SEXUAL HARASSMENT AND DISORDERED EATING SYMPTOMATOLOGY IN FEMALES: OBJECTIFICATION, SILENCING, AND SYMBOLIC EXPRESSION OF SELF

by

RONI STILLER FUNK

(Under the Direction of Nancy P. Kropf)

ABSTRACT

Sexual harassment and disordered eating symptomatology are two aspects of female experience that are both widespread and understudied (MacMillan, Nierobisz, & Welsh, 2000; Striegel-Moore & Smolak, 2001; Welsh, 1999). Recent research has demonstrated a relationship between sexual harassment and disordered eating attitudes and behavior in females (Harned, 2000; Harned & Fitzgerald, 2002). Based on these empirical studies and feminist theoretical frameworks, this study aimed to answer research questions about the interrelationships between the external variable of sexual harassment, the internal variables of self-objectification, self-silencing, and internalized shame, and the dependent variable, disordered eating symptomatology.

Two hundred and two college age females at a large public university in the southeast completed an anonymous questionnaire survey. The expected relationship between sexual harassment experience and disordered eating symptomatology was not found. Self-objectification and internalized shame were significant predictors of disordered eating symptomatology. To understand interrelationships more fully, subscale variations were

examined and are discussed. It appears that there is a relationship between the factor that is measured by the oral control subscale of the EAT-26 and some aspects of sexual harassment experience as measured by the SEQ.

The relevance of sexual harassment and disordered eating to social work practice is emphasized. The results of the study suggest roles for social workers in treatment, research and prevention. Specific clinical and policy recommendations are proposed. Additionally, suggestions are made for future research regarding the complex relationship between sexual harassment and disordered eating.

INDEX WORDS: Sexual harassment, Disordered eating symptomatology, Self-objectification, Self-silencing, Internalized shame, Feminist Theory, Social Work

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DEDICATION

This dissertation is dedicated to my daughters, Sharon and Deborah and to my husband, Sidney with my deepest love…MTT

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CHAPTER I

INTRODUCTION

"To lose confidence in one's body is to lose confidence in one's self" Simone de Beauvoir

Both sexual harassment and disordered eating attitudes and behavior are understudied aspects of the experience of being female in our culture (MacMillan, Nierobisz, & Welsh, 2000; Striegel-Moore & Smolak, 2001; Welsh, 1999). In both areas of study, fundamental definitions remain unresolved among experts. Both sexual harassment and eating disorder symptomatology are considered widespread, almost normative female experiences (Larkin, Rice, & Russell, 1999; Nichter, Vuckovic, & Parker, 1999; Smolak & Murnen, 2001) although in both instances prevalence reports vary widely. Furthermore, both problems are overlooked and minimized in multiple sectors of society by authorities and throughout educational, religious, cultural, and governmental institutions (Hostile Hallways, 2001; Striegel-Moore & Smolak, 2001). Moreover, women's sexual and eating problems have been trivialized and exploited in the mass media (Kilbourne, 1994; Striegel-Moore & Smolak, 2001). Two recent studies have demonstrated a relationship between sexual harassment and disordered eating attitudes and behavior in females (Harned, 2000; Harned & Fitzgerald, 2002). The present research will focus on further investigation of this relationship.

First, descriptions and prevalence of each problem as experienced by females will be briefly presented. Next, research on the relationship between sexual harassment and disordered eating symptoms will be described, followed by a description of the major theoretical constructs that will be used to understand the relationship. Finally, the relevance of this

relationship to social work theory and practice will be discussed, concluding with recognition of social work's potential to contribute further to ongoing treatment, research, and prevention in both areas, individually and synergistically.

Significance and Background

Although males experience sexual harassment and disordered eating problems, prevalence of both problems is greater in females (Klonoff, Landrine, & Campbell, 2000; Macmillan, Nierobisz, & Welsh, 2000; Smolak & Murnen, 2001). Furthermore, no relationship between sexual harassment and disordered eating has been demonstrated in males (Harned & Fitzgerald, 2002). While both sexual harassment and eating problems in males are important areas of future research, this study will focus exclusively on female experience.

Sexual Harassment

Sexual harassment of females is pervasive, occurring in schools, workplaces, and public spaces (Fineran & Bennett, 1998; Kopels & Dupper; Richman et al. 1999; Macmillan, Nierobisz, & Welsh, 2000). The results of a recent survey of 8th through 11th grade public school students that defined sexual harassment as "unwanted and unwelcome sexual behavior that interferes with your life" (Hostile Hallways, 2001, p.2) pointed to the severity of the problem. The American Association of University Women's educational foundation commissioned study reported that 83% of girls had experienced sexual harassment and that 30% had experienced it frequently (Hostile Hallways).

Studies of workplace harassment vary, but it "appears to affect about 50% of females in the workplace in the industrialized nations that have participated in surveys" (Sbraga & O'Donohue, 2000, p. 264). Despite the prevalence of sexual harassment, definitions are varied and elusive. However, Fitzgerald (1997), an acknowledged authority offered the following

psychological definition: “an unwanted sex-related behavior at work that is appraised by the recipient as offensive, exceeding her resources, or threatening her well-being” (Fitzgerald, Swann, & Magley, 1997, p.20 as quoted in Sbraga & O’Donohue, 2000, p. 260). Fitzgerald distinguished between psychological and legal definitions of sexual harassment. Her research and widely used measuring instrument, The Sexual Experiences Questionnaire, are concerned with the psychological definition.

Canadian researchers Macmillan, Nierobisz, and Welsh (2000) investigated harassment from strangers “[i]ncluding behaviors such as unwanted physical contact, verbal comments, ogling, and stalking” (p.307) and found that 80% of women experienced sexual harassment by strangers in public places. Their research supported and added to that of previous investigators (Gardner, 1995) to show “the wide prevalence of sexually threatening activities that are “normalized” in society and are a key source of women’s fear in public and private environments (Macmillan, Nierobisz, & Welsh, 2000, p. 319).

Disordered Eating Symptomatology

Eating disorders inclusion in medical diagnostic classification is fairly recent. Currently eating disorders in the DSM-IV include Anorexia Nervosa (AN), Bulimia Nervosa (BN), Eating Disorder Not Otherwise Specified (EDNOS), and provisionally Binge Eating Disorder (BED). Although Anorexia Nervosa was recognized at the end of the 19th century, currently accepted diagnostic criteria were defined as recently as the late 1970s. Bulimia Nervosa, originally proposed as a sub-type variant of AN, was recognized as a separate disorder in 1980. Eating Disorder Not Otherwise Specified (EDNOS) has been used as a diagnosis for individuals who do not meet criteria for either AN or BN; for example, individuals who meet all criteria for AN, but have not missed three consecutive menstrual cycles. Although more prevalent than the other

categories, there has been less research focused on individuals with EDNOS. Binge Eating Disorder (BED), which had been included within EDNOS, entered the Psychiatric diagnostic manual as a provisional category in 1994, stimulating much research on BED. However, such classification issues as clinical severity, discrete or continuous categories, and subtyping continue to be debated among authorities on eating disorder research (Herzog & Delinsky, 2001).

Research on eating problems has not received treatment equivalent to other serious mental health problems (Striegel-Moore & Smolak, 2001). Funding has been inadequate and "there are no nationally representative data regarding the incidence, prevalence, and basic demographic distribution of eating disorders" (Striegel-Moore & Smolak, 2001, p.4). Referencing an American Psychiatric Association work group on eating disorders, the National Institute of Mental Health (NIMH) reports that 0.5% - 3.7% of females suffer from Anorexia Nervosa in their lifetime and 1.1% - 4.2% of females suffer from Bulimia Nervosa (Spearing, 2001). Eating disorders have serious physical and mental health consequences and are associated with both high levels of chronicity and high rates of mortality (Herzog & Delinsky, 2001; Herzog et al., 1999; Zipfel, Lowe, Reas, Deter, & Herzog, 2000). Females are at greatest risk for developing eating disorders between the ages of 15 and 29 (Polivy & Herman, 2002). Approximately one-third of eating disorder patients still meet diagnostic criteria five years after beginning treatment. Mortality rates (including suicide) range from 5% to 8% (Polivy & Herman).

Eating disorders involve extreme distress over and preoccupation with one's body and weight, distorted perceptions of one's body, and disturbed eating behaviors and attitudes. The National Eating Disorders Association, a non-profit organization that advocates for awareness,

elimination, and prevention of eating disorders and body dissatisfaction estimated that:

> **as many as 10 million females**…are fighting a life and death battle with an eating disorder such as anorexia or bulimia. Approximately **25 million more** are struggling with binge eating disorder...In addition, many individuals struggle with body dissatisfaction and sub-clinical disordered eating attitudes and behaviors. For example, it has been shown that **80%** of American women are dissatisfied with their appearance. (National Eating Disorders Association, Statistics 2002, p. 1).

Investigators have studied disordered eating and body image problems as precursors of full syndrome eating disorders in an attempt to understand eating disorder etiology and to augment prevention efforts. Recent research findings, which question existing distinctions between partial and full syndromes in Anorexia Nervosa, Binge Eating Disorder (Crow et al., 2002), and Bulimia Nervosa (Hay, 2003) supported Herzog and Delinsky's (2001) assertion regarding confusion over "clinically sufficient impairment to warrant a diagnosis" (p. 41). Hay (2003) found that bulimic eating disorder behaviors seriously lowered individual quality of life scores on both physical and mental health dimensions. Stice et al. (1999) reported evidence that disordered eating increases risk for future onset of obesity, which has significant associated physical health and quality of life risks.

This investigation will concentrate on disordered eating behavior and attitudes instead of diagnosed eating disorders for multiple reasons including the above stated research (Crow et al., 2002; Hay, 2003; Stice et al., 1999), which support this focus. Additionally, the works of feminist theorists (Bloom et al., 1994; Fredrickson & Roberts, 1997; Gutwill, 1994) corroborated this viewpoint. Finally, this investigation is building upon studies of the

relationship between eating disorder symptomatology rather than full syndrome diagnoses and sexual harassment.

In describing the epidemic proportions of eating problems and body image distortion among women, social work feminist psychoanalytic theorist Gutwill (1994) asserted that understanding the dynamics of compulsive eating and restricting is central to understanding all eating disorders (Gutwill). In fact, she and her colleagues at the Women's Therapy Centre Institute highlighted this point in titling their book *Eating Problems*. They chose this phrase to avoid the use of the word, disorders with its implication of individual pathology. Instead, they stress the centrality of cultural pathology as evidenced by their estimate that 85% of women chronically diet and 75% experience body shame and dissatisfaction. They asserted that medical and psychological models have not adequately weighted the importance of sociocultural factors as they are incorporated by families and internalized by individual women.

Although increasingly eating disorder research identifies multiple risk factors for eating pathology including genetics, co-morbid individual psychopathology, trauma, families, and culture, many questions remain (Stice, 2002). Identification of additional risk factors, mediators, and moderators is still needed, as are theoretical models that include both risk and protective factors (Smolak & Murnen, 2001; Stice, 2002; Striegel-Moore & Smolak, 2001). Smolak and Murnen (2001) pointed out that despite long standing awareness of the significance of gender in eating problems, "there is surprisingly little empirical data showing what it is about being female that contributes to the increased vulnerability to eating disorders" (Smolak & Murnen, 2001, p. 91). Although a variety of sociocultural factors are believed to contribute to this increased vulnerability, one of those highlighted by Smolak and Murnen (2001) is especially germane to the current research:

> sexual harassment and sexual abuse…may contribute to both body shame and loss of voice (p.96)…. Loss of voice (i.e., an inability to express, even to oneself, one's wishes, needs, and opinions) has been associated with increased risk for eating problems (p.99).

Sexual harassment and eating problems

Harned (2000) and Harned and Fitzgerald (2002) investigated the relationship between sexual harassment and eating disorder symptoms. Harned (2000) controlled for the effects of sexual and physical abuse and reported:

> …although sexual abuse/assault and physical abuse appear to be general risk factors for psychological disorder, the present results suggest that sexual harassment is more closely associated with eating disorder symptomatology than with other types of psychological distress (Harned, 2000, p. 344).

She looked to trauma theory to elucidate the highly statistically significant relationship she found. "By conceptualizing disordered eating as a way to cope with various forms of victimization, trauma-based theory discourages victim blaming by redefining the origins of eating-related pathology in trauma victims as social and external to the victim" (Harned, 2000, p. 346). Additionally, trauma based theory offered an explanation, which considered the importance of gender, later confirmed in Harned and Fitzgerald's (2002) subsequent research. However, both researchers stressed that causes of eating disorder symptoms are complex, multidimensional, and in need of additional theoretically based models.

Theoretical Perspectives

Smolak and Murnen (2001) suggested that objectification theory, which was developed to shed light on women's lived experience, may provide "a parsimonious explanation for…

gendered risk factors for the development of eating disorders" (p.101). Additionally, as cited above, they refer to the importance of loss of voice as a factor in the development of eating disorders. Reindl's (2001) study of women recovering from Bulimia Nervosa emphasized the importance of an individual's sense of self. 'Loss of voice' and 'sense of self' are concepts used in Jack's (1991) construct, silencing the self from which she developed the Silencing the Self Scale. Jack's original research was focused on women with depression; however, subsequent researchers have investigated females with disordered eating using Jack's concepts and scale (Cawood, 1998, Zaitsoff, et al., 2002).

The present study uses ideas and measurement instruments based primarily on the work of Fredrickson and Roberts (1997), Jack (1991), and Jack and Dill (1992). Each of the theoretical perspectives is presented briefly here and in greater depth in Chapter II where constructs of other feminist theorists and researchers (Bloom et al., 1994; Reindl, 2001) are described. In Chapter II, several related constructs are combined into a proposed model to illuminate the relationship between sexual harassment and disordered eating symptomatology.

Objectification Theory

Objectification theory is relevant to this research because of its grounding in societal, gendered issues and their relationship to individual females' experience. This perspective is especially pertinent to social work's psychosocial treatment model in contrast to the more psychologically centered trauma theory used by previous researchers of this relationship. Moreover, objectification theory explicitly connects the independent variable, sexual harassment with the outcome variable, disordered eating symptomatology, specifically describing the mechanisms involved in the relationship.

According to Fredrickson and Roberts' (1997) objectification theory, the societal climate of devaluation of women as agents or actors on behalf of their own subjective needs and wishes along with the valuation of women as objects to meet the needs of others is the context in which the sexualized objectification of women occurs. The objectified female is not viewed as a person with value and human rights. Instead, Fredrickson and Roberts described a very different paradigm. "The common thread running through all forms of sexual objectification is the experience of being treated as a body (or collection of body parts) valued predominantly for its use to (or consumption by) others" (Fredrickson & Roberts, p.174).

Objectification is inextricably tied to sexism, "the socially sanctioned right of all males to sexualize all females, regardless of age or status" (Westkott, 1986, p. 95 as quoted in Fredrickson & Roberts, 1997, p.175). This sexualization occurs along a continuum ranging from sexual evaluation to violence. Sexualized gazing is an ever-present way that males sexually evaluate women. Two important aspects of sexually objectifying gazing are: first, it can be denied and not easily proved, second, the recipient or object of the gaze does not have power or control over its receipt.

An essential construct of objectification theory is self-objectification. Accordingly, females internalize society's objectification into their own self-concept viewing their bodies as objects to be used by others. Several deleterious consequences accompany self-objectification including shame, anxiety, diminished "flow," i.e. heightened experiences during which an individual loses self-consciousness, and weakened awareness of one's own internal states.

Silencing the self

Based on her studies of depression in women, prior to the development of objectification theory, Jack (1991) proposed the concept of self-silencing, which focused on female suppression

of self in interpersonal relationships resulting from internalization of cultural gender roles.

> This model suggests that cognitive schemas about how to create and maintain safe, intimate relationships lead women to silence certain feelings, thoughts, and actions. This self-silencing contributes to a fall in self-esteem and feelings of a "loss of self" as a woman experiences over time, the self-negation required to bring her into line with schemas directing feminine social behavior. (Jack & Dill, 1992, p. 98)

Jack (1991) described a female's silencing aspects of her own identity, both emotional and physical to obtain and maintain an intimate heterosexual "relationship with a particular man and acceptance by the wider (male) world" (Jack, p. 135). She portrayed this process as one possible way that females "create intimacy within inequality (p.57)…Women are taught to lie with their bodies: hair is shaved, make-up applied, physical attributes are made over to please men" (p.59).

Jack's (1991) concept of self-silencing is included in this study because it relates to and supplements objectification theory. Like Fredrickson and Roberts (1997) theory, it is based in a social context, pertinent to social work's diagnostic and treatment model. Furthermore, the constructs, 'sense of self' and 'loss of voice' relate to issues of personal identity and control considered important in the etiology of disordered eating and in its connection to sexual harassment.

Implications for Social Work

The relationship between sexual harassment and eating disorder symptoms in females has significance for the social work profession related to its client base, professional traditions, and guiding mission. As the predominant provider of mental health services in the United States,

social workers treat individuals and families affected by sexual harassment, eating disorder symptoms, and related problems. In addition, social workers are employed in societal institutions including community centers, hospitals, and schools affording them access to individuals and systems involved in these problems. Importantly, social work's treatment model is particularly well suited to such multidimensional problems because of its dual focus on psychological and societal issues. Accordingly, social work training prepares practitioners to intervene in multiple systems. Finally, the profession of social work is committed to social justice including the universal provision of such common human needs as safety and security.

Based on their professional values, treatment model, strategic placements, and skills, social workers are uniquely positioned to deal with the treatment and prevention of eating disordered symptoms and sexual harassment. However, there is a relative dearth of writing on these issues in the social work literature. For example, Social Work Abstracts lists fewer than one hundred articles on disordered eating from the 1990s through 2003, whereas Psych Info lists over six thousand for the same period. Social work abstracts lists fifty-two articles on sexual harassment compared to 1,364 in Psych Info. Combining the two subjects yields seven items in Psych Info and none in Social Work Abstracts. Despite this discrepancy, as previously stated, social workers (Bloom et al. 1994; Hirschmann & Munter, 1988; Hirschmann & Munter, 1995) have recognized the relationship between gender and eating problems and made significant contributions to the treatment literature.

However, even though feminist social workers and psychologists have spoken to the gendered societal aspect of eating disorder symptomatology, there is little empirical data that illuminates the relationship between being female and vulnerability to eating disorder symptoms. Smolak and Murnen (2001) attributed this lack to difficulties in researching societal level

variables such as gender and “to reluctance to acknowledge sexism in society in general and psychology in particular” (p.103). This dilemma seems to apply equally to the profession of social work and to speak to the relative lack of research support for female issues and professions.

The majority of social work practitioners and the majority of recipients of mental health services are female. The majority of individuals who suffer from eating disorders and sexual harassment are female. The impact of sexual harassment on eating disorder symptoms seems to be gender related, affecting females only. Therefore, feminist theoretical constructs seem especially well suited to social work practitioners and the clients they serve in dealing with these problems separately and in connection.

Several important hallmarks of feminist theory and therapy converge with social works’ principles and perspective. Feminist theory insists on recognizing the political or societal aspect of individual women’s problems, frequently stated as ‘the personal is political.’ Simultaneously, feminist theory stresses the uniqueness of each individual’s viewpoint and the importance of personal power and expression. The importance of relationship is essential to feminist therapy (Brown, 1994).

The use of feminist constructs to clarify the relationship between sexual harassment and disordered eating symptomatology has ramifications for the three levels of social work practice. On the micro level, social workers treat girls and women and their families for issues relating to both problems. Greater understanding of contributory and protective factors is potentially useful to social workers as providers of direct services to individuals and families.

On the mezzo level, social workers are positioned to influence group cultures in settings relevant to the treatment and prevention of sexual harassment and eating disorder symptomatology. This research has the potential to shed light on the lived experiences of females in support of

social workers' efforts to transform organizations and institutions. By illuminating the lived experience of females, it is expected that this research will support previous research counteracting the current 'silencing' and 'normalizing' of issues and experiences that are harmful to girls and women. Also, it is expected that this research will confirm previous findings of a strong relationship between sexual harassment and eating disorder symptoms in females.

