clinical Interventions

While this study failed to find a relationship between feminist identity and objectified body consciousness or between objectified body consciousness and sexual dysfunction, there were significant results found in the relationship between objectified body consciousness and both psychological well-being and disordered eating. This demonstrates that therapists need to heighten their awareness the role a woman's

relationship with her body plays later in life. Therapists need to be especially sensitive to a broader array of etiologies when working with older women struggling with low psychological well-being (or depression) and who report disordered eating. As was discussed in the literature review, not only does society exclude older women from the realm of sexual beings, it too ignores helping a woman embrace her changing body. The relationship with her body needs to be fully explored as *one* of many contextual questions in therapy. How many therapists ask women how they are approaching the aging process and what the aging process means to them? How many routinely explore the socio-cultural impact on this relationship with their body, both when they were younger and now? The inclusion of self-body relationship in the therapeutic context may be easier to grasp when a client presents with disordered eating; however, it is much easier to forget when a client presents with depression. This study demonstrates, though, that as women age, this relationship continues to be complex and has a definite impact on a woman's mental health and should routinely be assessed, minimally, in the clinical interview.

Implications for Further Research

There are varied research implications stemming from this current study. While this study clearly identifies that these women do self-objectify and do suffer some of the mental health ramifications of such objectification, what is not clear is how some women escape these ramifications. Clearly a disconnect exists between the results of this study and those of Hurd's (2001) qualitative study with women over the age of 65. Many of the Hurd (2001) women identified a process of distancing from their bodies in a way that

seemed helpful, even protective and a process of reengaging in other aspects of their lives (spiritual, emotional, artistic). Are what these women experiencing, something different from simply continuing or ceasing to self-objectify? Are they two different processes altogether? Furthermore, how can we identify what the women in the Hurd (2001) study do in this process and can it be taught or encouraged in other women? Finally, the resulting paths of the modified path model indicate that there may be processes at work that were not included in the original model. Specifically, the path from feminist identity to psychological well-being is noteworthy. Whether or not these two concepts are truly related should be investigated. The covariance matrix represented on the modified path model mainly focus around the error terms for the various sexual dysfunction scales. Perhaps this measure should, in the future, be evaluated as testing one concept rather than several dimensions of sexual dysfunction. As indicated by the covariance structure in this path model, the dimensions may significantly overlap.

This study also has research implications for those practitioners brave enough to undertake research in their clinical practice. While this study does identify that there is a relationship between self-objectification and depression/psychological well-being, it does not identify how salient a role body issues play in women who present with depression and eating issues in actual clinical practice. Would these women self-identify a link with the relationship she has with their bodies? Would these issues emerge through the course of therapy?

Additional research with samples from other ethic groups would also address the limitation of this work due to a predominant Caucasian sample. It might be

hypothesized that ethnic groups other than Caucasians have vastly different criteria for body image and are, therefore, affected differently by socio-cultural obsession with thinness. In other words, is the larger socio-culture based on white values? This is likely. The phenomenon of the "J-Lo booty" may indicate a value on something other than thinness in other ethnic groups. Are other ethnic groups susceptible to self-objectification? If so, on what criteria do they objectify? Are there "within" cultural ideals that are in conflict with the dominant culture? If so, what impact does this have on a woman's relationship with her body?

Finally, there are implications for research and work on the socio-cultural level. Clearly, being raised a female in this western culture has an impact on women, and this study demonstrates that women 65 and older are not magically immune. Continued research on interventions at all developmental stages of life may lead to fruitful programs that provide a buffer between women and the negative impact of the wider culture. Research into the development of programs should also include efforts to begin to change the tide of a sexist culture and the cultural obsession with physical beauty.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1) Age: _____years old

2) Ethnic Group:
_____African American
_____Asian or Pacific Islander
_____Hispanic (Mexican, Puerto Rico, Cuban, Central or South American)
_____Native American
_____White (Not of Hispanic Origin)
_____Other: Please specify: _____

3) Marital Status:
_____Married: Length of Marriage: _____
_____Separated
_____Single, Never Married
_____Widowed
_____Divorced

4) Level of Education:
____Less than 12th Grade; indicate exact number _____
____High School or Equivalent
____Vocational/Technical School (2 year)
____Some College
____Associate's Degree or Trade School
____Bachelor's Degree
____Master's Degree
____Doctoral Degree
____Professional Degree
____Other: please specify_____

5) What is your occupation? (if retired, please indicate occupation prior to retirement) _____

6) Please consider how healthy you see yourself. On a scale of 0 to 5, where 5 indicates excellent health and 0 indicates poor health. Please circle a number:

0 1 2 3 4 5
poor health excellent health

7) Please indicate your height and weight. If you do not know your exact height and weight, please estimate as best as you can.