Last, on the macro level, social workers advocate for social justice and social policies consistent with universal provision of safety, security, and other common human needs. Empirical research using feminist constructs of self-objectification and self-silencing has the potential to enhance understanding of the connection between sexual harassment and eating disorder symptomatology in females. This understanding is expected to promote shared prevention efforts thereby synergistically enhancing rather than fragmenting and diluting resources. Such synergy has the potential to transform societal conditions that currently tacitly permit the perpetuation of sexual harassment and eating disorder symptomatology in females.

CHAPTER II

LITERATURE REVIEW

"Are there women, really?" Simone de Beauvoir

Feminist theories are grounded in the premise that gender is an influential variable affecting an individual's life experience broadly and deeply (Brown, 1994; Wolf, 1994; Wooley, 1994). This seemingly obvious assumption is explicitly stated in response to alternate frequently unexpressed presumptions based in patriarchal power relations, historically and currently.

> By making the term "man" subsume "woman" and arrogate to itself the representation of all of humanity, men have built a conceptual error of vast proportion into all of their thought. By taking the half for the whole, they have not only missed the essence of whatever they are describing, but they have distorted it in such a fashion that they cannot see it clearly (Lerner, G., 1986, p.220).

This literature review will center on two feminist theoretical perspectives, which speak to the relationship between sexual harassment and disordered eating symptomatology. Objectification and self-silencing, which were briefly described in the last chapter, will be presented in more depth. Additional feminist constructs will be interjected because of their significance to the issues and relationships being studied.

The theoretical aspects of objectification theory will be presented first. Next, empirical research using objectification theory in relation to disordered eating symptomatology will be

reviewed. Following a discussion of the conceptual underpinnings of the construct, silencing the self, empirical research using the scale derived from it will be presented. One study using The Silencing the Self scale to investigate sexual harassment and several studies using the scale to examine disordered eating symptomatology will be presented. Finally, research on the relationship between sexual harassment and disordered eating symptomatology will be described.

Objectification Theory

> "To men a man is but a mind. Who cares what face he carries or what form he wears? But woman's body is the woman…A woman absent is a woman dead." Ambrose Bierce

Fredrickson and Roberts' (1997) objectification theory was offered as a framework for understanding the lived experience of females. In their chapter reviewing the relationship between gender and eating disorders, Smolak and Murnen (2001) suggested that objectification theory may provide a way of understanding how sexual harassment impacts eating disordered attitudes and behaviors. Following their suggestion, the present research utilized objectification theory to study this relationship.

Objectification theory is grounded in the awareness of the differential treatment of male and female bodies in our culture. Female bodies are sexualized and treated as objects for the use of others rather than for the individual's subjective needs. To varying degrees, individual females come to regard their bodies in this way, to be gazed upon by others rather than to be used for functioning in the service of self.

Fredrickson and Roberts (1997) proposed four consequences of this process of self-objectification, which negatively impact the quality of females' lives. The proposed consequences, heightening of shame, increased anxiety, decreased experiences of flow, and

diminishment of awareness of internal bodily states will be elaborated in this chapter. Although Fredrickson and Roberts (1997) suggested that three mental health problems, which disproportionately affect females: unipolar depression, eating disorders and sexual dysfunction may be understood in terms of their theory, this study is investigating disordered eating symptomatology only.

Objectification Theory: A Psychosocial Model

Objectification theory is an emphatic psychosocial model stressing that a female's sense of her body is experienced within a social frame. "This theoretical framework places female bodies in a sociocultural context with the aim of illuminating the lived experiences and mental health risks of girls and women who encounter sexual objectification" (Fredrickson & Roberts, 1997, p. 174). The essence of objectification entails disregard of the individual as a person with value and human rights, instead the objectified female is considered essentially as a body whose purpose is to serve the needs of others.

> Sexualized objectification occurs whenever a woman's body, body parts, or sexual functions are separated out from her as a person, reduced to the status of mere instruments, or regarded as if they were capable of representing her….when objectified, women are treated *as bodies*—and in particular, as bodies that exist for the use and pleasure of others (Fredrickson & Roberts, 1997, p. 175).

Fredrickson and Roberts (1997) did not seek to explain why visual evaluation and objectification of female bodies occur, but they related Horney's observation regarding the existence of heterosexuality in our society to the culturally sanctioned right of males to sexualize females. They described sexualization occurring along a continuum with sexualized gazing as an ever-present way that males sexually evaluate females. "Always present in contexts of

sexualized gazing is the potential for sexual objectification" (Fredrickson & Roberts, 1997, p.175). The recipient of sexually objectifying gazing has no power to prevent its receipt nor to clarify its reality, contributing to the recipient's anxiety and confusion. Thus, heterosexuality and objectification are inextricably bound up with issues of power over female bodies and females' fears of loss of safety, security and selfhood.

Fredrickson and Roberts (1997) described three situations in which sexual objectification may be expected including real life social encounters and media portrayal of interpersonal relationships. However, they suggested that the visual media's ever present concentration on female bodies and body parts may be the most damaging of the three. Perhaps this is because of its omnipresence and consequent impact on self-objectification, a concept central to Fredrickson and Roberts's theory.

Cultural assumptions and values support women's preoccupation with their bodies. In the process of socialization, individuals identify cultural values as their own and incorporate them into their sense of self. Thus, females internalize the observer's gaze and to varying degrees, integrate the observer's perspective on their bodies as an integral part of their self-concept. "Objectification theory posits that the cultural milieu of objectification functions to socialize girls and women to, at some level, treat *themselves* as objects to be looked at and evaluated"(Fredrickson & Roberts, 1997, p. 177).

At times, the concepts of sense of self and body self seem to be confused and conflated. Because objectification theory is still in an early stage of formation, researchers are continuing to refine and differentiate concepts. Recently, Miner-Rubino, Twenge, and Fredrickson (2002) addressed conceptual differences between self-objectification and the

related constructs of body surveillance (McKinley & Hyde, 1996), body as object (Franzoi,1995), and public self-consciousness.[1] In this dissertation, the alternate constructs will be discussed to shed light on aspects of objectification theory especially the confusion between the impact of self-objectification on one's physical self and one's sense of self.

In differentiating self-objectification from McKinley and Hyde's (1996) construct of body surveillance, the authors stated that the dissimilarities relate primarily to issues of measurement. "Both measures assess the degree to which a woman thinks of her body in terms of how it looks rather than how it feels" (Miner-Rubino et al., 2002, p. 153). However, when differentiating self-objectification from Franzoi's (1995) body as object, the authors' emphasis seemed to shift from a focus on body to one on self. "The major difference between trait self-objectification and body-as-object is that body-as-object refers to attitudes toward one's body parts, while self-objectification refers to the adoption of an observer's perspective on the self " (Miner-Rubino et al., p. 153). This focus on self rather than body was maintained when the authors differentiated the construct, self-objectification from the personality trait, public self-consciousness. "[R]ather than simply having awareness of being observed, high self-objectifiers take a peculiar stance on their selves and actually become the observers" (Miner-Rubino et al., p. 154).

Although there is a lack of consistent specificity regarding self versus body self, Fredrickson and Roberts (1997) were clear about the significance of physical appearance for women. In spite of the fact that few women can meet media driven ideals of beauty and thinness, many women base their feelings of self worth and happiness on their physical

[1]For a more complete discussion of these distinctions, please see Miner-Rubino, K., Twenge, J.M., & Frederickson, B.L. (2002). Trait self-objectification in women: Affective and personality correlates. *Journal of Research in Personality, 36*, 147-172.

appearance. Society's rewards and deprivations reinforce women's basing self-judgments on appearance.

> Being physically attractive brings a multitude of benefits, and being physically unattractive brings an array of costs. Physical attractiveness has been shown to correlate highly with popularity, amount of dating experience, and marriage opportunities for women…Being beautiful can also translate into women's economic power…Obesity, on the other hand, can negatively affect women's social mobility. (Miner-Rubino et al., 2002, p.149)

Fredrickson and Roberts (1997) pointed out that the benefits of self-objectification come at great personal cost. They elaborated mechanisms by which self-objectification negatively impacted females' mental health and quality of life. They suggested that self-objectification "can lead to a form of self-consciousness characterized by habitual body monitoring of the body's outward appearance" (Fredrickson & Roberts, p.180). To reiterate, they predicted that habitual body monitoring would result in increased shame, increased anxiety, decreased 'flow' or 'peak motivational states' and decreased 'awareness of internal bodily states.' Each of these consequences will be discussed now in greater detail.

Predicted consequences: heightening of negative experiences - shame and anxiety. One of the predicted consequences of habitual body monitoring was shame. Shame is the experience of being found defective in a global way. It generates feelings of powerlessness, worthlessness, and extreme self-focus often accompanied by cognitive and psychomotor impairment. Shame involves the possibility of others' awareness of one's defectiveness along with the wish to disappear and escape gaze. "Shame, then, results from a fusion of negative self evaluation with the potential for social exposure" (Fredrickson & Roberts, 1997, p.182). Shame is considered a moral emotion,

powerfully motivating self-change and conversely powerfully upsetting when such change is not possible.

Changing one's body to meet cultural standards becomes a moral imperative in a culture in which female bodies are objectified. Females come to both desire the "thin ideal" and to believe in the possibility of its achievement. The beauty and diet industries promote this self-serving false belief, namely that through a combination of self-control and outside manipulation, i.e. purchase of products, diet and cosmetic aids, "ideal" bodies are achievable (Gutwill, 1994; Hirschmann & Munter, 1995). The media, where images of women's bodies are presented as real when in fact they are airbrushed and manipulated to 'perfection,' powerfully enforces this message (Kilbourne, 1994). Having been socialized to believe this 'beauty myth,' females experience the discrepancy between the reality of their own bodies and the achievement of the idealized media image as a devastatingly shameful failure of self (Gutwill, 1994; Hirschmann & Munter, 1995; Wolf, 1994).

The connection between anxiety and habitual body monitoring seems to follow a somewhat different course (Fredrickson & Roberts, 1997). Anxiety seems to result from sexual objectification and the accompanying possibility of sexualized violence directly rather than indirectly through habitual body monitoring. Furthermore, anxiety seems to contribute directly to habitual body monitoring.

Anxiety is experienced in relation to anticipated danger accompanied by feelings of uncontrollability (Barlow, 2003). "Thus, this state could be characterized, roughly, as a state of helplessness because of perceived inability to predict, control, or obtain desired results or outcomes in certain upcoming situations or contexts" (Barlow, p. 2). Objectification theorists posited that women are chronically at risk for anxiety regarding their appearance and safety.

"[A] culture that objectifies the female body presents women with a continuous stream of anxiety-provoking experiences, requiring them to maintain an almost chronic vigilance both to their physical appearance and to their physical safety" (Fredrickson & Roberts, 1997, p. 183).

Some feminist theorists (Hirschmann & Munter, 1988, 1995) have viewed disordered eating symptoms including binging, restricting, and purging as coping strategies to deal with anxiety. By translating problems of personal control and identity (Polivy and Herman, 2002) into food and body language, painful problems and feelings that may seem irresolvable on their own terms are avoided. Simultaneously, they are transformed into issues with seemingly simple, manageable solutions related to attitudes and behavior about food and body image. Additionally, anxiety may be lowered through actual body transformation that either meets societal body ideals or "desexualizes" one's body, thus lessening the risks of objectification related victimization.

Predicted consequences: diminished experience - flow and interoceptive awareness. Fredrickson and Roberts (1997) predicted two pathways through which the disruption of peak motivational experiences negatively impact the quality of women's lives. These experiences called "flow" (Csikszentmihalyi, 1990, p.4) are characterized by complete un-self-conscious absorption of the body and/ or mind in a voluntary activity, which the individual highly values and regards as difficult to attain. 'Flow' experiences are "those rare moments during which we feel we are truly living, uncontrolled by others, creative and joyful" (Fredrickson & Roberts, p. 183). Flow is interrupted by the sexually objectifying experience of males calling attention to females' bodies or their parts and by the self-conscious habitual body monitoring that accompanies self-objectification.

Disrupted and/or diminished 'flow' may be expected to contribute to disordered eating symptomatology as an attempt to regain personal control. Disordered eating symptoms can be completely absorbing and may be viewed as a protest against being sexually objectified. As

described above with anxiety, disordered eating symptomatology may symbolize repossession of one's self through control of one's body.

Objectification theorists offered two explanations for the fourth factor they tied to habitual body monitoring, interoceptive awareness or awareness of internal bodily states. Empirical studies documented that males are more aware of their internal bodily states than are females. (Pennebaker & Roberts, 1992; Roberts & Pennebaker, 1995). Fredrickson and Roberts (1997) proposed that vigilant body monitoring may tax perceptual resources so that there are few left to attend to internal signals. Additionally, they suggested that the disregard of body signals required for dieting and restrained eating may generalize to other bodily signals.

Another factor that might contribute to a female's diminished interoceptive awareness is the cultural devaluation of females as subjects with ownership rights to their bodies. Fredrickson and Robert's (1997) observation of the negation of female's subjective rights was supported by feminist theorist Kaschak's (1992) parallel observation, which she labeled The Antigone Complex based on Greek mythology. According to the moral code of Greek society, Antigone, the daughter of Oedipus, was expected to relinquish her own agentic life to serve the needs of her blinded father. Following his guilt induced self-blinding, Antigone was expected to surrender the use of her eyes and consequently her subjective self to his.

To summarize, Fredrickson and Roberts (1997) proposed an indirect pathway through which sexual objectification may impact women's mental health: a cultural climate that encourages self-objectification results in increased shame and anxiety and decreased peak experiences and impaired interoceptive awareness. They affirmed that sexual victimization including sexual harassment is a direct trajectory through which sexual objectification impacts women's mental health. Although this study will focus solely on the relationship between self-

objectification, sexual harassment, and disordered eating attitudes and behaviors, the other mental health problems, unipolar depression and sexual dysfunction that Fredrickson and Roberts predicted from their theory are interrelated and frequently co-occur in the same individual.

Fredrickson and Robert's (1997) model seemed to relate to broad sociological issues as they impact individual females. However, their model lacks clarity in accounting for individual differences in reaction to the trauma of objectification. They referenced the diathesis stress model of Nolen-Hoeksema and Girgus (1994) to explain individual differences in trait self-objectification.

Nolen-Hoeksema and Girgus's (1994) model, which was developed to account for gendered differences in adolescent depression, described a two-phase process whereby differential childhood experiences impact later responses to stresses encountered in adolescence. This conceptualization seemed to provide a link that connects Fredrickson and Robert's (1997) theory with Jack's (1991) conceptual work, which addresses the association between early transmission of gendered cultural expectations and the intrapsychic organization of individual women. Jack's theoretical perspective is elaborated in later sections of this chapter.

The diathesis stress concept. According to Nolen-Hoeksema and Girgus's (1994) model, girls are more likely to enter adolescence with heightened risk factors for depression. These factors, which are related to issues of relationship orientation, aggression management and coping styles, may then interact with the challenges of adolescence. Girls' descriptions of themselves are more communally and socially oriented than are boys' self descriptions. In groups, girls' interaction style is more focused on cooperation and relationship maintenance in contrast to boys' more competitive dominant style. Girls are less aggressive than boys in

general, but especially less physically aggressive. Girls tend to use more ruminative, self-focused coping strategies in response to personal distress.

Nolen-Hoeksema and Girgus's (1994) model proposed that these pre-existing risk factors disadvantage females in coping with the challenges of adolescence. This disadvantage might explain the increased incidence of depression in adolescence even if the challenges of adolescence were equal for boys and girls. However, they are not; girls are more "likely to be subjected to negative and distressing biological and social challenges" (Nolen-Hoeksema & Girgus's, p. 439).

These challenges relate to gendered societal attitudes and expectations and sexual victimization. The pubertal changes in girls' bodies are devalued by society whereas the changes in boys' bodies are highly valued. Adolescents mirror this differential valuing in their feelings about their own bodies. Moreover, society's differential evaluation of bodies seems to reflect and symbolize society's higher valuing of men over women which seems confirmed by parental expectations and gender role stereotyping. Parents have lower expectations of daughters compared to comparably talented sons. Society assigns more restrictive, subordinate, lower status, lower paying roles to females. Sexual victimization including rape, incest, and other unwanted sexual interactions increases at adolescence with prevalence for girls being two or three times greater than for boys.

Nolen-Hoeksema and Girgus (1994) summarized their proposed model accounting for gender differences in adolescent depression, which they suggest may apply to eating disorder pathology as well.

> In early adolescence, all girls may experience a substantial increase in arduous social conditions that create a sense of defeat and distress. But perhaps only when

> these social conditions interact with the less active, less instrumental style of coping with distress that is more common in females than males…does it become more difficult for girls and women to overcome their arduous social conditions and more likely that girls and women will be depressed (pp. 437-438).

The diathesis stress model authors recommended that future research explore whether their model or a similar one could be used to explain the emergence of gender discrepancies in other "internalizing" disorders including eating disorders in adolescence (Nolen-Hoeksema & Girgus, 1994). Empirical research on objectification theory includes attempts to explain these gender discrepancies.

Objectification Theory: Empirical Research

Research on objectification theory has sought to test various aspects of the overall model. This includes the existence of objectification in society (Matschiner & Murnen, 1999), self-objectification in women (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Huebner & Fredrickson, 1999), and the relationship between self-objectification and disordered eating (Fredrickson et al., 1998; Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). In addition, various pathways predicted by the model (Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998; Slater & Tiggemann, 2001; Tiggemann & Lynch, 2001) and the physical and psychological correlates of self-objectification (Davis, Dionne & Shuster, 2001; Miner-Rubino et al., 2002) have been tested.

Objectification and Self-Objectification

One study attempted to demonstrate the existence of sexual objectification among college students. Matschiner and Murnen (1999) found that college men were influenced more

by very hyperfeminine than by mildly hyperfeminine women even though they judged the more influential persuader to be less competent. This result did not hold for female listeners. The authors interpret the results of their study in support of the existence of objectification. They claim that hyperfeminine women persuaded men because the women's hyperfemininity demonstrated their compliance with women's subordinate status. These authors suggested that women are objectified because of their lower status. Additionally, in an insistently perpetuating pattern, objectification further promotes subordinate status. They make a parallel interpretation about sexual aggression against women, which is both the result of the diminished status of women and a cause contributing to the perpetuation of women's lower status. Matschiner and Murnen (1999) recommended that future research focus on the interpersonal dynamics that maintain relationships of inequality between men and women.

Confirmation of self-objectification in women has been demonstrated in two studies. In one, self-objectification was artificially induced in a laboratory experiment. For women only, self-objectification heightened body shame and restrained eating and diminished math performance (Fredrickson et al., 1998). The researchers asserted that their results support objectification theory hypotheses predicting that self-objectification in females increases body shame and drains attentional resources. They recommended that future researchers investigate the connection between sexually objectifying experiences and self-objectification.

In a second laboratory-induced experiment, gender differences in memory perspectives supported the hypothesis that women internalize an observer's viewpoint on their physical selves more so than do men (Huebner & Fredrickson, 1999). This phenomenon was most pointedly observed in the situation of a university party where the sexual objectification of women's bodies was most expected. Additionally, women reported experiencing more shame

and anxiety than men in connection with these memories. The researchers recommended that future investigators study individual variation in self-objectification both as a trait variable and as a state variable in reaction to particular situations.

Self-objectification and disordered eating symptomatology

Mixed results are reported in studies that tested either specific aspects or the overall model of self-objectification in relationship to disordered eating symptomatology; however, investigators reported their findings as generally supporting objectification theory's model. Two studies found direct relationships between self-objectification and disordered eating symptomatology (Muehlenkamp & Saris-Baglama, 2002; Noll & Fredrickson, 1998), whereas another found no direct relationship in either a sample of former dancers or non-dancers (Slater & Tiggemann, 2001).

Four of the five studies examining the relationship between body shame and disordered eating reported a positive connection between the two variables (Fredrickson et al., 1998; Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Slater, 2001). The fifth study that included the variable body shame investigated changes in women's body image across the life span (Tiggemann & Lynch, 2001). These researchers found that self-objectification and disordered eating decreased with age, as did habitual body monitoring and appearance anxiety. However, body dissatisfaction and body shame remained steady across women's life span. The researchers proposed a model of divergent simultaneous changes to account for the consistency of body dissatisfaction and shame. They suggested that BMI increases as women age, but self-objectification decreases, as older women are less likely to be viewed as sexual objects or to self-objectify. Moreover, they are more likely to focus on functional aspects of body such as eyesight and mobility.