Height_____ Weight_____

8) Type of residence: ____nursing home ____assisted living ___independently

APPENDIX B

INFORMATION SHEET 1

Hi!

My name is Alisa VanLandingham and I am a 3rd year Counseling Psychology doctoral student at Texas A&M, College Station. The following information is for my dissertation. I hope you will consider participating in my study, which will take about 25 minutes to complete.

Please find a quarter attached. I wish I could compensate you more for your valuable time and information, however, the budget of a full-time graduate student is pretty tight!

You may notice that some of the questions ask about sensitive areas such as sex and how you feel about your body. They will ask you about such things as how you feel about your body, your eating habits, and sexual practices. I realize that at times, this may be embarrassing. However, it is ok to answer these questions in this anonymous survey. The answers will help me complete my study and will contribute greatly to what we know about mature women. You may stop answering the questions at any time during the survey.

If you do choose to participate, please be sure to first read through the information sheet and remember:

- You must be female to participate in this study
- You must be at least 65 year of age or older
- This study is completely anonymous- your name will not be associated with your survey in any way.

Then, please complete the demographic sheet and the 5 surveys. You may hand them back to me or mail them back to me in the envelope I have provided you.

Please try to answer each and every item on the survey!

Thank you SO MUCH for helping me collect my data!

Much Appreciation,

Alisa VanLandingham

APPENDIX C

INFORMATION SHEET 2

Information Sheet
Testing the Objectification Theory Model and Exploration of Factors Contributing to the Development of Objectified Body Consciousness

Individuals have been asked to particiapte in a dissertation study of western culture's view of women's bodies, factors contributing to women's body image, and the consequences of western culture's view of women's bodies. They were selected to be possible participants due to gender and age qualifications. A total of 200 women age 65 and over have been asked to particiapte in this study. The purpose of this study is to determine the realtionship between one's level of feminist values, opinion of her body, level of positive and/or negative outlook on life, possible sexual problems, and rate of eating disorders.

If individuals agree to participate in this study, they will be asked to complete a demographic sheet and five short surveys exploring feminist values, opinion of her body, outlook on life, eating behavior, and sexual behavior. A single dollar bill is included with each survey to serve as compensation. This study will take approxiamtely 25 minutes. The risks associated with this study are minimal. In the event a participant experiences an emotional reaction to any of the questions, she may contact the following counselor/mental health professional:

Insert Name/Contact Information Here

This study is anonymous and all records of this study will be kept private. Research records will be stored securely. Only Alisa VanLandingham and her docotoral committee (Dr. Donna Davenport, Dr. Linda Castillo, Dr. Ludy Benjamin, and Dr. Victor Willson) will have access to the records.

An individual's decision whether to particiapte or not to participate will not affect her current or furture relations with Texas A&M University, or her community or organization through which she was recruited. If she decides to particiapte, she is free to refuse to answer any of the questions. Participants can withdraw at anytime without relations with the university, job, benefits, etc being affected.

This research has been reviewed and approved by the Institutional Review Board-Human Subjects in Research, Texas A&M University. For research related problems or questions regarding subjects' rights, contact the Institutional Review Board through Ms. Angelia Raines, Director of Research Compliance Office of Vice President for research at (979) 458-4067.

Participants have read and understand the explanation provided and all questions have been answered. Contact Alisa VanLandingham, MSW or Dr. Donna S. Davenport with any questions about this study.

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APPENDIX D

FEMINIST IDENTITY DEVELOPMENT SCALE*

On the following pages you will find a series of statements which people might use to describe themselves. Read each statement carefully and decide to what degree you think it presently describes you. Then select one of the five answers that best describes your present agreement or disagreement with the statement.