Slater and Tiggemann (2001) reported self-surveillance as an additional factor mediating the relationship between self-objectification and body shame, a factor consistent with Fredrickson and Robert's (1997) model, which was not measured in Noll and Fredrickson's (1998) study. Tiggemann and Lynch (2001) found appearance anxiety to be an important factor mediating the relationship between habitual body monitoring and disordered eating.

Muehlenkamp and Saris-Baglama (2002) investigated self-objectification's relationships to both disordered eating and depressive symptoms. The study focused specifically on the variable, diminished internal awareness as a factor predicted to result from self-objectification. They found that diminished internal awareness was related to depressive symptomatology, but not to restrictive or bulimic eating; however, depressive symptoms mediated the relationship between self-objectification and bulimic symptoms.

Physical and Psychological Correlates

The studies that looked at correlates of self-objectification found relationships supporting some aspects of objectification theory's model. Davis et al. (2001) reported a relationship between neurotic traits and appearance orientation. Miner-Rubino et al. (2002) found correlations between trait self-objectification and shame, depression and neuroticism. They used two instruments to measure neuroticism, one of which had been used by Davis et al.; however they used their combined measure of neuroticism to represent general anxiety. Miner-Rubino et al. recommended that future researchers use a different instrument to measure anxiety more directly.

Miner-Rubino et al. (2002) concluded that self-objectification is a useful construct in predicting negative affect, however their prediction of a negative relationship between

extraversion/ surgency that included such attributes as dominance and assertiveness and self-objectification was not found. Tiggemann and Lynch (2001) used independent measures of self-objectification (Noll & Fredrickson, 1998) and habitual body monitoring (McKinley & Hyde, 1996) and reported that habitual body monitoring is a result rather than a component of self-objectification.

Gaps in Research and Recommendations

Methodological problems with objectification research have been identified. Some of the cited researchers have pointed to their studies' problems with sample size and power (Slater & Tiggemann, 2001); others have questioned the adequacy and specificity of measurement instruments (Miner-Rubino et al. 2002; Slater & Tiggemann, 2001). All the researchers recommended continued investigation of objectification theory including its major constructs and related hypotheses. Areas highlighted for future research included the relationship between self-objectification and other personality variables, individual variation in both trait and state objectification, and protective factors that moderate the deleterious effects of objectifying experiences. In the present research, the relationship between self-objectification and self-silencing, a related self-dimension that involves the negation of one's subjective self will be investigated.

The connection between self-objectification and self-silencing

Disordered eating researchers (Cawood, 1998; Geller, Cockell, & Goldner, 2000; Smolak & Munstertieger, 2002) and feminist theoreticians (Brown, 1994; Smolak & Murnen, 2001) have described a connection between loss of voice, loss of self, and disordered eating symptoms in females. The ideas postulated by Jack (1991), developed prior to the publication of Fredrickson and Roberts' (1997) theory, foreshadowed many of their insights. Jack's

analysis, which is grounded in feminist relational theory and based on her work with depressed women, laid the groundwork for understanding the connection between self structures, relationship schema, and gendered societal issues, issues which shed light on the connection between sexual harassment and disordered eating symptomatology, enhancing the potential explanatory power of Fredrickson and Roberts' objectification theory.

First, the theoretical underpinnings of Jack's (1991) construct, silencing the self are described. Then, the Silencing the Self Scale (Jack & Dill, 1992), derived from Jack's work is presented. Finally, empirical research using the Silencing the Self Scale to study either sexual harassment or disordered eating symptomatology is reviewed. A qualitative study of recovering bulimics by Reindl (2002) is highlighted because the author's insights parallel those of Nolen-Hoeksema and Girgus (1994) and help to elucidate the association between objectification theory and self-silencing.

Silencing the Self: Theoretical Considerations

"I am beginning to know my place:
my place is woman….

but to say the secrets in English
Man/glish really makes me tongue-tied," Mary Pierce Brosmer

All women must deal with the facts of the sexualization and devaluation of their gender in our culture (Jack, 1991). Jack explored the impact of these conditions on the self-concepts and relationships of individual women. Grounded in feminist self-in-relation theory (Baker Miller, 1976; Westkott, 1986) she described how culturally sanctioned power imbalances result in subordination, loss of voice, and loss of self for women.

Jack (1991) linked the influence of gender differentiating child-rearing practices to women's vulnerability to loss of self in relationships. Whereas boys are urged to be independent and to achieve in the world, girls are encouraged to maintain connection and to nurture. A girl's gendered maturation is based on identification with her mother, in contrast to a boy's, which based on paternal identification, requires separation from mother. These dissimilar acculturating experiences impact individual self-schema, deeply held beliefs about self and relationships. Furthermore gender differences are reinforced in schools where boys are encouraged toward activity and intellectuality and girls toward compliance and helpfulness (Owens, Smothers, & Love, 2003; Zittleman & Sadker, 2002/2003)

Jack (1991) proposed that females' self-structures consist of two parts, an "I" and an Over-Eye. The "I" is the authentic self, derived from one's own sensory experience. The Over-Eye is experienced as an internal voice that belongs to the self yet has power over and judges the "I."

> The imperatives of the Over-Eye are not authentic moral strivings, but are aspects of roles defined by a patriarchal culture. However, the imperatives are not experienced as deriving from roles. Instead, they feel like part of the self, a voice that tells a woman to act in certain ways in order to gain approval from others, from the culture and from herself. (Jack, 1991, p. 108)

Jack (1991) equated the Over-Eye to the "false self" described by object relations theorists. Both serve the defensive function of protecting the true self by conforming to external expectations. Jack distinguished her construct, the Over-Eye from Freud's conceptualization of the superego. In contrast to the superego, which functions to prohibit

socially unacceptable behavior by warning of punishments, the Over-Eye represents an internalization of familial and cultural beliefs about what is required of females in order for them to be loveable and loved.

> The Over-Eye carries a decidedly patriarchal flavor, both in its collective viewpoint about what is "good" and "right" for a woman and in its willingness to condemn her feelings when they depart from expected "shoulds." The Over-Eye persistently pronounces harsh judgment on most aspects of a woman's authentic strivings, including her wish to express herself freely in relationship, her creativity, and her spirituality. Because the judgments of the Over-Eye include a cultural consensus about feminine goodness, truth, and value, they have the power to override the authentic self's viewpoint. (Jack, 1991, p. 94)

The disparities in gendered development and socialization described above with reference to self-structures also effect superego development and functioning. According to post-Freudian psychoanalytic theorists (Greenberg & Mitchell, 1983) for both genders the beginnings of the superego are based in the pre-oedipal phase, a more pre-verbal period in which there is less differentiation between self and other. Females' superegos reflect these origins more so than do those of males. Males repress their superego beginnings and develop their morality through identification with their fathers including powerful cultural and religious fathers.

> [G]irls moral values and sense of prerogative remain primarily derived from identification with the mother--or more generalized Mother, culturally devalued and stripped of mythic power. Since women do not "distance from their origins" in the same way as men, their morality…arises from an earlier period and

> continues to bear the strong imprint of early attachment with the mother…(Jack, 1991, p. 109)

Girls experience the imperatives of the super ego in addition to those of the Over-Eye as irrefutable moral truths. Because of their very early origins and deeply embedded relational ties, these imperatives are neither easily accessible for challenge by the authentic self nor readily responsive to change. It seems that both the Over-Eye and the female superego work to silence and constrain the female agentic "I" with a mandate for female goodness. "This image of goodness as selfless love joins with the deep desire to make and maintain relationships to create a powerful obstacle to self-expression and recognition of anger" (Jack, 1991, p. 110).

Expression of one's sense derived viewpoint reinforces one's authentic self whereas suppression of this voice is accompanied by the feeling of loss of self. Our "culture prepares women to abdicate their own perspectives and values in order to adopt the prevailing male-oriented view" (Jack, 1991, p.33). Our male dominated language supports the suppression of a female's authentic self. Our educational and religious institutions discount feminine knowledge and perspective and uphold a gendered hierarchy. As succinctly expressed by the Catholic feminist theologian, Mary Daly, "if God is male, then the male is God" (Daly, 1974, p. 19). With history, language, and deity reflecting male experience and values, females come to view the masculine standpoint as truth leading to continued suppression of "I" and loss of self.

When a female's family of origin mirrors and echoes societal patriarchal values engendered in a parental relationship of female submission and male dominance, the sustained experience of the "I" and of self-esteem become even more problematic. The "I"

or first person self of sensed experience may become obscured entirely, especially in the face of subsequent traumatic experiences and relationships.

> When mother authority defers to father authority, a mother hands her daughter over to the patriarchy without teaching her how to resist. Such early learnings make it difficult for women, in adulthood, to bring their own needs and feelings, their *agency,* into heterosexual relationships (p.111).

Although Jack (1991) emphasized the connection between loss of voice and loss of self regarding adult intimate heterosexual relationships, she recognized that females lose themselves as they try to fit into others' expected images including those from parents, other relationships, specific institutions, and culture in general. Some of these expectations explicitly suggest loss of self, including the expectation that males' needs are more important than females'. Moreover in some families both mothers and fathers look to their daughters to meet their own emotional needs, reinforcing for the child the impossibility of having her needs met in relationship. These characteristics are described in qualitative studies of families of females with eating disorders (Haworth-Hoeppner, 2000; Weschselblatt, Gurnick, & Simon, 2000).

Jack's (1991) insights about heterosexual relationships and depression in women can be extrapolated to explain the impact of cultural expectations of sexually mature females on disordered eating symptomatology in girls and women. Although both disordered eating symptomatology and sexual harassment occur prior to adolescence, both are greatly exacerbated in adolescence, the time when gendered role expectations are heightened coinciding with physical maturation and the expectation of intimate heterosexual relationships. Jack's feminist analysis of the experience of depressed women in a patriarchal

culture anticipates and coheres with eating disorder theorists' (Polivy & Herman, 2002) view that disordered eating symptoms are symbolic expressions of issues relating to personal identity and control. Disordered eating symptoms reflect a confluence of individual, familial, group and societal factors. Jack's focus on self-structures and processes promotes clarity regarding the impact of sexual objectification on the "I" or sense of self.

Researchers are using the Silencing the Self Scale to investigate loss of voice, sense of self, and relationship schema. Several researchers have used the scale to look at relationships between these constructs and disordered eating symptomatology. To this writer's knowledge, only one study has used the Silencing the Self Scale to study sexual harassment. In the following section, the use and efficacy of the scale as well as the findings of these studies will be considered.

Silencing the Self: Empirical Research

Based on Jack's research with depressed women, she and Dill developed the STSS (Silencing the Self Scale, Jack & Dill, 1991). The scale, which was designed to measure the "gender-specific schemas hypothesized to be associated with depression in women"(Jack & Dill, p. 97) consists of four subscales based on "specific cognitive schemas, derived from the culture, that guide a woman's social behaviors and her self-assessment" (Jack & Dill, p. 98). The four subscales measure important components of Jack's model of self-silencing, which includes decreased self-esteem and the experience of "loss of self."

1. Externalized self-perception (judging the self by external standards).
2. Care as self-sacrifice (securing attachments by putting the needs of others before the self).

3. Silencing the self (inhibiting one's self-expression and action to avoid conflict and possible loss of relationship).
4. The divided self (the experience of presenting an outer compliant self to live up to feminine role imperatives while the inner self grows angry and hostile (Jack & Dill,1992, p. 98).

Sexual Harassment and Silencing the Self

The investigation of sexual harassment using the STSS looked at the effect of self-silencing on the perception of and reaction to hypothetical vignettes describing situations of sexual harassment. Bozzano's (1998) findings from her study of 143 female college students at a private mid-Western university did not consistently concur with her hypothesized expectations. However, some of her results illuminate the connection between sexual harassment and disordered eating symptomatology.

Bozzano (1998) found that high self-silencers perceived gender harassment, a more ambiguous form of sexual harassment, more frequently than did low self-silencers. "This finding suggests that those with less "voice" may be more sensitive to the existence of a vague or easily ignored situation of sexual harassment" (Bozzano, p.140). Furthermore, Bozzano reported that high self-silencers were more likely than low self-silencers to take some forms of action in response to gender harassment. High self-silencers were more likely to choose the following categories in response to a vignette in which a male college teacher harassed a female student: "avoid the instructor," "change your appearance," and "remove yourself from the situation" (Bozzano, p.143). In contrast, low self-silencers were more likely to choose the two categories in which the focus of change was on the harasser and the

relationship with him “confront the instructor” (Bozzano, p.144) and “make a report” (Bozzano, p.144).

Although Bozzano (1998) reported that high self-silencers were more likely to take some form of action, a different interpretation seems likely if “actions” are considered in terms of coping styles and targets of change. High self-silencers chose avoidant actions and directed change strategies to self. This would seem to imply self-blame, self-responsibility or expectations of impotence regarding effecting change in either the harasser, the relationship or the potentially protecting environment. These possibilities are supported in part by the finding in a later study that self blame mediated the relationship between sexual harassment and eating disordered eating symptoms in females (Harned & Fitzgerald, 2002).

Disordered Eating Symptomatology and Silencing the Self: Quantitative Studies

Several recent studies have explored relationships between dimensions of self-silencing and disordered eating symptoms in women (Geller, Cockell, & Goldner, 2000; Smolak & Munstertieger, 2002) and female adolescents (Lieberman, Gauvin, Bukowski, & White, 2001; Zaitsoff, Geller, & Srikameswaran, 2002). One of the adult studies (Geller, Cockell, & Goldner) compared women with Anorexia Nervosa to two different control groups. The other studies used non-clinical samples, one of which included males. All reported statistically significant relationships between some aspects of silencing the self and disordered eating symptoms in females.

Adult quantitative studies. Geller, Cockell, and Goldner (2000) studied the relationship between self-silencing, anger expression, and perfectionism. They used the STSS to compare women with Anorexia Nervosa to both non-eating disordered psychiatric patients and to women with neither eating disorder nor other psychiatric diagnoses. Geller et al.’s

investigation looked at the association between self-silencing in intimate relationships, suppression of anger as measured by STAXI (The State-Trait Anger Expression Inventory, Spielberger, et al, 1986), perfectionism as measured by both MPS (Multidimensional Perfectionism Scale, Hewill & Flett, 1991) and PSPS (Perfectionism Self-Presentation Scale, Hewill, Flett & Ediger, 1996), and disordered eating symptoms. They found that women with anorexia nervosa had higher scores on the STSS subscales than either of the control groups. The difference between the two control groups was not statistically significant.

Geller et al. (2000) performed additional statistical analyses in response to their findings that depression, self-esteem, and global functioning differed based on group membership. Controlling for these variables and for age, they found a statistically significant difference between women with anorexia nervosa and the control groups on the Care and Silence subscales of the STSS. Again, there was not a statistically significant difference between the two control groups.

Additionally, Geller et al. (2000) reported findings about body image dissatisfaction and perfectionism that applied to the three groups in their study. The Care, Silencing, and Divided subscales were statistically significantly correlated with the cognitive and affective components of body image dissatisfaction, as was the Anger In subscale of the STAXI which "measures the frequency with which angry feelings are held in or suppressed" (Geller et al., p. 12). There were statistically significantly relationships between all four subscales of the STSS and self-oriented, socially prescribed, and self-presentation perfectionism.

Smolak and Munstertieger (2002) compared the STSS to the SWIT (Saying What I Think Around Others scale, Harter & Waters, 1991), a measure of voice, which in contrast to the STSS is contextually based, to determine if the two instruments measured the same

construct in men and women. Correlations between the two measures were small to moderate suggesting that they might not be measuring the same construct. Furthermore, gender comparisons did not support the assumption of feminist theorists (Gilligan, 1990) that women had less voice than men. Gilligan's work, which influenced Jack & Gill's (1992) scale development, was based on using female samples exclusively. Smolak and Munstertieger suggested that the constructs of voice and silencing may be situationally dependent and may have different meanings for males and females.

Additional evidence of different meanings by gender was found in the different relationships between scores on voice and eating measures. Although STSS-Externalizing was a significant predictor of binge eating in both women and men, for women, the relationship was much stronger. On measures of restrained eating, STSS-Silencing was a significant predictor for women, but not for men. STSS-Externalizing significantly predicted restrained eating for both genders; however, again accounting for more of the variance in women. Finally, on all three emotional eating scales, i.e. eat when angry, eat when anxious, and eat when depressed, there were significant relationships with some measures of voice in women and with none in men. STSS-Silencing predicted emotional eating in response to anger. STSS-Externalizing predicted emotional eating in response to both anger and anxiety. Although the STSS did not significantly predict emotional eating in response to depression, three out of four of the SWIT subscales did.

Adolescent quantitative studies. Zaitsoff, Geller, and Srikameswaran (2002) investigated the relationship between disordered eating symptoms and "an interpersonal style that focuses on others' needs and expectations" (Zaitsoff et al., p.51) using the STSS in a sample of female adolescents. At the same time, they used the Anger Expression Scales to determine the

interconnections between the above-described interpersonal style and inhibiting expression of negative emotions. They also measured global self-esteem using the Rosenberg Self Esteem Scale (RSES; Rosenberg, 1979) and specific aspects of self-esteem using the Shape-and Weight Based Self-esteem Inventory – Adolescent Version (SAWBS-A; Geller, Srikameswaran et al., 2000).

According to Zaitsoff, Geller, and Srikameswaran (2002) both the interpersonal style of focusing on the desires and wishes of others and suppressing emotions appear to have unique relationships with sub clinical disordered eating symptoms. However, the specific and general measures of self-esteem were the most significant predictors of disordered eating symptoms in this non-clinical sample. When the researchers controlled for global self-esteem, even though the relationships continued to be statistically significant, interpersonal style and inhibiting emotional expression accounted for small percentages of the variance. Zaitsoff et al. (2002) suggested that future research replicate their study in a clinical sample of adolescents.

Lieberman et al. (2001) created a version of the STSS specifically for adolescents focusing the 26 item scale on relationships with friends instead of intimate partners in order to investigate the influence of same sex peers on disordered eating symptomatology. Only the STSS externalizing subscale was used in this study in a sample of 876 girls in grades seven through ten. Using hierarchical multiple regression, they found that high externalized self-perceptions and high "attributions about the importance of weight and appearance for popularity and dating" (p. 224) were statistically significant and important predictors of dieting, bulimic behavior, and body esteem. Although in this study a subscale of an instrument designed by the first author

measured the attributions described, they seem to concur with both self-silencing and objectification theory constructs.

Based on the above-described studies, the STSS seems to be a useful instrument for measuring the construct of self-silencing in relationship to disordered eating symptomatology in females. The issue of the connection between global self-esteem, interpersonal orientation, and suppression of negative feelings continues to be unanswered. The problem may reflect measurement issues as diminished self-esteem is related to self-silencing by definition.

However, even in the absence of complete understanding of the interrelationships of these constructs, interpersonal orientation and suppression of negative feelings in females seem to be relevant to issues of treatment and prevention of eating disorders.

Moreover, these variables may have particular relevance to issues that underlie the relationship between sexual harassment and disordered eating. Lieberman et al.'s (2001) findings indicated this possibility. Although they investigated the relationship between same sex peer teasing only, they report statistically significant relationships between teasing and disordered eating and body image problems.

> After controlling for both biomaturational and interpersonal characteristics, self-reported severe teasing about weight (but not appearance or body shape) was a significant predictor of dieting, while weight, appearance, and body-shape teasing were important predictors of body esteem (p.230).

They recommended that future research examine the effect of opposite-sex teasing and predicted that it would have a comparable impact. Based on the differential valuing of male and female bodies as explicated by objectification theory, this writer concurs with previous researchers

of the relationship between sexual harassment and disordered eating and expects the influence of opposite sex teasing especially sexually harassing teasing to have an even stronger effect.

A qualitative study - sensing the self

Reindl's (2001) qualitative study of recovering bulimics suggested a model that addresses some of these issues. Her work shed light on the impact of early familial relationships on later responses to objectification experiences. Her analysis provided a meaningful way of understanding the intrapsychic processes involved in individual females' responses to objectifying traumas.

Reindl's (2001) findings supported a diathesis or two-phase model for bulimia that parallels Nolen-Hoeksema and Girgus's (1994) analysis of adolescent depression. Whereas Nolen-Hoeksema and Girgus focused on broad cultural patterns transmitted through families, Reindl highlighted the role of familial trauma in laying the foundation for later vulnerabilities. The women Reindl studied reported early shaming experiences that laid the groundwork for profound defenselessness to later traumatic experiences. Each woman reported experiencing non-repaired emotional disconnection from a parent that led to a chronic internalized sense of shame.

> When a child's emotional connection with the parent is repeatedly broken, whether by neglect or abuse, and not rebuilt, she experiences chronic invalidation of her core yearnings and needs. If that which derives from the core of her is deemed unworthy of attention or unacceptably bad by the parent, she experiences her very self as unworthy and unacceptably bad (Reindl, 2001, p.18).

Reindl (2001) explained the connection between the lack of early attuned care taking and later subsequent deficits in self-structure and self-regulation. The women she interviewed were unable to soothe or comfort themselves in response to negative feelings and experiences. As they had not experienced acceptance of their needs and feelings, they were unable to accept themselves. Because they had not been comforted, stimulated, and affirmed, they were unable to provide these functions for themselves.

Reindl's (2001) participants avoided awareness of their internal experience, which they feared would be accompanied by devastating shame, based on their experience with early caretakers. Moreover, this avoidance was motivated by fear of ego fragmentation and disintegration. Avoidance of experiencing self led to a diminished sense of self, reliance on external cues and external control, continually invalidating and weakening the individual's sense of self. Furthermore, her participants avoided authentic connection with others, again fearful of being shamed if they revealed vulnerable aspects of themselves.

Reindl (2001) presented her participants descriptions of the function of their disordered eating symptoms. They used the binge-purge cycle and related thoughts and feelings to avoid internal experience, to avoid potentially shaming relationships, and to dissociate unacceptable aspects of self. Additionally, their symptoms and identification as eating disordered affirmed a personal identity and the illusion of control over internalized representations of significant early caretakers. Although the disordered eating symptoms of bingeing and purging temporarily served self-integrating functions, paradoxically, they perpetuated self-structure and self-regulating deficits.

In the absence of reparative relational experiences, Reindl's (2001) participants were unable to experience their own subjectivity. Instead, they experienced themselves

as devalued unworthy objects, thus predisposing them to vulnerability to the negative messages and consequences of sexual objectification. Reindl's participants described the emergence of bulimic symptoms in response to "precipitating experiences in adolescence that evoked a profound sense of inadequacy" (p.18). Thus, an early self-perception of defectiveness and unloveability was confirmed by latter experience. Reindl's description of her participants' early experiences resembled Fredrickson and Roberts' (1997) description of objectification. Although she does not reference the objectification theory authors, she uses the term "objectifying themselves" referring to that which needs to change in order to recover from bulimia.

Theoretical and Empirical Connection

In 1996, three Canadian women (Larkin, Rice, & Russell, 1996) published a paper connecting the pervasive experience of sexual harassment in young females to eating and body image problems. These women had worked in a University level women's studies program, an associated women's health center, and an upper level elementary school. Through separate projects, working with somewhat diverse populations, Larkin and Russell became aware of the pervasive experience of objectification, as girls' bodies physically mature into sexual, women's bodies. Using focus groups and other qualitative research methods, they described a phenomenon, which shed light on Gilligan's (1990) observation that girls shut down and become less confident during adolescence.

> In a society where women are devalued, there is little positive affirmation of female identity in any stage of a woman's life. But a young woman's developing sense of herself as a valuable and autonomous person comes up against a formidable block when her sexual development becomes

visible and she realizes the danger in her developing sexuality (Larkin et al., p.7).

Larkin et al. (1996) noted that researchers had investigated relationships between physical and sexual abuse and eating and body image problems. However, the connection between sexual harassment and eating and body image problems had not been studied. They related this lack of empirical research to the notion that sexual harassment was so pervasive that it was seen as normative, consequently disregarded as a research variable. This normalization and disregard support objectification theorists' observation concerning the right of all males to sexualize females described earlier in this chapter.

The first empirical study of the relationship between sexual harassment, body image, and eating problems was published in the Psychology of Women Quarterly (Harned, 2000). Publication in this journal as opposed to a less gender specific periodical may be seen as a reflection of the lack of general interest in gender as a variable in eating disorder research, confirming the observation of Smolak and Murnen (2001) described in the previous chapter. However, the first empirical study of the relationship was followed by another, larger study (Harned & Fitzgerald, 2002) which was published in the Journal of Consulting and Clinical Psychology.

Harned (2000) studied the relationship between eating disorder symptomatology and sexual harassment in female college students at a large Mid-Western University. She used structural equation modeling to elucidate the directionality of the statistically significant relationship between the two variables after controlling for the effects of sexual and physical abuse. Because her design was cross-sectional, she was unable to test a model of bidirectionality. She concluded that her data supported a model of sexual harassment

preceding eating disorder symptoms. She used the finding that psychological distress partially mediated the relationship in addition to trauma theory to corroborate her proposed model. Accordingly, she proposed that eating disorder symptoms serve as coping strategies to deal with negative emotions engendered by sexual harassment.

Harned (2000) valued the use of trauma theory because in her view it supported an explanation for eating disorder symptoms that was not victim blaming. Instead, she asserted that it shifted responsibility from the individual to societal conditions. "This shift from identifying the problem as existing within the individual to placing responsibility on the problematic social conditions that promote and perpetuate violence against women has far reaching implications for treatment and prevention strategies" (p. 346).

In Harned's discussion of her results, she recognized limitations with her trauma theory based model. The majority of the women she studied did not report that disordered eating symptoms followed episodes of sexual harassment. Additionally, in spite of the highly statistically significant relationship between sexual harassment and a composite eating disorder symptom variable, sexual harassment accounted for only 13% of the variance in predicting the dependent variable. Posttraumatic stress, anxiety, and their interaction with sexual harassment moderated the relationship between sexual harassment and the dependent variable. In other words, "…women with low levels of comorbid distress remained below the mean on the eating disorder composite variable, even at high levels of harassment " (p. 344).

Harned and Fitzgerald (2002) studied three separate samples to expand upon and clarify Harned's (2000) earlier research. Each of the samples consisted of adults, one of active duty military men, one of active duty military women, and one of women involved in a

class action sexual harassment suit against a national company at which 90% of the study participants were no longer employed. They found no relationship between sexual harassment and eating disorder symptoms in their sample of men, supporting Harned's assumption about the "gender-based nature of eating problems and the possible relation between such struggles and violence against women" (p. 346).

In Harned and Fitzgerald's (2002) study, both sexual harassment and eating disorder symptomatology were defined more limitedly than in the previous study. In the 2002 study, only sexual harassment in the workplace was considered whereas the previous study had defined sexual harassment to include experiences that had taken place since junior high school in social and academic as well as workplace settings. In the 2002 study, only behavioral eating disorder symptoms were measured whereas the former study had included both attitudinal and behavioral symptoms. Yet, in the two female samples, Harned and Fitzgerald found statistically significant relationships between sexual harassment and eating disorder symptoms which were mediated by psychological distress, self-esteem and self-blame. The total effect of sexual harassment on behavioral eating disorder symptoms varied: (.03) in the sample of military women (N=419) and (.16) in the sample of class action women (N=1,218). In comparison, the effect was (.27) in Harned's (2000) sample of college students (N=195)[2].

[2] This effect is based on the broader definition of sexual harassment used in the Harned (2000) study. It is based on behavioral eating disorder symptoms only rather than the eating disorder composite variable referred to previously to be consistent with measurements for the 2002 samples.

Harned and Fitzgerald (2002) asserted the robustness of the relationship between sexual harassment and disordered eating symptoms because it was consistently statistically significant across diverse female samples despite variability in the relationship's strength across samples. In both Harned (2000) and Harned and Fitzgerald's studies, psychological distress mediated the relationship between sexual harassment and disordered eating symptoms. Harned and Fitzgerald recommended that future research "attempt to further clarify the specific processes that underlie this link" (p.1178).

This study builds upon the research of Harned (2000) and Harned and Fitzgerald (2002). Following Harned and Fitzgerald's recommendation, the study investigates the processes that lie beneath the relationship between sexual harassment and disordered eating symptomatology. It is expected that the psychosocial constructs of self-objectification and self-silencing will add clarity to current understanding of the connection between sexual harassment and disordered eating symptomatology.

Conceptual Model

The present research measures sexual harassment experience, self-objectification, self-silencing, internalized shame, and disordered eating symptomatology in a purposive sample of college students. It attempts to elucidate the relationship between sexual harassment experience and disordered eating symptomatology focusing on issues of self, including self-objectification, self-silencing schema, and internalized shame. In so doing, this research follows the recommendations of objectification theory researchers to investigate the relationships between objectifying experiences and self-objectification and between self-objectification and other personality variables.

For females, valuing self is related to secure attachment, to the certain sense that one is valued and accepted as an individual with rights and needs for whom a loved significant other will be accessible and responsive when needed. Cultural evaluation may support or impede secure attachment on a deep, mythic level. When valuing of one's subjective self is missing in one's familial relationships, and not replaced by such valuing in other relationships including institutional and cultural ones, problems in women's self-esteem and sense of self ensue. Disordered eating symptoms along with unipolar depression and sexual dysfunction, the other problematic responses that objectification theorists predicted, may be viewed as dysfunctional attempts to manage one's self in a culture in which one's essential subjective self is devalued. By withdrawing focus from nurturing and valuing self through relationships, instead meeting attachment needs through focus on food and body, disordered eating symptoms seem to be an attempt to translate complex seemingly unsolvable problems of personal identity and control into concrete problems with individually manageable solutions.

Sexual harassment that is perpetrated by males on females reinforces the objectification, sexualization, and devaluation of females. The prevalence and normalization of sexual harassment reminds the female that the culture and in many cases specific institutions and relationships are not supporting her authentic, agentic self. Moreover, her personal safety is threatened by this normalization and consequent lack of protection from violence against women. Disordered eating symptomatology including the resulting bodily changes may represent an attempt to repossess one's body, to provide safety, as well as to symbolically express and reclaim one's self.

When the message underlying sexual harassment reflects the female's familial and/or internal experience of devaluation and shame, the expectation of disordered eating symptomatology as described in Reindl's qualitative study is strong. On the other hand, when a female enters adolescence with a stable, secure sense of self, she may respond to the devaluing, disempowering messages of sexual harassment experience with repudiation. She may be able to subvert the patriarchal position and to replace it with her authentic viewpoint of self value and self-esteem. In so doing, consistent with the goal of feminist therapy theory, she may become empowered to respond to sexist devaluation with active attempts to change institutions and culture in the direction of social justice, in support of ending violence against women.

To summarize, this study is investigating the connection between sexual harassment experience and disordered eating symptomatology in females based on a conceptual model that uses the feminist constructs of self-objectification and self-silencing. It is building on previous research that has found evidence of a relationship between sexual harassment and disordered eating symptoms. The study aims to provide further evidence of the prevalence of sexual harassment and disordered eating symptomatology and of their connection. In so doing, it attempts to further the idea that sexual harassment and disordered eating symptomatology reflect and symbolically express both institutionalized sexism and sexism internalized by individual females.

This research is being conducted to benefit social work practitioners and their clients who are affected by both sexual harassment and disordered eating symptomatology. It is hoped that illumination of the relationship between the independent and dependent variables will be useful to social workers in working with clients in diverse settings on the micro, mezzo, and macro levels of practice. Furthermore, it is expected that awareness of the connection

between the study variables and underlying sexism will enable coordinated prevention efforts that address issues of social justice consistent with social work's professional mission and values.

CHAPTER III

METHODOLOGY

The purpose of this study is to examine the relationship between sexual harassment and disordered eating symptomatology in college women. It is expected that the study's findings will be useful to social work practitioners working in education, recreation, and mental health settings dealing with these issues separately or in combination. Furthermore, this research is expected to shed light on the possibility of coordinated, parsimonious prevention strategies for sexual harassment victimization and disordered eating symptomatology in females.

Based on several feminist theoretical stances elaborated in Chapter II, this study emphasizes internal factors including self-schema and traits that influence the relationship between sexual harassment experience and disordered eating symptomatology. More specifically, this study focuses on self-objectification, self-silencing, and internalized shame with the aim of elucidating the best predictors of disordered eating symptomatology in college women in connection with the experience of sexual harassment.

In a recent study that examined the fundamental relationship being investigated in the present research, Harned (2000) found that sexual harassment accounted for 13% of the variance in predicting an eating disorder symptom composite variable. She concluded that her findings underscored the "gender-based nature of eating problems and the possible relation between such struggles and violence against women," (p.346); however, her model did not include variables specifically derived from feminist theory and research. This study builds on the relationship established by Harned by including such variables in the research model.

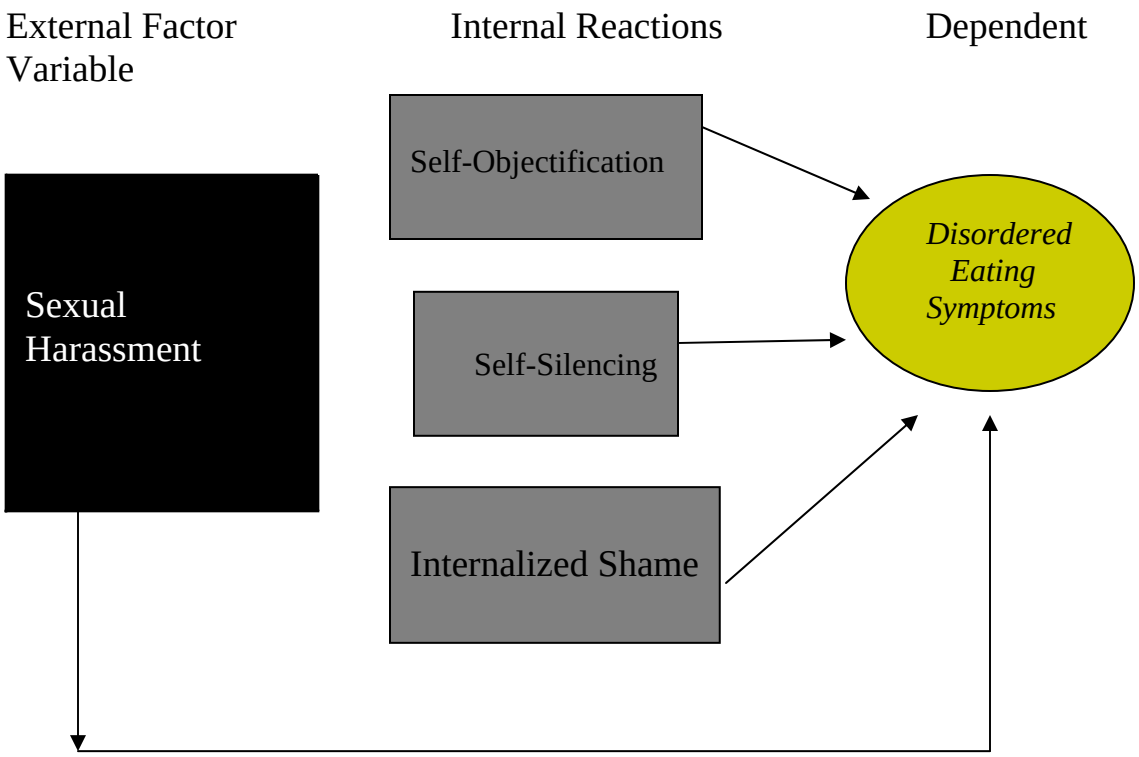

Figure 1. Research Model: Sexual Harassment and Disordered Eating Symptoms: A Proposed Model

Research Model

The research model (Figure 1) depicts the relationships among the variables of the study. The external variable, sexual harassment represents, results from, and reinforces societal patriarchal power and devaluation of females. Self-objectification and self-silencing are internal variables, derived from cultural messages and personal relational experience. These variables reflect the degree to which an individual female has incorporated or rejected patriarchal devaluation into her sense of self. Internalized shame represents negative affect incorporated into one's sense of self. It reflects societal, relational, and personal experience, both distal and proximate consistent with Noel-Hoeksema and Girgus's diathesis stress model and Reindl's theory of two-phase trauma affecting one's sense of self. In other words, these researcher-

theorists described early trauma damaging one's sense of value being reinforced by later external destructive experiences.

Self-objectification represents the degree to which a female regards her body as an object in contrast to viewing it from a subjective perspective. A high degree of self-objectification indicates a high degree of internalization of messages that devalue females' agentic selves including females' rights to ownership of their own bodies. A low degree of self-objectification suggests a high degree of resistance to the internalization of such devaluation and disempowerment.

Self-silencing represents the degree to which one's voice is suppressed. Rather than being used to express one's subjective interests, one's own viewpoint is censored in the service of maintaining relationships. A high degree of self-silencing is an indicator of acceptance of or problematic resistance to patriarchal devaluation and disempowerment of females. High self-silencing reflects and contributes to problems of identity and personal control, which expert eating disorder researchers (Polivy & Herman, 2002) regard as the underlying issues that are being expressed symbolically in disordered eating symptomatology.

Internalized shame represents a generalized pervasive negative conception of self, involving both individual and relationship competencies in contrast to a specific or state reaction to a single experience. A high degree of internalized shame is an additional indicator of lack of resistance to external messages of devaluation of self. It is the measure that most represents one's sense of self, influenced by external, societal factors, and relationship factors, as well as internal factors. It is influenced by and responsive to sexual harassment experience, self-objectification, and self-silencing.

Research hypotheses addressed correlations between the independent variables, between each independent variable and the dependent variable, and between the package of independent variables and the dependent variable. Moreover, the proportion of variance accounted for by the independent variables was investigated. The following hypotheses were derived from the research model.

1. There will be a positive correlation between the level of sexual harassment experience and the level of disordered eating symptomatology.
2. There will be a positive correlation between the level of self-objectification and the level of disordered eating symptomatology.
3. There will be a positive correlation between the level of self-silencing and the level of disordered eating symptomatology.
4. There will be a positive correlation between the level of internalized shame and the level of disordered eating symptomatology.
5. It is predicted that shame will be positively correlated with: a) sexual harassment, b) self-objectification, and c) self-silencing.
6. The package of independent variables including sexual harassment, self-objectification, self-silencing, and internalized shame will be statistically significant with the level of disordered eating symptomatology.
7. While sexual harassment experience will predict disordered eating symptomatology, when the internal variables are entered into the equation, they will be the primary predictors of disordered eating symptomatology.

Research Design

This study used a correlational design as it was a survey. Data were collected from female college students enrolled at the University of Georgia, a large, co-educational public institution in the southeastern United States. All data were collected using an anonymous questionnaire (Appendix C) which was expected to take less than thirty minutes to complete based on a pilot study with eight participant consultants. Each participant received $10.00 for filling out the questionnaire. The money was given in an envelope with a thank you note listing two numbers (Clarke County Community Mental Health and Counseling and Psychological Services) that might be useful if uncomfortable feelings resulted from study participation.

Participants

This study used a purposive community non-clinical sample. Participation was open to female students between the ages of 18 and 24 enrolled at the University of Georgia for the spring and/or summer semesters, 2004. The researcher recruited approximately 200 survey participants.

The researcher used several solicitation methods including classroom presentations of the project. She invited interested students to sign up to participate in the study (Appendix A 3). Then, students met with the researcher in small groups to complete the survey questionnaire. These small group sessions were held in a conference room in Tucker Hall and were scheduled at different times to accommodate student schedules.

The researcher contacted the pan Hellenic counsel and requested the opportunity to present this research project to sorority members. Also, the researcher solicited participation by placing posters (Appendix A 2) at several public campus locations and advertising in the Campus newspaper (Appendix A 1). Students who responded to ads and

posters were invited to meet with the researcher and other participants in small groups as described above. There, they were asked to read and sign an informed consent letter (Appendix B). After completing the consent forms, students were asked to complete the study's anonymous questionnaire. The consent forms and questionnaires were collected and kept separately, so there is no way to match participants consent forms with completed questionnaires.

Measures

The questionnaire for this study contains six sections. Each of the first five sections consists of a scale or subscale for which reliability and validity had been established in previous research. These measures are presented as ordered in the research model with the external factor, sexual harassment first. Next each of the three internal factors is presented, followed by and ending with the dependent variable, disordered eating symptomatology.