For example, if you strongly agree with the statement, "I like to return to the same vacation spot year after year," you would rate the statement with the number 5 in the space provided as shown below:

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

5 I like to return to the same vacation spot year after year.

Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
1. I don't think there is any need for an Equal Rights Amendment; women are doing well.	1	2	3	4	5
2. Being a part of a women's community is important to me.	1	2	3	4	5
3. I want to work to improve women's status.	1	2	3	4	5
4. I feel that some men are sensitive to women's issues.	1	2	3	4	5
5. I used to think there wasn't a lot of sex discrimination, but now I know how much there really is.	1	2	3	4	5

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Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
6. Although many men are sexist, I have found that some men are very supportive of women and feminism.	1	2	3	4	5
7. Especially now, I feel that the other women around me give me strength.	1	2	3	4	5
8. I am very committed to a cause that I believe contributes to a more fair and more just world for all people.	1	2	3	4	5
9. While I am concerned that women be treated fairly in life, I do not see men as the enemy.	1	2	3	4	5
10. I share most of my social time with a few close women friends who share my feminist values.	1	2	3	4	5
11. I don't see much point in questioning the general expectation that men should be masculine and women should be feminine.	1	2	3	4	5
12. I am willing to make certain sacrifices in order to work toward making this society a non-sexist, peaceful place where all people have equal opportunities.	1	2	3	4	5

Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
13. 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
14. My social life is mainly with women these days, but there are a few men I wouldn't mind having a non-sexual friendship with.	1	2	3	4	5
15. I've never really worried or thought about what it means to be a woman in this society.	1	2	3	4	5
16. I evaluate men as individuals, not as members of a group of oppressors.	1	2	3	4	5
17. I just feel like I need to be around women who share my point of view right now.	1	2	3	4	5
18. I care very deeply about men and women having equal opportunities in all respects.	1	2	3	4	5
19. It makes me really upset to think about how women have been treated so unfairly in this society for so long.	1	2	3	4	5
20. I do not want to have equal status with men.	1	2	3	4	5

Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
21. It is very satisfying to me to be able to use my talents and skills for my work in the women's movement.	1	2	3	4	5
22. If I were married and my husband was offered a job in another state, it would be my obligation as his spouse to move in support of his career.	1	2	3	4	5
23. I think that most women will feel most fulfilled by being a wife and mother.	1	2	3	4	5
24. When you think about most of the problems in the world—pollution, discrimination, the threat of nuclear war—it seems to me that most of them are caused by men.	1	2	3	4	5
25. I am angry that I've let men take advantage of me.	1	2	3	4	5
26. It only recently occurred to me that I think that it's unfair that men have the privileges they have in this society simply because they are men.	1	2	3	4	5
27. I feel that I am a very powerful and effective spokesperson for the women's issues I am concerned with right now.	1	2	3	4	5

Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
28. 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
29. I think that men and women had it better in the 1950s when married women were housewives and their husbands supported them.	1	2	3	4	5
30. Some of the men I know seem more feminist than some of the women.	1	2	3	4	5
31. When I see the way most men treat women, it makes me so angry.	1	2	3	4	5
32. Generally, I think that men are more interesting than women.	1	2	3	4	5
33. Recently I read something or had a specific experience that sparked my greater understanding of sexism.	1	2	3	4	5
34. I think that rape is sometimes the woman's fault.	1	2	3	4	5
35. On some level, my motivation for almost every activity I engage in is my desire for an egalitarian world.	1	2	3	4	5

Remember to read each statement carefully and decide to what degree you think it describes you at the present time.	Strongly Disagree	Disagree	Neither Agree nor Disagree	agree	Strongly Agree
36. I am not sure what is meant by the phrase "women are oppressed under patriarchy."	1	2	3	4	5
37. 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
38. I have a lifelong commitment to working for social, economic, and political equality for women.	1	2	3	4	5
39. Particularly now, I feel most comfortable with women who share my feminist point of view.	1	2	3	4	5