On the survey questionnaire (Appendix C), the sections were arranged "to minimize potential demand effects" (Harned, 2000, p. 338). Therefore, the measures that evaluate disordered eating symptoms and internal factors preceded the one that assesses sexual harassment experience. Demographic questions selected because of their relevance to the study's hypotheses and prior use in disordered eating research comprised the final section of the questionnaire.

Sexual Harassment Experience

The 20-item Sexual Experiences Questionnaire (SEQ Forms W and E) measures sexual harassment experience. "The instrument assesses the behavioral and psychological experience of offensive gender-related behavior," (G. Ragle, Department of Psychology, University of Illinois at Urbana-Champagne, personal communication September 03, 2003).

The SEQ contains three subscales: gender harassment, unwanted sexual attention, and sexual coercion. The participant rates each item using a five point likert scale ranging from NEVER [0] to MANY TIMES [4]. The scale's authors suggested that two of the items be treated separately and not scored as part of the scale. "[T]he final item (*Have you ever been sexually harassed?*) is not scored on any of the subscales and is considered a measure of the participant's subjective perceptions, as opposed to her actual behavioral experience. The final *unwanted sexual attention* item *(…unwanted attempts to have sex with you that resulted in your pleading or physically struggling?)* assesses the legally defined experience of attempted rape in most states; because this is such a low base-rate item, we suggest treating it as a separate item…"(G. Ragle, personal communication September 03, 2003). These two items were scored separately in the current study in accordance with the author's recommendations.

Following are the alpha reliabilities for a sample of female graduate students from a midwestern university using the most recent version of the SEQ: GH = .72, USA = .67, SC = .49, Total SEQ = .78. Additionally, factor analyses indicated, "the variance in the SEQ can be adequately accounted for by …three behavioral constructs, which parallel the legal concepts of *quid pro quo* (sexual coercion) and *hostile environment* (gender harassment and unwanted sexual attention)," (G. Ragle, personal communication September 03, 2003)

Fitzgerald et al. (1995) and Gelfand et al (1995) argue for the construct validity of the SEQ based on the theoretical reasonableness of their model and its consistency across settings and cultures. Their statistical analysis using "an application of Joreskog's (1971) procedure for simultaneous factor analysis in several populations" (Fitzgerald et al., p.432) confirmed "a very good fit of the model to the data."(Gelfand et al., 1995, p. 172). Another support for the construct validity of the SEQ is the positive relationship between scores on perceived

organizational climate with regard to tolerance of sexual harassment and individual scores on the SEQ.

In the version of the SEQ that was used in this study, each of the twenty questions is followed by a distress rating question. "If at least once, how much did this bother you?" The respondent is asked to choose one from a five point likert scale ranging from NOT AT ALL [1] to EXTREMELY [5]. No information on the reliability and validity of the distress rating scores was included in the scale's packet nor has this author been able to find any psychometric information on the distress rating part of the scale (Fitzgerald, Gelfand, & Drasgow, 1995; Gelfand, Fitzgerald, & Drasgow, 1995).

The SEQ has been used in various versions to study sexual harassment in work places, school settings, and in the military. It has been used recently to study potential variables involved in vulnerability to sexual revictimization (Arata & Lindman, 2002). It was used in the two studies on which this research is building, examining the relationship between sexual harassment experience and disordered eating (Harned, 2000; Harned & Fitzgerald, 2002).

In the present study, sexual harassment is defined by the following parameters, based on those used by Harned (2000) in her study of the relationship between sexual harassment and eating disorder symptomatology in college females:

> The harassment could occur (a) in workplace, academic, and/or social settings; (b) from male supervisors, coworkers, teachers/professors, and/or peers; and (c) since junior high school.

Self-objectification

A 10-item instrument, the Self-Objectification Questionnaire (S-OQ) measures the degree to which one views one's body in terms of appearance versus competence. The S-O Q does not

purport to measure body satisfaction. Instead, it is concerned with one's view of one's body along a continuum from viewing it as an object to meet the needs of others to viewing it subjectively for one's own needs and use.

The respondent is asked to rank order ten different attributes based on relative importance to her physical self-concept. Miner-Rubino, Twenge & Frederickson (2002) reported high test-retest reliability for the instrument ($r = .92$, $p<.001$). They affirmed the convergent validity of the S-OQ (termed the TSOQ in their study) based on its high correlation ($r = .63$, $p<.001$) with the surveillance subscale of the Objectified Body Consciousness Scale, "an instrument shown to measure trait-like self-objectification constructs." Because of this correlation, Miner-Rubino et al. z-scored the OBCS subscale and the TSOQ, and combined them into a self-objectification composite score (Cronbach's alpha = .85).

The TSOQ is scored by assigning a ranking number to each attribute from MOST IMPORTANT [9] to LEAST IMPORTANT [0]. Next, appearance related items and competence related items are summed separately. Last, the sum of the competence item ranks are subtracted from the sum of the appearance item ranks. Final scores range from –25 to + 25 with higher scores representing greater appearance orientation which the scale authors construe as high trait self-objectification.

The S-OQ was developed to measure the construct, self-objectification (Noll & Fredrickson, 1998) proposed by objectification theory authors (Fredrickson & Roberts, 1997). It has been used to test aspects of the theory in additional studies (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Miner-Rubino et al. 2002; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). In the present study, scores on the S-OQ represent trait self-objectification, with higher scores indicating greater self-objectification.

Self-Silencing

The Silencing the Self subscale of the 31-item Silencing the Self Scale (STSS) measures women's cognitive schema about authentic expression of self in intimate relationships. The STSS assesses the degree to which women silence aspects of their intellectual and emotional expression in the service of heterosexual relationships. It is proposed that "this self-silencing contributes to a fall in self-esteem and feelings of a 'loss of self' as a woman experiences, over time, the self-negation required to bring her-self into line with schemas directing feminine social behavior"(Jack & Dill, 1992, p.98).

The STSS scale consists of four subscales. Externalized Self-Perception measures a construct involved in negative self-judgments, i.e. judging one's self by other directed criteria. Care as Self-Sacrifice refers to placing others' needs above one's own for the purpose of securing or maintaining attachments. Silencing the Self describes another interpersonal dimension, i.e. limiting one's self-expression and activity to prevent conflict and the possibility of relationship loss. The Divided Self subscale represents and measures symptomatology found in depressed women, i.e. the presentation of exterior compliance based on perceived social expectations of femininity with an increasingly hostile, upset inner self (Jack & Dill, 1992).

Psychometric properties of the STSS were tested on three samples of females including: 63 undergraduates, 140 women in a shelter for battered women, and 270 women who reported drug use during pregnancy as part of a National Institute of Drug Abuse study. Internal consistency for the total scale was reported for each sample (alphas ranged from .86 in the college sample to .94 in the shelter sample). Alphas on the subscales were acceptable with the exception of the Care as Self-Sacrifice subscale. The STSS authors warn against its separate use because of its marginality (e.g., in the undergraduate sample, alpha = .65). Jack and Dill (1992)

reported an alpha of .78 for the Silencing the Self subscale in the sample of undergraduates. Test-retest reliability for each sample on the total scale was excellent, ranging from .88 to .93.

The concurrent validity of the STSS was demonstrated by its high correlation with depression scores across the three samples of women who were nondepressed, mildly depressed, and moderately depressed. The authors cited variation in the predicted direction across the three sample groups as support of the construct validity of the STSS (Jack & Dill, 1992). STSS Externalizing and Silencing subscales have been found to be significant predictors of disordered eating behaviors in college age women (Smolak & Munstertieger, 2002).

The STS subscale that was used in the present study seems to complement the construct measured by the S-OQ; whereas, the constructs underlying the Externalizing Scale and the S-OQ seem to overlap. According to Remen, Chambless and Rodebaugh's (2002) analysis, nine items loaded on the Silencing the Self subscale. The one item with the lowest loading (.36) loaded on the Divided Self factor in a more recent study using a larger sample (Cramer & Thoms, 2003) and was not used in this study. The STSS was designed for use with females, based on a feminist understanding of self-schema in depressed women reflecting patriarchal devaluation of females' needs and selves.

The STSS has been used extensively in eating disorder research (Geller, Cockell & Goldner, 2000; Lieberman, Gauvin, Bukowski & White, 2001; Smolak & Munstertieger, 2002; Zaitsoff, Geller & Srikameswaran, 2002). In the present study, the eight-item Silencing the Self Subscale (items 2, 8, 14, 15, 18, 24, 26, 30) represents the construct, self-silencing with higher scores indicating greater degrees of loss of voice or negation of self-expression.

Shame

The Internalized Shame Scale (ISS) measures the degree to which respondents experience the trait of internalized shame as part of their sense of self. The scale's author asserts, "the construct of "negative affect" in the context of psychopathology is essentially defined as shame affect, and the ISS is a measure of the extent to which this "negative affect" of shame has become magnified and internalized into one's sense of self," (Cook, 1994, p. 16). Alternately, Cook (1994) explained that the ISS measures the "negative aspects of global self-esteem".

In responding to the ISS, respondents choose from a five point likert scale ranging from NEVER = 0 to ALMOST ALWAYS = 4. The scale consists of 24 negatively worded shame items and six positively worded self-esteem items. Scale scores are determined by summing the responses to the shame items; disregarding the six self-esteem items. Scores can range from 0 – 96. Scores of 50 or higher indicate possible preoccupation with shame, whereas scores above 60 suggest high levels of shame with probable clinical symptomatic associations.

Using a nonclinical sample of 645 university students, 60% of whom were female, the alpha reliability coefficient for the shame items was .95. The test-retest correlation based on a seven-week interval with a sample of 44 graduate students was .84. (Cook, 1994). High negative correlations with measures of global self-esteem provided evidence of divergent validity in samples of college students. The Ineffectiveness Scale of the Eating Disorder Inventory had the highest correlation with the ISS (.79) in a sample of 113 college females. This scale "assesses feelings of general inadequacy, insecurity, worthlessness, emptiness and lack of control over one's life," (Garner's professional manual, 1991, p. 5 as quoted in Cook, 1994, p.18).

The ISS has been used in recent studies with diverse samples including children of alcoholics (Morey, 1999), persons with HIV/AIDS (Fife & Wright, 2000), and survivors of childhood sexual abuse (Feinhauer, Hilton & Callahan, 2003). Additionally, the ISS has been used to study relationships between shame and early interpersonal experiences in non-clinical samples (Claesson & Sohlberg, 2002). In the present study, scores on the ISS represent shame, with higher scores indicating greater degrees of internalized shame.

Disordered Eating Behaviors

The EAT-26 is a 26-item measure that assesses eating attitudes and behaviors. It was created in 1982 on the basis of a factor analysis of the longer 40-item Eating Attitudes Test (EAT). The original EAT was developed in 1979 to assess symptoms of Anorexia Nervosa which was the only eating disorder recognized in the DSM at the time (Garner, 1982). Both versions of the EAT are now used extensively to assess disordered eating behavior and attitudes (Mintz & O'Halloran, 2000).

The EAT-26 contains three subscales: dieting, bulimia and food preoccupation, and oral control. The thirteen items on the dieting subscale revolve around concerns with being thinner and avoiding high calorie food. Three items on the bulimia and food preoccupation subscale relate to bingeing and purging; the other three deal with respondents' self judgments regarding over focus on food. Four items on the oral control subscale center on restriction of and power over food; three center on respondents' beliefs about others' judgments of them as too thin or too restrictive in their eating (Eme & Danielak, 1995; Lane, Lane, & Matheson, 2004).

Total scores, which are obtained by adding the three subscale scores, range between 0 and 78 with higher scores indicating greater disordered eating symptomatology. Twenty is considered the cutoff on the basis of which a psychiatric interview to determine a diagnosable

eating disorder is indicated (Garner et al., Retrieved November 1, 2003, from http://river-centre.org/information.html).

In a non-clinical sample of approximately 800 Israeli female teenaged soldiers, Koslowsky et al. (1992) reported a Cronbach's alpha of .83 for the EAT-26, demonstrating internal consistency and reliability. Additionally, the authors found criterion validity for the instrument, which is significantly correlated with body image (r = .43) and dieting (r = .47). Mintz and O'Halloran (2000) provided further evidence for the validity of the EAT-26 in concluding that it "has an accuracy rate of … 90% when used to differentially diagnose those with and without eating disorders and that mean EAT scores differed among eating-disordered, symptomatic, and asymptomatic participants," (p. 489). They concluded that the EAT is a useful screening instrument for use with nonclinical women and that "…when used without cutoff scores the EAT can be preliminarily conceptualized as a continuous measure of abnormal or disturbed eating" (p. 500).

The EAT-26 is used frequently as a screening test (Garner et al. n.d.; Holt & Espelage, 2002). It has been used in research related to this study (Bittinger & Smith, 2003; Lieberman, 2001; Tiggemann & Slater, 2001). In the present study, following Tiggemann and Slater, this section of the questionnaire is titled, "Your Thoughts on Food and Eating" and scored as a continuous measure, with higher scores indicating greater disordered eating symptomatology.

Demographics

This 7-item section seeks information relating to age, education, ethnic/racial group, weight, height and eating disorder history.

Data Analysis

Based on a significance level of .05, the expectation of a medium effect size and a power of .99, a minimum sample of 200 was indicated. Simple bivariate correlations were used to test hypotheses numbered 1 through 5, which predicted positive relationships between the independent variables being investigated and between each of them and the dependent variable. Hypotheses 6 and 7 were tested with stepwise regression based on the research model. Sexual harassment, self-objectification, self-silencing, and internalized shame were entered into a stepwise multiple regression equation with disordered eating symptomatology as the dependent variable. Sexual harassment experience was entered into the equation first as it represents an external experience related to the construct, violence against women. It, like the dependent variable, disordered eating symptomatology is so widespread that is often overlooked, minimized and "normalized." Respondent's distress ratings of sexual harassment experience were entered next.

Then, self-objectification was entered as it represents an individual's internalization of a societal value, potentially transmitted in several ways, but especially through the non-personalized media. Although the self-schema of self-silencing may also be received through generalized cultural transmission including the media, the construct relates more specifically to intimate relationships where the schema may be more powerfully learned. Therefore, self-silencing was the third variable entered into the regression. Internalized shame was entered last as although it too has a relationship component; it is experienced as a self-construct in a more global way than the other internal factors. It encompasses issues of both self-competence and relational competence. It is the measure in this study that singly most represents one's sense of self.

In summary, this cross-sectional survey research is investigating the relationship between sexual harassment experience and disordered eating symptomatology in college females. By investigating this relationship through the lens of feminist theoretical constructs, this research aims to shed light on the connection between individual, institutional, and societal violence against women and disordered eating symptomatology in females. By elucidating the connection, this research aspires to impact and ameliorate treatment and prevention efforts on the micro, mezzo and macro levels of social work practice.

CHAPTER IV

RESULTS

This study investigated the relationship between sexual harassment and disordered eating among college age females. First, descriptive statistics for the sample and for the major variables in the study are described. Next, bivariate correlations among the study variables are presented and discussed. Lastly, multivariate analyses of the proposed research model are presented.

Descriptive Statistics

Sample characteristics including age, education, ethnic/racial group, current weight and height, past and current treatment for an eating disorder are described and presented in Table 1. Additionally body mass index (BMI) scores are presented for the sample. BMI which is a more robust and relevant measure than either height or weight alone is derived according to the following formula: (Weight/2.2) / (Height x 2.54 / 100) x Height x 2.54 / 100) and is used in subsequent analyses. BMI guidelines and accompanying health risks are presented in Table 2.

In Table 3 descriptive statistics for the major variables in the study are presented. In Tables 4 and 5 descriptive statistics for the current sample are compared to statistics on the samples on which the measurement instruments were normed. Then, correlations among the major variables are described and explicated in Table 6. In Table 7 correlations among subscales are presented because of their relevance to the research model. Finally, the

proposed model is analyzed statistically using the regression methodology outlined in Chapter III.

Sample Characteristics

The sample was composed of female students between the ages of 18 and 24 (M = 20.10, SD = 1.4) enrolled at the University of Georgia for the spring and/or summer semesters, 2004. Students were recruited in a number of ways as planned. Posters were placed at several sites on the UGA campus including the school of social work, the student activity center (Tate) and the student learning center. An ad was placed in the school newspaper. Information about the study was presented by the researcher in several classrooms and at a Pan Hellenic council meeting. The Pan Hellenic council is comprised of sorority presidents and other official member representatives. Following the meeting, Council representatives e-mailed information about the research to their respective sorority members. Each of 128 participants recruited in these ways either signed up on sheets provided or contacted the researcher by e-mail or phone and arrangements were made for completing surveys in small groups in a conference room in Tucker Hall in the presence of the researcher.

Seventy-four participants were recruited by one sorority member. She informed her sorority sisters about the research project and arranged for volunteers to participate in the study. The participants remained following a full member meeting which was held at their sorority house. The researcher met with these participants together in a large meeting room in the sorority house.

Prior to completing the anonymous survey questionnaire, all 202 research participants signed consent forms which were stored separately from the completed questionnaires. Upon completing the questionnaire, each participant was given $10.00 in cash. Accompanying the cash, each participant was given information about available resources in case she experienced any problems resulting from taking part in the research.

Because there were no statistically significant differences between the group of seventy four and the one hundred and twenty eight participants on any of the independent variables in the research model, the total sample of two hundred and two will be treated as one group for the purpose of testing the research hypotheses. There were statistically significant differences on some of the demographic variables which will be presented and discussed below; however demographic data will first be presented for the group of participants as a whole.

Over 50% of the sample participants were either freshmen or sophomores. Another 39.8% were either juniors or seniors while approximately 5% were graduate students. Almost 90% of the sample participants were Caucasians while 6.9% were African Americans. One student was Asian American (.5%), one was Hispanic (.5), and 2.5% listed “other” in response to the question soliciting Ethnic/Racial Group. Sixteen participants (7.9%) affirmed having ever been treated for an eating disorder. One participant did not respond to the question. Three participants (1.5%) responded affirmatively to currently being treated for an eating disorder. In Table 1, the sample distribution of age, educational levels, ethnic/racial groups, weight and height, body mass indices, and eating disorder treatment experience is presented for the total sample.

Table 1: Sample Characteristics (N=202)

Variables	Mean (SD) or N	Frequency (Percentage)
Age	20.10 (1.40)	
18	20	9.9
19-20	113	55.9
21	40	19.8
22-23	25	12.4
24	4	2.0
Education		
Freshman	57	28.2
Sophomore	54	26.7
Junior	46	22.8
Senior	34	16.8
Graduate	11	5.4
Ethic/Racial group		
African American	14	6.9
Asian American	1	.5
Caucasian	181	89.6
Hispanic	1	.5
Other	5	2.5
Current weight	132.12 lbs. (19.43)*	
Current height	5’5.7” (7.10)*	
Body mass index (BMI)	21.83 (2.97) **	
Past treatment for eating disorder	Yes = 16	7.9
	No = 185	91.6
Current treatment for eating disorder	Yes = 3	1.5
	No = 199	98.5

*The participants’ weights and heights ranged from 90 to 230 pounds and from 5’0” to 6’0.”
**The participants’ BMIs ranged from 16.2 to 37.2

The body mass index distribution of participants is displayed below in Table 2 with accompanying National Institute of Health classifications and relative risk of developing health problems. Although almost 80% of the sample participants have BMIs in the normal range, there is a bimodal distribution among the remaining sample with 18 (8.9%) participants having BMIs in the underweight category, 20 (9.9%) in the overweight and 4 (2%) in two combined obese categories.

Table 2. Body Mass Index Distribution

BMI range	N	Percent	BMI classification	Risk of developing health problems
< 18.5	18	8.9	Underweight	Increased
18.5 - 24.9	160	79.2	Normal Weight	Least
25.0 – 29.9	20	9.9	Overweight	Increased
30.0 – 34.9	3	1.5	Obese Class I	High
35.0 – 39.9	1	.5	Obese Class II	Very High

Sample differences. On several demographic variables, there were statistically significant differences between the group of participants recruited in the ways originally planned (n=128) and the group of members of a single sorority who completed the survey together in their sorority house (n=74). Members of the first group were older (M = 20.48, SD = 1.45 vs. M =19.43, SD = 1.02) (t (192.06) = 6.03, $p < .000$) and accordingly had more years of education (M =2.82, SD = 1.25 vs. M = 1.80, SD = .83, p <.000) than the sorority group.