APPENDIX E

OBJECTIFIED BODY CONSCIOUSNESS SCALE*

Circle the number that corresponds to how much you agree with each of the statements on this page. Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with a statement.	Strongly Disagree			Neither Agree nor Disagree			Strongly Agree
1. I rarely think about how I look.	1	2	3	4	5	6	7
2. I think it is more important that my clothes are comfortable than whether they look good on me.	1	2	3	4	5	6	7
3. I think more about how my body feels than how my body looks.	1	2	3	4	5	6	7
4. I rarely compare how I look with how other people look.	1	2	3	4	5	6	7
5. During the day, I think about how I look many times.	1	2	3	4	5	6	7
6. I often worry about whether the clothes I am wearing make me look good.	1	2	3	4	5	6	7
7. I rarely worry about how I look to other people.	1	2	3	4	5	6	7
8. I am more concerned with what my body can do than how it looks.	1	2	3	4	5	6	7
9. When I can't control my weight, I feel like something must be wrong with me.	1	2	3	4	5	6	7
10. I feel ashamed of myself when I haven't made the effort to look my best.	1	2	3	4	5	6	7

*Reprinted with permission from "The objectified body consciousness scale" by McKinely, N.M. & Hyde, J.S., 1996. *Psychology of Women Quarterly*, 20, 181-215.

Circle the number that corresponds to how much you agree with each of the statements on this page. Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with a statement.	Strongly Disagree			Neither Agree nor Disagree			Strongly Agree
11. I feel like I must be a bad person when I don't look as good as I could.	1	2	3	4	5	6	7
12. I would be ashamed for people to know what I really weigh.	1	2	3	4	5	6	7
13. I never worry that something is wrong with me when I am not exercising as much as I should.	1	2	3	4	5	6	7
14. When I'm not exercising enough, I question whether I am a good enough person.	1	2	3	4	5	6	7
15. Even, when I can't control my weight, I think I'm an okay person.	1	2	3	4	5	6	7
16. When I'm not the size I think I should be, I feel ashamed.	1	2	3	4	5	6	7
17. 1 think a person is pretty much stuck with the looks they are born with.	1	2	3	4	5	6	7
18. A large part of being in shape is having that kind of body in the first place.	1	2	3	4	5	6	7
19. I think a person can look pretty much how they want to if they are willing to work at it.	1	2	3	4	5	6	7

Circle the number that corresponds to how much you agree with each of the statements on this page. Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with a statement.	Strongly Disagree			Neither Agree nor Disagree			Strongly Agree
20. I really don't think I have much control over how my body looks.	1	2	3	4	5	6	7
21 I think a person's weight is mostly determined by the genes they arc born with.	1	2	3	4	5	6	7
22. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same.	1	2	3	4	5	6	7
23. I can weigh what I'm supposed to when I try hard enough.	1	2	3	4	5	6	7
24. The shape you are in depends mostly upon your genes.	1	2	3	4	5	6	7

APPENDIX F

SCALES OF PSYCHOLOGICAL WELL BEING- SHORT FORM*

The following set of questions deals with how you feel about yourself and your life. Please remember that there are no right or wrong answers.

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
1. Most people see me as loving and affectionate.	1	2	3	4	5	6
2. In general, I feel I am in charge of the situation in which I live.	1	2	3	4	5	6
3. I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
4. When I look at the story of my life, I am pleased with how things have turned out.	1	2	3	4	5	6
5. Maintaining close relationships has been difficult and frustrating for me.	1	2	3	4	5	6
6. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.	1	2	3	4	5	6
7. The demands of everyday life often get me down.	1	2	3	4	5	6
8. I live life one day at a time and don't really think about the future.	1	2	3	4	5	6
9. In general, I feel confident and positive about myself.	1	2	3	4	5	6
10. I often feel lonely because I have few close friends with whom to share my concerns.	1	2	3	4	5	6