The first group weighed more (M = 134.93, SD = 21.7 vs. M = 127.26, SD = 13.53, p <.01) and had higher BMI's (M = 22.29, SD = 3.36 vs. M = 21.02, SD = 1.89, p <.001) than the

sorority group. Additionally, the first group affirmed ever having been treated for an eating disorder more than the sorority group ($M = .11$, $SD = .31$ vs. $M = .03$, $SD = .16$, $p < .05$).

As already stated, the two groups will not be treated separately. In addition to the fact that they did not differ on the independent variables in the model, the basis of the above stated differences is not clear. The research did not include a question about sorority membership, so it is not clear whether sorority membership is a significant variable or if it is age and educational level or other factors relating to method of selection or questionnaire administration.

Descriptive Statistics for Major Variables

The major variables in the research model include sexual harassment experience, self-silencing, internalized shame, self-objectification and disordered eating symptomatology. Additionally, another dimension of the SEQ, the distress rating of sexual harassment experience is included. Based on sample size, the study design excluded looking at subscales of the instruments used to measure the major variables except in the case of silencing the self for which a subscale was used. However, because correlations were not found in the expected direction, bivariate correlations were run using the subscales. Therefore, descriptive statistics for subscales of major variables are included in this section.

Two hundred (99%) of the 202 women surveyed reported one or more sexual harassing experiences on the Sexual Experiences Questionnaire (SEQ). One hundred ninety-eight (98%) participants reported one or more gender harassment experiences and one hundred ninety-two (95%) reported one or more experiences of unwanted sexual attention. Sixty-six (32.7%) participants reported one or more experiences of sexual coercion. The percentage of participants in this study who reported sexual harassment experience on the total scale and on each of the SEQ subscales is greater than that reported in a previous study (Harned, 2000). Harned's

72 subscale results are compared to this study's results in Table 4. The reliability for the SEQ (*a* =.89) reported by Harned is comparable to the present findings (*a* = .90).

Thirty-one participants (15.3%) responded positively to one or more experiences which meet the criterion for the legal definition of rape in many states, i. e. "Made unwanted attempts to have sex with you that resulted in your pleading or physically struggling?" Twenty-five percent of Harned's (2000) sample reported having experienced attempted rape, but it is not clear whether this information was derived from the above question. In response to the self-report question on sexual harassment experience, "Have you ever been sexually harassed?" one hundred sixteen (57.4%) participants responded affirmatively. Harned did not include this item in the report of her study.

Participants scores on the self-objectification questionnaire ranged from -25 to +25, the full range of score possibilities. Higher scores represent higher degrees of self-objectification. The mean score for the sample in the current study, M = 4.17; SD =13.01was higher than the mean

(M = 0.82) reported by Fredrickson et al. (1998) in the study in which the scale was developed.

Participants scores on the silencing the self subscale of the Silencing the Self Scale (STSS) ranged from 8 – 37, M = 18.99, SD = 6.45, *a = .86.* The mean score for participants was lower than for the sample on which the scale was normed. On that sample of 63 female undergraduate students, M = 20.6, SD = 5.9, *a* = .78 (Jack & Dill, 1992).

Participants scores on the Internalized Shame Scale ranged from 6 – 70, M = 32.53, SD = 15.27 which seems comparable to those reported for the sample of 645 undergraduates, 68% of whom were female. In that sample in which for males, M = 31.9 and for females, M = 33.7, there was not a statistically significant difference by gender. A score of 50 or above

indicates painful levels of shame while scores of 60 and above are considered very high and likely to be associated with psychiatric symptoms.

Forty-three women (21.3%) scored above the cut off of 21 on the Eating Attitudes Test (EAT-26) indicating the need for an interview to screen for an eating disorder. The mean score for the EAT-26 rescored to detect disordered eating was 11.77 (S.D. = 9.98). For comparison, the following mean score norms were reported in a 1982 article on the psychometric properties of the EAT-26: for a group of females with anorexia restricting type, 38.4 (S.D. = 15), for a group of females with anorexia bulimic type, 33.7 (S.D. = 18.7), for a comparison group of female college students, 9.9 (S.D. = 9.2).

Table 3: Descriptive Statistics for Major Variables and Subscales

Variables	Range	Mean (SD)	Reliability
Sexual experience questionnaire (SEQ)	0 – 53	17.47 (11.26)	.90
Gender harassment	0 – 22	7.41 (4.18)	.78
Unwanted sexual attention	0 – 28	8.99 (6.26)	.88
Sexual coercion	0 – 20	1.07 (2.64)	.83
Self-reported sexual harassment	0 – 4	.85 (.96)	
Distress rating (DRSE)	0 - 82	31.14 (16.74)	.91
Gender harassment	0 - 25	12.16 (5.99)	.80
Unwanted sexual attention	0 - 34	16.51 (9.39)	.85
Sexual coercion	0 - 27	2.47 (4.94)	.87
Self Objectification (SOQ)	(-)25 – (+)25	4.17 (13.01)	n/a*
Self Silencing (SSTS)	8 – 37	18.99 (6.45)	.86
Internalized Shame (ISS)	6 – 70	32.53 (15.27)	.93
Disordered Eating Symptoms (EAT)	0 – 55	11.77 (9.98)	.90
Dieting	0 – 33	8.16 (7.13)	.86
Bulimia and Food Preoccupation	0 – 17	2.09 (3.06)	.77
Oral Control	0 – 13	1.51 (1.97)	.47
			.66**

*not available due to rank ordered measurement

**The alpha for the oral control subscale is .66 when using the full range of scores

As stated above, in this study the expected relationship between sexual harassment experience and disordered eating symptomatology was not found. However, correlations between subscales were found and are presented in the following section of this chapter. First, descriptive statistics for the subscales of the major variables will be presented in comparison to findings from previous research.

The frequencies in Table 4 show the percent of individuals who reported one or more incidents on each of the three subscales of the SEQ, comparing the current study to Harned, 2000. Harned's sample was composed of 195 undergraduate women enrolled in a psychology course at a mid-western university.

Table 4: Prevalence Ratings for SEQ Compared to 2000 Sample

Subscale SEQ-R	Current Study	Harned Study, Midwestern University
Gender Harassment	98%	88%
Unwanted Sexual Attention	95%	74%
Sexual Coercion	32.7%	14%

In Table 5, the subscale scores for the EAT-26 are compared to those for a sample of non-clinical controls on whom the scale was normed (Garner, 1982). First, the total EAT-26 scores for both the clinical and non-clinical samples on which the EAT-26 was normed are presented along with the total EAT-26 scores for the current sample: females with anorexia restricting type, M = 38.4 (S.D. = 15); females with anorexia, bulimic type, M = 33.7 (S.D. = 18.7); non-clinical female college students, M = 9.9 (S.D. = 9.2); current study, M = 11.77 (S.D. = 9.98).

Table 5: EAT-26 Subscale Means and Standard Deviations Compared to 1982 Sample

Subscale EAT-26	Current Study	1982 Female Comparison Group
Dieting	8.2 (7.13)	7.1 (7.2)
Bulimia and food preoccupation	2.1 (.07)	1.0 (2.1)
Oral control	1.5 (1.97)	1.9 (2.1)

Bivariate Correlation Analysis

Bivariate correlation analyses were used to test the first five hypotheses of this study. Two-tailed tests and an alpha level of .05 were used in these analyses. In Table 6 all correlations among the major variables are presented. Next, each hypothesis is restated after which the relevant results are described. As stated previously, bivariate correlations were run on subscales of the major variables and are included in this section even though these correlations are exploratory, to suggest directions for future research.

Table 6: Zero-ordered Correlation Matrix among Major Variables

Variables	1	2	3	4	5	6
1. SEQ		.819***	.040	.096	.120	.053
2. DRSE			.002	.079	.160*	.097
3. SOQ				.069	.037	.303***
4. SSTS					.326***	.183**
5. ISS						.335***
6. EAT-26 rescored (Correlation with EAT-26 is .924**)						

* p<.05, ** p<.01, *** p<.001

Hypothesis # 1. There will be a positive correlation between the level of sexual harassment experience and the level of disordered eating symptomatology. No statistically significant correlation was found between the SEQ Total Score and the EAT-26 Total Score (*r* =. 053, n.s.). Because the expected positive correlation between these two major variables was not found, correlations using subscales were run and are included in this chapter in Table 7.

Statistically significant positive correlations were found between the oral control subscale of the EAT-26 and the total SEQ. Furthermore, there were statistically significant positive correlations between the oral control subscale and two of the SEQ subscales, unwanted sexual attention and sexual coercion. Additionally, a statistically significant positive correlation was found between the single-item self-report criterion variable, "Have you ever been sexually harassed?" and the oral control subscale of the EAT-26.

Table 7: Correlations among Subscales of Major Variables

SEQ/EAT	Dieting	Bulimia	Oral Control
Gender harassment	.004	.069	.058
Distress rating GH	.097	.042	.068
Unwanted sexual attention	.055	.015	.151*
Distress rating USA	.108	.011	.144*
Sexual coercion	-.016	-.078	.159*
Distress rating SC	.011	-.122	.178*
Self-reported sexual harassment	.049	-.012	.198**

* p<.05, ** p<.01, *** p<.001

One of the unexpected findings of this study, the almost universal occurrence of sexual harassment experience, may help to explain the lack of a statistically significant relationship between sexual harassment experience and disordered eating symptomatology. To explore this possibility, three groups were created based on degree of sexual harassment experience, scores 0 – 11 = low (n=65), 12 – 19 = medium (n=67), and 20 – 53 = high (n=70). A One-Way ANOVA was run on SPSS 11.5 for windows using the tertiary split of SEQ scores as the independent variable and the EAT-26 total score (rescored to screen for eating disorders) as the dependent variable. No statistically significant between group differences were found ($F(2,199) = 2.084$, $p>.05$). However, a statistically significant between group difference was found using the full range of EAT-26 scores ($F(2,199) = 3.973$, $p<.05$). The research questions and data suggest that the full range of EAT-26 scores is a better indicator of disordered eating, the variable under consideration, than the rescored EAT-26 which screens for eating disorders according to DSM-IV diagnostic categories.

Post hoc tests indicate a statistically significant positive difference between the low ($M = 37.06$) and medium ($M = 45.53$) groups and a statistically significant negative difference between the medium and high ($M = 38.12$) groups. There was not a statistically significant difference between the low and high gender harassment groups on the EAT-26 as shown in Figure 2. Additional research is indicated to explain this curvilinear pattern.

The results of further ANOVA tests seem to support and further clarify this study's expectation of a relationship between sexual harassment and disordered eating symptomatology. Each subscale of the SEQ was divided into three groups paralleling the procedure used on the total scale. The gender harassment subscale group scores were divided as follows: 0 – 4 = low

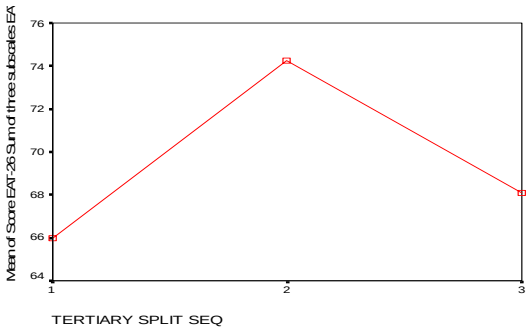

Figure 2: Tertiary split SEQ and EAT-26

gender harassment (n=52), 5 – 8 = medium gender harassment (n=77), and 9 – 22 = high gender harassment (n= 73). A statistically significant difference between groups was found based on level of gender harassment and each of the subscales of the SEQ. F scores, significance levels, and eta squared statistics are displayed in Table 8.

Table 8: Analysis of Variance (ANOVA): Gender Harassment Subscale as the Group Factor.

DEPENDENT VARIABLE (EAT-26 subscale)	F	Sig.	Eta Squared
Dieting subscale	6.224	.01	.059
Bulimia/ food preoccupation subscale	6.723	.001	.063
Oral control subscale	4.290	.05	.041

The curvilinear pattern presented above for the total SEQ and the total EAT-26 scores was found using the gender harassment subscale of the SEQ and each of the EAT-26 subscales; however, the pattern was markedly less evident with the oral control subscale as shown in Figure 3.

Figure 3: Tertiary split gender harassment subscale and oral control subscale

The unwanted sexual attention subscale was divided into three groups as follows: 0-5 =low unwanted sexual attention (n=66), 6 – 10 = medium unwanted sexual attention (n=61), and 11 – 28 = high unwanted sexual attention (n=75). No statistically significant between group differences were found for any of the EAT-26 subscales and the unwanted sexual attention subscale of the SEQ.

Similarly, the sexual coercion subscale was divided into three groups as follows: 0 = no sexual coercion (n=136), 1 – 2 = medium sexual coercion (n=45), and 3 – 20 = high sexual coercion (n=21). There was a statistically significant between group difference only for the oral control subscale ($F(2,199) = 4.103$, $p<.05$). Post hoc analyses indicated a statistically significant difference between no sexual coercion and high sexual coercion, but none between the no sexual coercion and low sexual coercion groups nor between the low and high groups. Part of this may result from the non-normal distribution of the sexual coercion subscale; however it is interesting to note that the relationship between the sexual coercion subscale which seems closest to sexual abuse relates to oral control. An additional interesting finding relating to the relationship between the sexual coercion and the oral control subscale which is depicted in Figure 4 is its linearity in contrast to the above described curvilinear relationships. This unilinear characteristic

may account for its being the only subscale that related to sexual harassment in the regression analyses as is shown in the last section of this chapter.

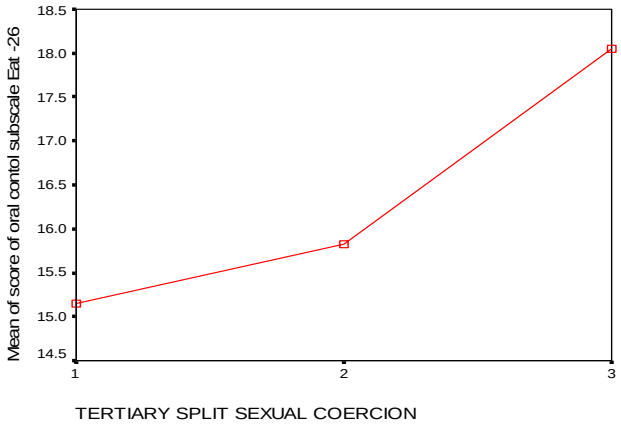

Figure 4: Tertiary split sexual coercion subscale and oral control subscale

Hypothesis # 2. There will be a positive correlation between the level of self-objectification and the level of disordered eating symptomatology. The level of self-objectification was positively correlated with the level of disordered eating symptomatology (r = .303, p <.001). Correlations between the S-OQ and the subscales of the EAT-26 were mixed. There was not a statistically significant correlation between the level of self-objectification and the oral control subscale of the EAT-26 (r = -.002, n.s.). There were statistically significant positive correlations between the dieting (r = .306, p <.001) and the bulimia and food preoccupation (r = .275, p <.001) subscales of the EAT-26.

Hypothesis # 3. There will be a positive correlation between the level of self-silencing and the level of disordered eating symptomatology. The level of self-silencing was positively correlated with the level of disordered eating symptomatology (*r = .183, p <.01).* Correlations between the STSS and the EAT-26 subscales varied as follows: oral control (*r = .040, n.s.),* dieting *(r* = .167, p <.05), bulimia and food preoccupation (r = .180, p <.05).

Hypothesis # 4. There will be a positive correlation between the level of internalized shame and the level of disordered eating symptomatology. The level of internalized shame was positively correlated with the level of disordered eating symptomatology (r = .335, p <.001). Correlations between the ISS and the EAT-26 subscales varied: oral control (r = .112, n.s.), dieting (r = .294, p <.001), bulimia and food preoccupation (r = .333,p <.001).

To further study this relationship, the full range of EAT-26 total score and each EAT-26 subscale were correlated with ISS scores. Although the magnitude of the relationship between ISS scores and the dieting subscale remained nearly the same (r = .292. p<.001), the other relationship magnitudes increased to (r = .371, p<.001) for ISS and the EAT-26 total score and to (r = .394, p<.001) for the ISS and bulimia and food preoccupation subscale. Moreover, the relationship between level of shame as measured by the ISS and the oral control subscale reached statistical significance (r = .224, p<.01).

Additional statistical analyses were done to illuminate the relationship between shame and the EAT-26 Total score and each subscale. The ISS scores were divided into low, medium, and high groups based on an equal tertiary split. One way ANOVAS were run using the shame groups as the independent variable and each subscale of the EAT-26 and the EAT-26 total score as dependent variables. Although, all ANOVA results were statistically significant as shown in Table 9, the strength of the relationship between shame and bulimia and food preoccupation was especially strong with ISS scores accounting for 13% of the variance in the subscale.

It is noteworthy that all relationships between ISS as measured in tertiary groups and the total score Eat-26 and its subscales are unilinear as can be seen in figures 5 – 8 below.

Hypothesis # 5. There will be positive correlations between the levels of internalized shame and a) sexual harassment, b) self-objectification, and c) self-silencing. No statistically significant

Table 9: Analysis of Variance (ANOVA): Internalized Shame Scores as the Group Factor.

DEPENDENT VARIABLE	F	SIG.	Eta Sqared
Score Eat-26	10.951	.001	.100
Dieting subscale Eat-26	6.106	.01	.058
Bulimia/ food preoccupation subscale Eat -26	14.826	.001	.131
Oral control subscale Eat-26	3.403	.05	.033

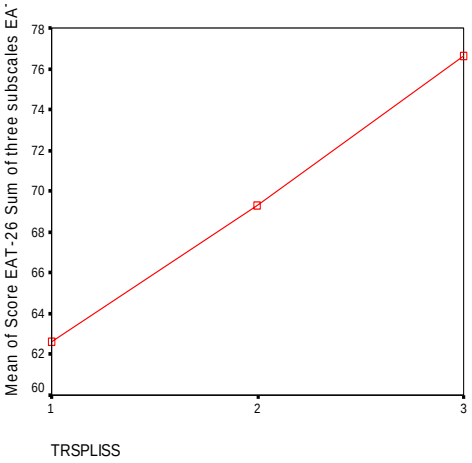

Figure 5. Shame and Eat-26

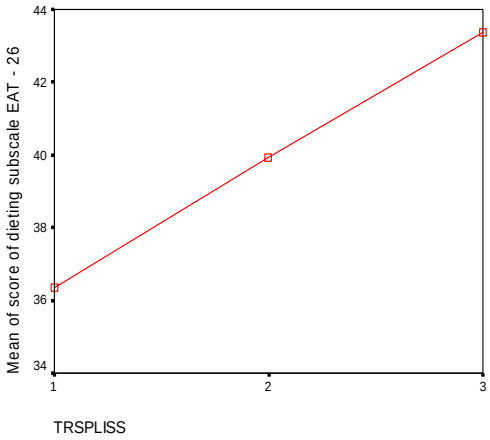

Figure 6: Shame and dieting subscale

correlation was found between the level of internalized shame and either sexual harassment (r = .120, n.s.) or self-objectification (r = .037, n.s.). There was a statistically significant positive relationship between the level of internalized shame and self-silencing (r = .326, p <.001).

Multivariate Analysis

Multivariate analyses were used to test hypotheses #6 and #7. Each hypothesis is restated before relevant findings are described. Multiple linear regression was conducted to test the research model relating the external experience of sexual harassment, the internal

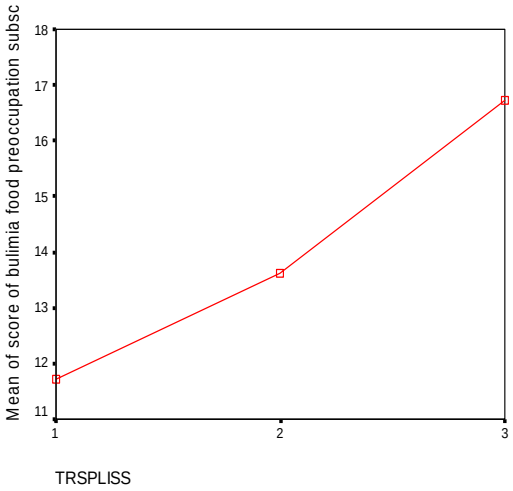

Figure 7: Shame and bulimia and food preoccupation subscale

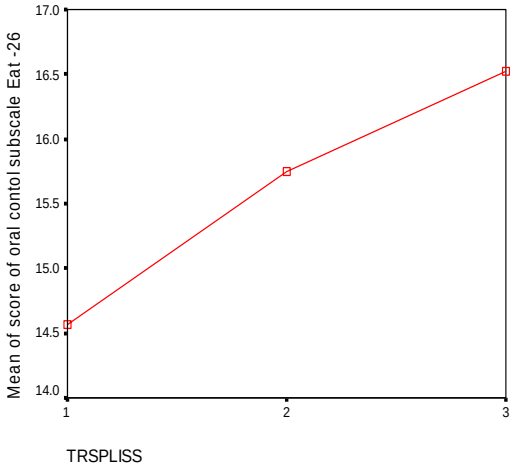

Figure 8: Shame and oral control subscale

reactions of self-objectification, self-silencing, and internalized shame with disordered eating symptomatology.