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Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
11. My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
12. I do not fit very well with the people and the community around me.	1	2	3	4	5	6
13. I tend to focus on the present, because the future nearly always brings me problems.	1	2	3	4	5	6
14. I feel like many of the people I know have gotten more out of life than I have.	1	2	3	4	5	6
15. I enjoy personal and mutual conversations with family members or friends.	1	2	3	4	5	6
16. I tend to worry about what other people think of me.	1	2	3	4	5	6
17. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
18. I don't want to try new ways of doing things - my life is fine the way it is.	1	2	3	4	5	6
19. Being happy with myself is more important to me than having others approve of me.	1	2	3	4	5	6
20. I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
21. I think it is important to have new experiences that challenge how you think about yourself and the world.	1	2	3	4	5	6
22. My daily activities often seem trivial and unimportant to me.	1	2	3	4	5	6
23. I like most aspects of my personality.	1	2	3	4	5	6
24. I don't have many people who want to listen when I need to talk.	1	2	3	4	5	6
25. I tend to be influenced by people with strong opinions.	1	2	3	4	5	6
26. When I think about it, I haven't really improved much as a person over the years.	1	2	3	4	5	6
27. I don't have a good sense of what it is I'm trying to accomplish in life.	1	2	3	4	5	6
28. I made some mistakes in the past, but I feel that all in all everything has worked out for the best.	1	2	3	4	5	6
29. I generally do a good job of taking care of my personal finances and affairs.	1	2	3	4	5	6
30. I used to set goals for myself, but that now seems like a waste of time.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
31. In many ways, I feel disappointed about my achievements in life.	1	2	3	4	5	6
32. It seems to me that most other people have more friends than I do.	1	2	3	4	5	6
33. I enjoy making plans for the future and working to make them a reality.	1	2	3	4	5	6
34. People would describe me as a giving person, willing to share my time with others.	1	2	3	4	5	6
35. I have confidence in my opinions, even if they are contrary to the general consensus.	1	2	3	4	5	6
36. I am good at juggling my time so that I can fit everything in that needs to be done.	1	2	3	4	5	6
37. I have a sense that I have developed a lot as a person over time.	1	2	3	4	5	6
38. I am an active person in carrying out the plans I set for myself.	1	2	3	4	5	6
39. I have not experienced many warm and trusting relationships with others.	1	2	3	4	5	6
40. It's difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
41. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	1	2	3	4	5	6
42. Some people wander aimlessly through life, but I am not one of them.	1	2	3	4	5	6
43. My attitude about myself is probably not as positive as most people feel about themselves.	1	2	3	4	5	6
44. I often change my mind about decisions if my friends or family disagree.	1	2	3	4	5	6
45. For me, life has been a continuous process of learning, changing, and growth.	1	2	3	4	5	6
46. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6
47. I know that I can trust my friends, and they know they can trust me.	1	2	3	4	5	6
48. The past had its ups and downs, but in general, I wouldn't want to change it.	1	2	3	4	5	6
48. I have difficulty arranging my life in a way that is satisfying to me.	1	2	3	4	5	6
50. I gave up trying to make big improvements or changes in my life a long time ago.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
51. When I compare myself to friends and acquaintances, it makes me feel good about who I am.	1	2	3	4	5	6
52. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6
53. I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
54. There is truth to the saying that you can't teach an old dog new tricks.	1	2	3	4	5	6

APPENDIX G

EATING ATTITUDES TEST*

The following set of questions deals with how you feel about your weight and eating habits. Please remember that there are no right or wrong answers.

Circle one response for each of the questions.	Always	Usually	Often	Sometimes	Rarely	Never
1. Am terrified about being overweight.	1	2	3	4	5	6
2. Avoid eating when I am hungry.	1	2	3	4	5	6
3. Find myself preoccupied with food.	1	2	3	4	5	6
4. Have gone on eating binges where I feel that I may not be able to stop.	1	2	3	4	5	6
5. Cut my food into small pieces.	1	2	3	4	5	6
6. Aware of the calorie content of foods that I eat.	1	2	3	4	5	6
7. Particularly avoid food with a high carbohydrate content (i.e.bread, rice, potatoes,etc)	1	2	3	4	5	6
8. Feel that others would prefer if I ate more.	1	2	3	4	5	6
9. Vomit after I have eaten.	1	2	3	4	5	6
10. Feel extremely guilty after eating.	1	2	3	4	5	6
11. Am preoccupied with a desire to be thinner.	1	2	3	4	5	6
12. Think about burning up calories when I exercise.	1	2	3	4	5	6
13. Other people think that I am too thin.	1	2	3	4	5	6
14. Am preoccupied with the thought of having fat on my body.	1	2	3	4	5	6

*Reprinted with permission from "The eating attitudes test: An index of the symptoms of anorexia nervosa" by Garner, D. M., & Garfinkel, D. M., 1979. *Psychological Medicine, 9*(2), 273-279. Copyright 1979 by David Garner, PhD.