Hypothesis # 6. The package of independent variables including sexual harassment, self-objectification, self-silencing, and internalized shame will be statistically significant with regard to the level of disordered eating symptomatology. The package of independent variables was statistically significant with regard to the level of disordered eating symptomatology. A statistically significant regression equation was found ($F(4,194) = 11.771$, $p < .001$) with an R^2 of .243.

Hypothesis # 7. It is expected that while sexual harassment experience will predict disordered eating symptomatology, once self-objectification, self-silencing, and internalized shame are entered into the equation along with such experiences, it is the latter three that will be the primary predictors of disordered eating symptomatology. As stated previously, sexual harassment experience as measured by the SEQ did not predict disordered eating symptomatology as measured by the EAT-26. However, both internalized shame as measured

by the ISS and self-objectification as measured by the S-OQ were significant predictors of disordered eating symptomatology ($F(2,196) = 23.250$, $p < .001$).

Subjects predicted disordered eating symptomatology score was equal to 2.585 + .199 (ISS Score) +.217 (S-OQ Score). Subjects increased their EAT-26 score .199 for each point scored on ISS and .217 for each point scored on the S-OQ. Whereas both internalized shame and self-objectification were significant predictors of disordered eating symptomatology, scores on the SEQ and the STSS were not statistically significant predictors of disordered eating symptomatology.

In Table10 the results of multivariate analysis model testing are presented. First, predisposing demographic variables are analyzed in relation to disordered eating symptomatology. Next, the external factor of sexual harassment and the distress reaction rating about these experiences are added to the demographic data. Neither of these factors changes the amount of variance accounting for disordered eating symptomatology. Finally, the internal factors are included in the model, yielding considerable change in the R^2.

In order to more fully understand the significance of the subscale correlations, multiple regressions were run using the same model and methodology as in Table 10, but using each subscale of the EAT-26 as the dependent variable. These results are presented here in Tables 11, 12, and 13.

Table 10: Predictors of Disordered Eating Symptomatology

Independent variables	Stage 1		Stage 2		Stage 3	
	Beta	t-value	Beta	t-value	Beta	t-value
(Pre-disposing)						
Age	-.065	-.910	-.065	-.903	-.061	-.922
BMI	.032	.440	.032	.444	.045	.673
Education	-.021	-.144	-.014	-.098	-.011	-.084

Past treatment	.288	3.744***	.289	3.616***	.224	3.028**
Current treatment	.002	.031	.005	.065	-.026	-.373
(External factors)						
SEQ			.009	.112	-.023	-.315
Gender harassment						
Unwanted sexual attention						
Sexual coercion						
Self-reported sexual harassment						
DRSE			.022	.282	-.004	-.059
Gender harassment						
Unwanted sexual attention						
Sexual coercion						
Self-reported sexual harassment						
(Internal factors)						
S-OQ					.261	4.068***
SSTS					.059	.872
ISS					.282	4.166***
Model Testing	R^2=.082 F (5, 196) = 3.524**		R^2=.083 F (7,194) = 2.516**		R^2 =.243 F(10,191)=6.141***	

*p<.05, ** p<.01, *** p<.001

The results of the multiple regression on the dieting subscale strongly resemble the total EAT-26 scale results as would be expected based upon this subscale's large percentage of the total scale's variance. However the relative weight of ISS and S-OQ on the EAT-26 parallels the bulimia and food preoccupation subscale with the ISS having higher Betas and t-values than

Table 11: Predictors of Dieting Subscale of the EAT-26.

Independent variables	Stage 1		Stage 2		Stage 3	
	Beta	t-value	Beta	t-value	Beta	t-value
(Pre-disposing)						
Age	-.098	-.676	-.110	-.730	-.087	-.619
BMI	.057	.778	.073	.968	.082	1.166
Education	.006	.039	-.028	-.189	-.026	-.184

Past treatment	.257	3.289***		.273	3.347***		.208	2.728**
Current treatment	.025	.320		.021	.264		-.011	-.149
(External factors)								
SEQ								
Gender harassment				-.144	-1.184		-.186	-1.650
Unwanted sexual attention				-.053	- .319		.024	.156
Sexual coercion				-.152	- .982		-.236	-1.645
SELF-REPORTED SH				.084	.899		.082	.947
DRSE								
Gender Harassment				.128	1.150		.089	.857
Unwanted sexual attention				.085	.604		.059	.450
Sexual coercion				.128	.821		.165	1.143
(Internal factors)								
S-OQ							.262	3.960***
SSTS							.067	.951
ISS							.254	3.580***
Model Testing	R^2=.073			R^2=.104			R^2=.248	
	F (5,192) =3.043*			F (12,185) =1.784			F (15,182) =4.001***	
				F Change =.893, n.s.			F Change =11.635***	

* p<.05, ** p<.01, *** p<.001

the S-OQ. This is reversed on the dieting subscale with the S-OQ accounting for a slightly higher percentage of the variance. On the total EAT-26, and the dieting and bulimia subscales prior treatment is a significant predictor at each stage of the model. BMI is a significant predictor of the bulimia and food preoccupation and the oral control subscales at each stage of the models.

Table 12: Predictors of Bulimia and Food Preoccupation Subscale of the EAT-26

Independent variables	Stage 1		Stage 2		Stage 3	
	Beta	t-value	Beta	t-value	Beta	t-value
(Pre-disposing)						
Age	-.017	-.121	-.031	-.210	.013	.093
BMI	.218	3.056**	.199	2.706**	.210	3.201**
Education	-.094	-.666	-.087	-.593	-.115	-.848
Past treatment	.293	3.861***	.289	3.633***	.223	3.004**
Current treatment	-.007	-.089	-.005	-.069	-.035	-.498

(External factors)				
SEQ				
Gender harassment		.100	.841	.054 .487
Unwanted sexual attention		-.079	-.482	-.003 -.002
Sexual coercion		.029	.193	-.062 -.443
SELF-REPORTED SH		.002	.018	-.008 .099
DRSE				
Gender Harassment		.035	.320	-.012 -.116
Unwanted sexual attention		.018	.131	-.005 -.040
Sexual coercion		-.134	-.883	-.105 -.741
(Internal factors)				
S-OQ				.218 3.369***
SSTS				.100 1.445
ISS				.292 4.228***
Model Testing	R^2=.11	R^2=.128		R^2=.285
	F (5,195) = 4.814***	F (12,188) =2.299**		F (15,182)= 4.848***
		F Change = .558, n.s.		F Change =13.231***

* p<.05, ** p<.01, *** p<.001

In the oral control subscale previous treatment is not a predictor at any stage of the model. In Stages 2 and 3, the self-report of sexual harassment is a significant predictor even though the F Change between stages 1 and 2 and between stages 2 and 3 is not statistically significant. Neither of the internal variables, ISS and S-OQ, that were significant predictors of the total scale and the other subscales, is a significant predictor of the oral control subscale.

Table 13: Predictors of Oral Control Subscale of the EAT-26

Independent variables	Stage 1		Stage 2		Stage 3	
	Beta	t-value	Beta	t-value	Beta	t-value
(Pre-disposing)						
Age	.062	.445	.101	.709	.097	.677
BMI	-.375	-5.318***	-.375	-5.241***	-.378	-5.245***
Education	.081	.587	-.058	- .792	.024	.166
Past treatment	.086	1.155	.077	1.001	.065	.834
Current treatment	-.066	-.897	-.058	-.792	-.055	-.738
(External factors)						
SEQ						

Gender harassment	-.077	-.667	-.083	-.717
Unwanted sexual attention	-.031	-.196	-.024	-.149
Sexual coercion	.072	.491	.073	.496
SELF-REPORTED SH	.185	2.091*	.197	2.205*
DRSE				
Gender Harassment	-.072	-.684	-.100	-.933
Unwanted sexual attention	.136	1.021	.145	1.086
Sexual coercion	-.005	-.036	.015	-.102
(Internal factors)				
S-OQ			-.012	-.173
SSTS			-.057	-.785
ISS			.107	1.469
Model Testing	R^2=.14		R^2=.199	R^2=.209
	F (5,192) =6.687***		F (12,185) =3.833***	F (15,182) =3.208***
			F Change =1.677, n.s.	F Change = .765, n.s.

* p<.05, ** p<.01, *** p<.001

CHAPTER V

DISCUSSION

The purpose of this study was to examine the relationship between sexual harassment experience and disordered eating symptomatology from the vantage point of feminist theory. It was expected that a statistically significant positive relationship would be found and that the feminist constructs of self-silencing and self-objectification in addition to the psychodynamic concept of shame would help elucidate this relationship. Using multiple regression statistical analysis as planned in the research design, the expected relationship between sexual harassment experience and disordered eating symptomatology was not found. However, both shame as measured by the Internalized Shame Scale and self-objectification as measured by the Self-Objectification Questionnaire were statistically significant predictors of disordered eating symptomatology.

In this chapter measurement issues and theoretical hypotheses will be considered and discussed to clarify the study's results. Paralleling previous chapters, discussion will first center on each hypothesis. A section on the study's limitations will follow. Then, the relevance of this study's findings to social work practice will be presented. In conclusion, recommendations for future research will be offered.

Study Hypotheses

Discussion of the study's hypotheses will be presented in two sections. The first will deal with Hypotheses # 1-5 which were tested using bivariate correlations. This will be followed by a discussion of Hypotheses #6 and 7 which were tested using multiple regression analysis.

Bivariate Correlation Analysis

Hypothesis # 1: There will be a positive relationship between sexual harassment experience and the level of disordered eating symptomatology. As has already been discussed this hypothesis was not proved. There are several possible explanations for this including the finding of the curvilinear nature of the relationship presented in Chapter IV. It is possible that after a certain amount of sexual harassment experience, alternate responses supplant dieting attitudes and behavior, bulimia and food preoccupation and oral control as measured by the SEQ subscales. Such possibilities might include anger, dissociation, depression, acting out and/or other indices not measured in this study.

Another explanatory possibility may be related to measurement instruments. It is possible that questionnaire instruments may not be able to accurately assess problem eating in the way that interviews or direct observation might. It is possible that the social climate at a large public southern university stimulates norms regarding eating that exert a powerful influence on students. This may be especially true of sorority women who living and eating together may develop a group culture in which disordered eating is normalized. This group standard may confound the accuracy of questionnaires that measure disordered eating symptomatology. In spite of this caveat, there was variation in the presence and degree of support found for the study's hypotheses involving questionnaire instruments.

Hypothesis # 2 predicting a positive relationship between the level of self-objectification and the level of disordered eating was affirmed in this study; however the variation in subscale correlations is noteworthy. The positive correlations with both the dieting subscale and the bulimia and food preoccupation subscale were in the expected direction whereas the lack of a statistically significant correlation between the oral control subscale of the EAT-26 and the

S-OQ was unexpected. This unforeseen result may be explained from a feminist psychodynamic theoretical perspective.

Those participants who score high on oral control successfully exert power over their eating behavior and body size. In so doing they seem to use oral control behavior for self needs, to symbolically express issues of identify and separation rather than to serve the narcissistic needs of the other as viewer or gazer of an idealized object. Such questions as "Other people think I'm too thin" and "Feel that others would prefer if I ate more" seem to support this notion.

Reviewing pro-anorexia websites seems to further support the above described possibility. At these sites including www.BlueDragonFly.org and www.plagueangel.net, anorexia is viewed as a lifestyle choice, not as a disease from which to recover. Pro-anorectics do not view themselves as victims, rather they see themselves as individuals who are in control and striving for personal perfection.

This line of discussion is not to suggest that individuals who score high on oral control are anorectic, but to elucidate the nature of such thought patterns and defenses by looking at them in the most extreme form. Individuals who successfully adopt oral control defenses seem to defy the gender stereotypes of communal and social orientation suggested by Nolen-Hoeksema and Girgus (1994). Instead of cooperation and relationship maintenance focus, they develop a persistent self focus, both disregarding and caricaturing society's gender role expectations and overvaluation of thinness.

The results of hypothesis # 3, predicting a positive correlation between the level of self-silencing and the level of disordered eating symptomatology are similar to those described above in connection with hypothesis # 2. The positive relationships between the dieting subscale and

the food and bulimia subscale can be viewed from the standpoint of the impact of self-silencing on the sense of self. Silencing the self involves self-denial in the service of relationship.

As self needs in relationship are suppressed, they may be symbolically displaced onto food and body image as suggested by feminist psychodynamic social workers in "Eating Problems" (1994) supporting Polivy & Herman's (2002) contention that disordered eating symptoms are symbolic expressions of personal identity and control. The lack of a significant correlation between the silencing the self subscale and the oral control subscale seems to support the explanation outlined above regarding the use of oral control behavior and an extremely slender body for expressive self needs. This reasoning contradicts the findings of Geller, Cockell & Goldner (2000) who reported higher STSS scores for women with Anorexia Nervosa than for non-eating disordered psychiatric patients or for women with no eating disorder or other psychiatric diagnosis. It is possible that Geller et al.'s sample of AN patients were those for whom the anorectic ego-syntonic defenses were no longer working in a way that would allow them to serve the identity and control self functions described above.

The results of hypothesis # 4 predicting a positive relationship between the level of internalized shame and the level of disordered eating paralleled the relationships described above regarding hypotheses #2 and #3. The results suggest that the finding of a lack of relationship between shame and the condensed oral control scale reflects the societal value of *pride* rather than *shame* both in oral control and in a very thin body. The fact that a relationship is found between shame and oral control when the total range of scores is used may indicate that those who attempt oral control with less success, experience shame because of their failure to achieve idealized anorectic-like defenses, not because of the success of oral control.

The strength of the relationship between shame and the bulimia and food preoccupation subscale seems important. The positive strong relationship found in this study seems to offer partial support for Reindl's (2001) dual genesis thesis. She theorizes that shame internalized from childhood distress may predispose individual females to react to traumatic experiences in adolescence with bulimic behaviors and attitudes.

Hypothesis # 5 predicts that the levels of three variables, sexual harassment experience, self-objectification, and self-silencing will be positively correlated with the level of internalized shame. A statistically significant relationship was not found between either sexual harassment experience or self-objectification and shame. The expectation of a relationship between self-objectification and shame was based on Fredrickson & Robert's (1997) theory which predicted that shame would be a consequence of self-objectification.

This study's results tend to suggest that the influence of self-objectification on shame may be moderated by other factors, perhaps including cultural norms and relative success accruing in relationship to self-objectification. In other words, it is possible to understand the lack of a relationship between shame and self-objectification as a consequence of the normalization of self-objectification, perhaps especially in the sorority subculture from which much of this study's sample volunteered. When a self-objectified female experiences herself as esteemed by the dominant culture, she may similarly view herself based on her internalization of predominant cultural standards. Then, self-esteem and pride or conversely shame and disgrace would correlate with relative success or failure at achievement of internalized cultural ideals, not with the level of self-objectification.

Another way to conceptualize the lack of a relationship between internalized shame and self-objectification is to view the former as a measure that reflects "one's sense of self as a

unique and individuated person," (Adams & Marshall, 1996, p.431) and the latter as a measure that reflects one's "sense of mattering in the form of a social or collective identity" (Adams & Marshall, 1996, p.431) which would include gender. Although both aspects of identity would be multicausal, individual identity might be more influenced by individual and familial relationships whereas social identity might be more impacted by messages transmitted through language, institutions, and the media. The construct of a gendered identity is comparable to an ethnic, racial, or sexual orientation identity. An individual belonging to a socially devalued group might have a positive personal identity or high individual self esteem and a more problematic identity as a group member.

The differences in the relationships between shame scores and self-objectification scores and the EAT-26 subscale scores seem to support this possibility. Dieting which is almost normalized for females in our culture is almost equally influenced by self-objectification and shame. When S-OQ scores and ISS scores are regressed on the dieting subscale, the ISS scores account for .086 percent of the variance and the S-OQ scores for .07 percent. This contrasts with the bulimia and food preoccupation subscale where ISS scores account for .17 percent of the variance and the S-OQ scores for .058 percent. Dieting like self-objectification may be seen as a normative experience in this sample of primarily freshman, sophomore, and junior undergraduate students. In contrast, bulimia which may reflect greater pathology is more influenced by personal shame.

A third and related way to consider the negative finding regarding a relationship between self-objectification and shame is to examine the definition of each concept. Self-objectification as measured by the S-OQ can bring benefits and rewards in addition to problems to the individual who succeeds in achieving the objectified cultural ideal (Fredrickson & Roberts,

1997). Internalized shame as measured by the ISS reflects painful negative affect, deep feelings of inferiority with no upside resulting from moderating variables (Cook, 1994).

The expectation of a relationship between shame and sexual harassment was based on the expectation that the experience of sexual harassment would increase shame or self-directed negative affect as predicted by objectification and other feminist theorists (Fredrickson & Roberts, 1997; Smolak & Murnen, 2001). However, this expectation failed to consider the difference between *trait* and *state* shame.

Tangney (1996) distinguishes between *trait* and *state* emotions, describing the former in relationship to *disposition* or *character* and the later in relation to specific *situations* or *conditions*. The Internalized Shame Scale used in this study measures internalized or *trait shame,* "the more enduring or chronic results of frequent shame experiences over developmental time" (Cook, 1994, p. 8). Reindl (2001) elaborates on the development of trait shame as described by women recovering from bulimia. They recalled repeated, unrepaired experiences of emotional disconnection from their caretakers which led them to experience themselves as unworthy and unacceptable. Each internalized a sense of shame which was incorporated into her sense of self.

Although s*tate* sham*e* would be the expected consequence of a particular experience such as an incident of sexual harassment, internalized shame as measured by the ISS would be expected to affect the distress reaction of sexual harassment. In other words, the disposition to view one's self as unworthy would affect how one experiences a self deprecating incident. Supporting this expectation, statistically significant positive correlations between ISS scores and both the distress reaction to gender harassment subscale scores ($r = .188$, $p < .01$) and the total distress reaction to sexual experience scores ($r = .160$, $p < .05$) were found.

It is not clear why statistically significant positive relationships were not found between ISS scores and either the distress reaction of the unwanted sexual attention subscale (r =.102, p = .152) or the distress reaction of the sexual coercion subscale (r = .120, p = .091). Both of these relationships merit further study. It is possible that for high shame individuals the psychological reaction to unwanted sexual attention is confounded by the wish for attention. It is also possible that high shame individuals use denial, repression and avoidance to defend against experiencing distress in response to unwanted sexual attention and sexual coercion. Perhaps because these harassing experiences impact the individual's unique personal sense of self, they are more threatening than harassing experiences that affect one's social group or gendered identity.

As stated above Reindl's (2001) theoretical depiction of the development of bulimia nervosa received partial support in this study's finding of the relationship between internalized shame and disordered eating symptomatology. Based on her dual genesis theory, it was hypothesized that sexual harassment experience would contribute to the variance of bulimia and food preoccupation subscale scores over and above the contribution of internalized shame scale scores. However, this was not the case.

Neither the SEQ nor any of its subscales contributed to the variance of the subscale score. This was also true of the self-report of sexual harassment experience question and the question that addressed the experience that met the legal definition of rape in most states. Perhaps the paradigm depicted by Reindl applies to clinical populations and is moderated by other factors in non-clinical samples.