APPENDIX H

BRIEF INDEX OF SEXUAL FUNCTIONING FOR WOMEN*

This next index covers material that is sensitive and personal. Your responses will be kept completely confidential. If you are unable or do not wish to answer any question, you may leave it blank.

Answer the following questions by choosing the most accurate response *for the past month*.

1. Do you currently have a sex partner? _____YES _____NO

2. Have you been sexually active during the past month? _____YES _____NO

3. During the past month, how frequently have you had sexual thoughts, fantasies, or erotic dreams? (circle the most appropriate answer)

   (0) Not at all
   (1) Once
   (2) 2 or 3 times
   (3) Once a week
   (4) 2 or 3 times per week
   (5) Once a day
   (6) More than once a day

4. Using the table to the right, indicate how frequently you have **felt a desire** to engage in the following activities during the past month? *(An answer is required for each, even if it may not apply to you.)*

Kissing_____	(0) Not at all
Masturbation Alone_____	(1) Once
Mutual Masturbation_____	(2) 2 or 3 times
Petting and Foreplay_____	(3) Once a week
Oral Sex_____	(4) 2 or 3 times per week
Vaginal Penetration/Intercourse_____	(5) Once a day
Anal Sex_____	(6) More than once a day

*Reprinted with permission from "Self-report assessment of female sexual function: Psychometric evaluation of the brief index of sexual functioning for women" by Taylor, J.F., Rosen, R.C., & Leiblum, S. R., 1984. *Archives of Sexual Behavior*, 23, 627-637.

5. Using the scale to the right, indicate how frequently you have **become aroused** by the following sexual experiences during the past month. *(An answer is required for each, even if it may not apply to you.)*

Kissing_____	(0) Not at all
Masturbation Alone_____	(1) Once
Mutual Masturbation_____	(2) 2 or 3 times
Petting and Foreplay_____	(3) Once a week
Oral Sex_____	(4) 2 or 3 times per week
Vaginal Penetration/Intercourse_____	(5) Once a day
Anal Sex_____	(6) More than once a day

6. Overall, during the past month, how frequently have you become anxious or inhibited during sexual activity with a partner? (Please circle the most appropriate response.)

(0) I have not had a partner.

(1) Not at all anxious or inhibited.

(2) Seldom, less than 25% of the time.

(3) Sometimes, about 50% of the time.

(4) Usually, about 75% of the time.

(5) Always became anxious or inhibited.

7. Using the scale to the right, indicate how frequently you have engaged in the following sexual experiences during the past month? *(An answer is required for each, even if it may not apply to you.)*

Kissing_____
Sexual Fantasy_____
Masturbation Alone_____
Mutual Masturbation_____
Petting and Foreplay_____
Oral Sex_____
Vaginal Penetration/Intercourse_____
Anal Sex_____

(0) Not at all
(1) Once
(2) 2 or 3 times
(3) Once a week
(4) 2 or 3 times per week
(5) Once a day
(6) More than once a day

8. During the past month, who has usually initiated sexual activity? (Please circle the most appropriate response.)

(0) I have not had a partner.
(1) I have not had sex with a partner in the past month.
(2) I usually have initiated activity.
(3) My partner and I have equally initiated activity.
(4) My partner has usually initiated activity.

9. During the past month, how have you usually responded to your partner's sexual advances? (Please circle the most appropriate response.)

(0) I have not had a partner.
(1) Has not happened during the past month.
(2) Usually refused.
(3) Sometimes refused.
(4) Accepted reluctantly.
(5) Accepted, but not necessarily with pleasure.
(6) Usually accepted with pleasure.
(7) Always accepted with pleasure.

10. During the past month, have you felt pleasure from any forms of sexual experience? (Please circle the most appropriate response.)

(0) I have not had a partner.

(1) Have had no sexual experience during the past month.

(2) Have not felt any pleasure.

(3) Seldom, less than 25% of the time.

(4) Sometimes, about 50% of the time.

(5) Usually, about 75% of the time.

(6) Always felt pleasure.

11. Using the scale to the right, indicate how often you reached orgasm during the past month with the following activities. *(An answer is required for each, even if it may not apply to you.)*

In dreams or fantasy_____
Kissing_____
Masturbation Alone_____
Mutual Masturbation_____
Petting and Foreplay_____
Oral Sex_____
Vaginal Penetration/Intercourse_____
Anal Sex_____

(0) I have not had a partner
(1) Have not engaged in this activity
(2) 2 or 3 times
(3) Once a week
(4) 2 or 3 times per week
(5) Once a day
(6) More than once a day

12. During the past month, has the frequency of your sexual activity with a partner been: *(please circle the most appropriate response.)*

(0) I have not had a partner

(1) less than you desired

(2) As much as you desired

(3) More than you desired

13. Using the scale to the right, indicate the level of change, if any, in the following areas during the past month. *(An answer is required for each, even if it may not apply to you.)*

Sexual Interest_____
Sexual arousal_____
Sexual Activity_____
Sexual Satisfaction_____
Sexual Anxiety_____

(0) Not applicable
(1) Much lower level
(2) Somewhat lower level
(3) No change
(4) Somewhat higher level
(5) Much higher level

14. During the past month, how frequently have you experienced the following? *(An answer is required for each, even if it may not apply to you.)*

Bleeding or irritation after vaginal penetration or intercourse_____
Lack of vaginal lubrication_____
Painful penetration or intercourse_____
Difficulty reaching orgasm_____
Vaginal tightness_____
Involuntary urination_____
Headaches after sexual activity_____
Vaginal infection_____

(0) Not at all
(1) Seldom, less than 25% of the time
(2) Sometimes, about 50% of the time
(3) Usually, about 75% of the time
(4) Always

15. Using the scale to the right, indicate the frequency with which the following factors have influenced your level of sexual activity during the past month. *(An answer is required for each, even if it may not apply to you.)*

My own health problems_____
My partner's health problems_____
Conflict in the relationship_____
Lack of privacy_____
Other (please specify)_____

(0) I have not had a partner
(1) Not at all
(2) Seldom, less than 25% of the time
(3) Sometimes, about 50% of the
(4) Usually, about 75% of the time
(5) Always

16. How satisfied are you with the overall appearance of your body? (Please circle the most appropriate response.)

(0) Very satisfied
(1) Somewhat satisfied
(2) Neither satisfied nor dissatisfied
(3) Somewhat dissatisfied
(4) Very dissatisfied

17. During the past month, how frequently have you been able to communicate your sexual desires or preferences to your partner? (please circle the most appropriate response.)

(0) I have not had a partner
(1) I have been unable to communicate my desires or preferences
(2) Seldom, about 25% of the time
(3) Sometimes, about 50% of the
(4) Usually, about 75% of the time
(5) I was always able to communicate my desires or preferences

18. Overall, how satisfied have you been with your sexual relationship with your partner? (please circle the most appropriate response.)

(0) I have not had a partner

(1) Very satisfied

(2) Somewhat satisfied

(3) Neither satisfied nor dissatisfied

(4) Somewhat dissatisfied

(5) Very dissatisfied

19. Overall, how satisfied do you think your partner has been with your sexual relationship? (Please circle the most appropriate response.)

(0) I have not had a partner

(1) Very satisfied

(2) Somewhat satisfied

(3) Neither satisfied nor dissatisfied

(4) Somewhat dissatisfied

(5) Very dissatisfied

20. Overall, how important a part of your life is your sexual activity? (please circle the most appropriate response.)

(0) Not at all important

(1) Somewhat important

(2) Neither important nor unimportant

(3) Somewhat important

(4) Very important

21. Circle the number that corresponds to the statement that best describes your sexual experience.

(1) Entirely heterosexual

(2) Largely heterosexual, but some homosexual experience

(3) Largely heterosexual, but considerable homosexual experience

(4) Equally heterosexual and homosexual

(5) Largely homosexual, but considerable heterosexual experience

(6) Largely homosexual, but some heterosexual experience

(7) Entirely homosexual

22. Circle the number that corresponds to the statement that best describes your sexual desires.

(1) Entirely heterosexual

(2) Largely heterosexual, but some homosexual desire

(3) Largely heterosexual, but considerable homosexual desire

(4) Equally heterosexual and homosexual

(5) Largely homosexual, but considerable heterosexual desire

(6) Largely homosexual, but some heterosexual desire

(7) Entirely homosexual

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