The relationship found between internalized shame and self-silencing was in the expected direction. However, self-silencing as measured by the STSS subscale was not a significant

predictor of disordered eating when entered into a multivariate analysis with the other internal factors in the model. This will be discussed in the multivariate analysis section of this chapter. It is interesting to note that mean self-silencing scores were lower for this sample than for the sample of sixty-three female undergraduates on which the STSS was normed in 1991. It is not clear if this difference reflects change in women's voices or a chance finding based on sampling error.

Multivariate Analysis

Hypothesis #6 which predicted that the package of independent variables including sexual harassment, self-objectification, self-silencing, and internalized shame would be statistically significant with regard to the level of disordered eating was supported; however, the results differed from expectations in two ways. First, silencing the self was not a significant predictor of disordered eating symptomatology. Perhaps its impact was eclipsed by the other internal variables as it was a less powerful measure being a subscale of a larger instrument. On the other hand, perhaps this effect resulted from its collinearity with shame as measured by the ISS. Both possibilities may be operating simultaneously.

Secondly, the fact that neither sexual harassment experience nor the distress reaction to sexual harassment experience were significant predictors of disordered eating symptomatology was a surprising finding, inconsistent with previous research. It is possible that the instrument used to measure disordered eating in this study was not as sensitive to sub clinical disordered eating as were the instruments used in previous research. Additionally, the use of only one instrument may have impeded replicating the results of these studies. Harned (2000) used three instruments to measure eating disorder symptomatology: a 16-item version of the Body Shape Questionnaire (BSQ; Evans & Dolan, 1993), the Eating Disorder Examination – Questionnaire

(EDE-Q; Beglin & Fairburn, 1992) and the Emotional Eating Scale (EES; Arnow, Kenardy, & Agras). Harned and Fitzgerald (2002) used the latter two instruments in their research.

The EAT-26 used in this study is widely used as a screening instrument in college age populations; however it may have been less effective in this research which was looking for less severe and more pervasive symptomatology. Additionally, the fact that one part of the EAT-26 was not administered in this study (see Appendix D) may have disadvantaged its effectiveness. Finally, the discrepancies in the subscales of the EAT-26 suggest that it may not be accurately and adequately capturing disordered eating symptomatology.

The dieting and bulimia and food preoccupation subscales seem to be measuring related constructs, both affected by the degree of self-objectification and the degree of shame. The oral control subscale, the psychometrically weakest in a non-clinical sample seems to be measuring a somewhat different dimension that is not similarly affected by the internal variables investigated in this study.

Those individuals who defend against unwanted sexual attention and sexual coercion with oral control defenses seem to minimize their experience of shame and self-objectification because they symbolically reject "bad feelings" and "bad objects" by keeping food, fat, and relationships away from their experience of self. Julia K. DePree's (2004) description of her sense of self during her struggle with Anorexia seems to affirm this possibility. "I became an empty purity: mercury in a glass thermometer, the edge of a white wing flying in blue space, a drift of clean snow, a white sheet hanging on a line," (p. 35). In her chapter, *Starving Body*, she describes an incident of sexual assault, which she speculates may have precipitated her relapse into weight loss. Using anorectic defenses, she seems to be able to isolate her experience of sexual coercion from her "pure" sense of self.

Kearney-Cook and Striegel-Moore (1994) describe a similar dynamic with childhood sexual abuse survivors with eating disorders.

> For the eating disordered client, regaining..safety..becomes associated with being able to restrict "bad" foods and only take in "good foods." Moreover, reestablishing control is associated with needing no one, with isolating oneself on an "anorexic island" with becoming a self-contained system…The need to be "perfect" to cover up the "badness"...becomes associated with being in complete control over one's appearance.., over one's needs and feelings.., and over one's relationships with others…Thus the eating disorder represents an effort to develop a positive sense of self (p. 307).

Although, the oral control scale is the only one associated with the unwanted sexual attention and sexual coercion subscales, it is interesting to note that when distress reaction to gender harassment is divided into low, medium, and high groups there is a statistically significant positive correlation only with the dieting subscale of the EAT-26 (r = .189, p <.01). To further explore this relationship, a multiple regression was run using the dieting subscale as the dependent variable and the distress reaction to gender harassment as an independent variable. A significant regression equation was found (F (1,197) = 6.697, p <.01). Distress reaction to gender harassment accounted for .033 percent of the variance in predicting the dieting subscale score. Scores on the ISS and the S-OQ accounted for .070 and .073 respectively.

Although gender harassment experience is not a direct significant predictor of the dieting subscale, it is a highly significant predictor of distress reaction to sexual harassment experience accounting for .359 percent of the variance. S-OQ scores do not make an additional contribution to the prediction and ISS scores add only .014 predictive value to the dependent variable. Other factors that might contribute to or mediate this relationship that are not in this study include

anger expression (Zaitsoff, Geller, & Srikameswaran, 2002) parental (Archibald et al., 2002l Botta & Dumlao; 2002, Dixon, Gill, & Adar, 2003; Tantillo & Sanftner, 2003), peer (Lieberman, M. et al., 2001), and institutional (Daigneault, 2000, Gaskill, D. & Sanders, F.,2000) support.

To reiterate, the oral control scale is the only subscale that has statistically significant correlations with other dimensions of sexual harassment experience including unwanted sexual attention (r = .155, p <.05), sexual coercion (r = .17, p <.05), and self reported sexual harassment (r = .179, p <.05). It is not clear why gender harassment is not correlated with oral control. It is possible that this is related to the omnipresence of gender harassment and/ or the oral controlling individual's use of defenses that dissociate her sense of self from gender harassment experiences or from gender itself. The fact that the scores on the S-OQ do not account for any of the variance in predicting the oral control scale seems to support the notion described above that for individuals high on oral control the body is used in the service of the subjective expressive self rather than as an object to serve the needs of other.

Hypothesis #7 predicting that the internal reactions of self-objectification, self-silencing, and internalized shame would be the primary predictors of disordered eating symptomatology was partially supported. As discussed above self-silencing was not a significant predictor of disordered eating symptomatology; however it was correlated with the total EAT-26 (r = .189, p <.01), and the dieting (r = .152, p <.05) and bulimia and food preoccupation subscales (r = .185, p <.01). This pattern was maintained with the rescored version of the EAT-26. This finding seems consistent with the research of Zaitsoff, Geller, and Srikameswaran (2002).

Zaitsoff, Geller, and Srikameswaran (2002) studied 235 non-clinical adolescents. They found that global self-esteem, which may be viewed as a reverse but equivalent measure to internalized shame, and shape and weight based self-esteem were the greatest predictors of

disordered eating symptoms. When they controlled for global self-esteem, they found that the additional variance accounted for by self-silencing using the full STSS scale was 3%.

Self-objectification and shame were statistically significant predictors of disordered eating symptomatology, contributing to the total EAT-26, the dieting, and the bulimia and food preoccupation subscales in similar proportions. These findings support previous research connecting both self-objectification and shame to disordered eating symptomatology (Fredrickson et al., 1998; Muehlenkamp & Saris-Baglama, 2002, Noll & Fredrickson, 1998; Slater & Tiggemann, 2002; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). The finding of the relationship between self-objectification and disordered eating symptomatology in conjunction with not finding a relationship between sexual harassment experience and disordered eating symptomatology may be viewed as support for Fredrickson & Robert's (1997) suggestion that even more than real life social encounters and the media portrayal of real life experience, the visual media's ubiquitous focus on female bodies, both as a whole and its parts may be the most damaging to females' subjective selves.

Several descriptive factors in this study's sample are noteworthy and point to directions for additional research. First, the discrepancy between SEQ information in which 99% of the sample recorded at least one experience of sexual harassment and the criterion variable question, "Have you ever been sexually harassed?" to which only 57.4% of the sample responded affirmatively requires some explanation. Most likely, this confirms the normalization and consequent denial of sexual harassment experience.

Bozzano (1998) found a relationship between self-silencing and sensitivity to subtle forms of sexual harassment. In hypothetical scenarios, the individuals who were more aware of sexual harassment took more action to deal with sexual harassment; however the actions they

chose were self-directed. They did not chose actions that were directed at changing either the abuser or the institutional context in which the harassment took place. Perhaps the relationship found in this study between oral control and sexual harassment experience supports Bozzano's findings. The lack of relationship between the other EAT-26 subscales and sexual harassment experience seems to support the possibility of normalization and denial described above.

Several differences between Harned's (2000) college sample and the current study raise questions. Twenty-five percent of Harned's sample reported having experienced attempted rape which contrasts with 15.3% for this study's sample. The reasons for this difference are not clear and contrast with the direction of difference regarding sexual harassment experience. The percentage of students who reported sexual harassment experience was far greater in this study than in Harned's for each subscale. The difference seemed especially strong on the sexual coercion scale: 32.7% versus 14%.

The difference between the EAT-26 subscale means in this study and the sample on which the instrument was normed in 1982 is remarkable. The mean on the oral control subscale was slightly less in the current study. In contrast, the mean on the dieting subscale was higher and the mean on the bulimia and food preoccupation subscale was much higher in the current study. The meanings of these differences are not clear, but suggest areas for future research.

Limitations

This study has several important limitations relating to sampling, design and measurement. The study's sample was drawn from one site and was purposive, rather than random, which limited its heterogeneity and therefore limits the generalizability of its results. Reflecting the student population at the public university from which it was recruited, the sample

consisted of predominantly white (89.6%) women. Over 65% of the sample was between 18 and 20 years of age. Over 50% of the study participants were freshmen and sophomores.

The methods used to recruit study participants did not promote diversity in the sample. Whereas 22% of undergraduate females participated in sororities in the fall semester 2003[2], over 36% of this study's sample were members of just one participating sorority. Sorority culture may promote the thin ideal more than other subcultures while simultaneously providing a nurturing environment to young women as they move from their families to more independence.

Over 40% of the full time students at the university are from families who reside either in the same county as the university or from the four nearby counties that encompass the region's largest metropolitan area. Living in relative geographic proximity to their families of origin combined with sorority status may have prejudiced the study's results. Additional bias may have resulted from the sample's skewness with regard to race, age and educational status.

This sample scored higher on both the dieting and bulimia and food preoccupation subscales than the college population on which the EAT-26 was normed (Garner, 1982). It is not clear if this reflects real increases in these types of disordered eating or if other factors are influencing these statistics. However, the biasing factors discussed above may be masking even more problematic disordered eating. Although approximately 79 percent of the study participants were in the normal weight range, there was a bimodal distribution of underweight and overweight in the remainder of the sample. Based on the EAT-26 subscores and the demographic factors discussed above, more disordered eating, overweight, and obesity may appear as the women in the sample age and become less dependent on sorority culture.

[2] UGA Fact Book 2003 describing fall 2003 student population, the closest to the population from which this sample was recruited in the spring and summer semesters 2003.

The cross sectional design limits understanding of causality among the variables under investigation. For example, the impact of preexisting shame on the relationship between sexual harassment experience and disordered eating may have been better illuminated with another design. The lack of a qualitative component is an additional limitation of this research. The choice to make the survey anonymous served to protect the study's participants, but precluded the possibility of follow-up interviews that might have provided more nuanced information regarding the study's complex concepts and relationships.

Additional limitations relate to measurement issues several of which have been mentioned previously. In spite of the S-OQ author's recommendation, this research did not use the Surveillance subscale of the Objectified Body Consciousness Scale. The OBSC has more stable psychometric properties than the S-OQ because it is based on a likert scale rather than on ranking. It has been used in previous research (Miner-Rubino et al., 2002) to supplement the S-OQ. This researcher's choice to not include the OBSC based on considerations of parsimony and the fact that the …" OBSC trades appearance concerns off with "comfort" whereas the TS-OQ trades appearance concerns off with "health & functioning"" (Fredrickson, B., e-mail, 11.05.03) is another limitation of this study as its addition might have provided useful information.

The use of the STSS subscale instead of the full scale may have minimized the true contribution of self-silencing to disordered eating symptomatology. The use of the ISS limited the study's findings to *trait* shame. Failure to use a measurement of *state* shame may account for the negative finding regarding the expected relationship between sexual harassment and shame as explicated earlier in this chapter.

The omission of the addendum to the EAT-26 may have precluded more accurate findings about the prevalence and levels of disordered eating among study participants. The use of only one instrument to measure the dependent variable seems to have contributed to a diminished understanding of disordered eating symptomatology in this sample. These measurement limitations may have weakened the strength of this research, diminishing its ability to shed light on the study variables and their interrelationships.

Implications for Social Work

In spite of its limitations, this study offers information of potential use to social work practitioners in the areas of clinical practice, social policy, and research. First, the amount of sexual harassment experience reported in this sample both reinforces and surpasses the expectation of the severity of the problem of sexual harassment experience among college age females. Consequently, this study supports recommendations regarding social workers' roles in prevention and treatment. These include raising awareness on individual, familial, and institutional levels about the insidiousness of sexual harassment experience.

Denial, normalization, and victim blaming have created a climate in which sexual harassment is underreported and over tolerated. The contrast between this study's findings and the university fact book report is striking. The fact book records eleven sex offenses and two incidences of stalking for the period January 1, 2002 – December 31, 2002. Even though this study inquired about sexual harassment from junior high school to the present, the discrepancies between the university records and the results of this study are disquieting.

Universities that highly value competitive male athletics such as the site of this study may unwittingly endorse macho culture and institutional sexism. Institutional sexism promotes an

atmosphere in which individual acts of harassment are tolerated to the detriment of females' well being. The objectification of women is implicitly sanctioned in macho cultures.

Greek life contributes to both sexual harassment (Winston, 2005) and disordered eating symptomatology (Wyler, 2003). Fraternities sponsor events which involve heavy alcohol consumption, known to contribute to sexual harassment and other forms of violence (Winston, 2005). It is possible that the high percentage of sorority members in this study's sample contributed to the high level of sexual harassment experience. A recent study at Duke University found that women who belonged to sororities were more likely to engage in disordered eating (Wyler, 2003). Trying to explain a similar finding at Lehigh University, the director of Women's studies suggested that women in sororities may be "trying to satisfy the image of beauty and sex appeal that fraternity brothers will praise," (Tapper, 2003). This analysis seems to affirm the relationship between the "objectified" thin ideal, valued in the Fraternity/Sorority culture and disordered eating corroborating the results of this research.

This study's finding of the relationship between self-objectification and disordered eating symptomatology confirms and solidifies existing knowledge. Social work clinicians have been leaders in working with clients with disordered eating problems and in developing feminist psychosocial theories and treatment models (Bloom et al., 1994). This study lends support to these theories and models which relate the cultural treatment of women to self-objectification, shame, and disordered eating symptomatology. Social work practitioners can continue to be leaders in promoting psychosocial treatment models in clinical work with individuals, families, and groups.

Social workers have a long history of group work in various settings. Beginning with immigrant and impoverished groups in the settlement house movement, social work groups have had

> "a similar focus and process: to gather people together and provide the opportunity to share their experiences, be heard, understood, appreciated by each other, offer input, learn, organize, and empower each other to make changes for their own lives, their families, their organizations, their communities, and for society as a whole,"(Gagerman, 2004).

Social workers could serve university communities on the group work level by providing a variety of groups to empower individuals and to improve understanding and cooperation between genders, thereby enhancing the lives of individuals and the quality of communal living.

Social workers can contribute to working against institutional sexism in secondary school and university settings as they have in the past (Linn, 1999). Social work community organization skills could be enlisted to raise community consciousness about the problems inherent in macho cultures. Moreover, social work methods and values emphasizing stakeholder involvement, coalition building, and self-determination could support communities in the development of cultural norms valuing equal human rights and denouncing institutional sexism and other forms of bias that privilege some individuals and groups and disadvantage others. Since competitive athletics and Greek life benefit both individual students and the community at large, elite athletes, athletic departments and fraternities and sororities would be among the stakeholders that social workers could involve in organizing to change cultural norms.

The results of this study offer compelling support for social work involvement with social policy issues that impact sexual harassment. Based on the requisite skills and social justice

values, social workers should participate at both the institutional and governmental levels. By changing cultural norms from the current levels of acceptance and minimization to vehement intolerance of and accountability for sexual harassment, all forms of gendered violence may lessen. Moreover, other forms of violence against minority groups may decrease. Social workers have the potential to assume a leadership role in building alliances with other disciplines including counseling, education, law, and women's studies to develop and enforce sexual harassment policies.

Likewise, social workers could be instrumental in organizing coalitions to change policies that affect disordered eating symptomatology. Promotion of self-attuned eating and self-caring exercise has the potential to impact health and to avert disordered eating behaviors which increase the risk of developing health problems. Perhaps social work departments could unite with health promotion and communication departments to redefine health proactively in relation to lifestyle rather than accepting the current dichotomous paradigm of health versus illness. This approach would deal with both ends of the disordered eating and body image continuum simultaneously addressing problems of restricting and over eating and under and over exercising that result in the unhealthy BMI extremes seen in the bimodal distribution in this study's sample.

In a similar vein, social workers in various settings including institutions of higher learning have a role to play in consciousness raising regarding standards of beauty and the relationship between the idealization of thinness and disordered eating. Sypeck, Gray, and Ahrens (2004) studied the pattern of fashion magazines from 1959 – 1999. Previous studies had investigated the weights of models, but the focus had been on Playboy centerfolds and Miss America contestants. The authors surmised that females would be more exposed to and influenced by fashion magazines. They found a significant decrease in body size during the

1980's and 1990's contributing to the thin ideal. Three additional findings contribute to the objectification of women. There were many more full body portrayals in contrast to previous images of faces and torsos. There was a striking increase in the revealing nature of the models' clothing. Finally, magazine circulation had increased markedly over the last forty years. Thus, females are exposed to myriad images of full bodies of very thin women in revealing clothes, increasing their vulnerability to self-objectification and disordered eating symptomatology.

Recently a bill was introduced into the Israeli Knesset to discourage glamorizing the thin ideal. The bill's sponsor recognized a connection between eating disorders in models and promotion of the "skinny" ideal. According to the sponsor's proposal, models would have to pass a health screening including BMI testing. Modeling agencies would not be permitted to hire models whose BMI's are under eighteen (Rubenstein, 2005). Social workers could be leaders in advocacy programs to bring similar messages to the attention of institutions and the public.

Feminist values dovetail with social work values around the issue of the objectification of women. Both deplore the devaluation or dehumanization of any group of people; both deplore the disregard of any groups' human rights. Social work's commitment to a strengths perspective dovetails with feminist empowerment ideology. Perhaps based on shared values and ideology, social workers could work together with feminists against the continuing objectification of women.

Social work has additional roles to consider in working with individuals and families. Although this study did not find the relationship between sexual harassment and disordered eating that Harned (2000) had, her results are relevant to social work goals and treatment. She found that post-traumatic stress, anxiety and their interaction with sexual harassment moderated the relationship between sexual harassment and disordered eating. "…[W]omen with low levels

of co morbid distress remained below the mean on the eating disorder composite variable, even at high levels of harassment"(p. 344). This research confirms the need for social work prevention and treatment efforts to focus on individual, familial and societal issues that contribute to individual females' self devaluation and depreciation. In individual and family work, it is important for social workers to be mindful of gender issues to proactively support human equal rights.

Recommendations for Future Research

Recommendations for future research include university wide studies of sexual harassment, disordered eating, and their relationship. The discrepancy between this study's findings and the information in the University fact book indicate the need for a more complete university wide survey of sexual harassment experience. Similarly, the results of this study support the need for a study of disordered eating. According to the lead investigator of a 2003 study of eating disorders at Duke University, there had not been any prior studies of eating disorders that surveyed entire undergraduate populations (Wyler, 2003). Based on many factors already enumerated, a reexamination of the relationship between sexual harassment and disordered eating using additional measurements of disordered eating symptomatology is recommended.

Studies of each of the major variables and the relationship between them should be undertaken with diverse populations in order to understand the scope of each problem and their interrelationship more fully. Such studies might help illuminate factors that both stimulate and minimize each problem and the connection between them. For example, do regional differences account for the disparate findings between this study and Harned's (2000) study of Midwestern

college students? How might Northeastern, Southwestern and Western campuses compare? How would results compare at historically Black colleges or at women's colleges?

Although Harned and Fitzgerald (2002) studied the relationship between sexual harassment and disordered eating symptomatology among women who had been involved in a class action suit against a single employer and in military women, studying older women in other contexts is recommended. How do diverse organizational cultures impact disordered eating, sexual harassment and their relationship? For example, would findings be the same in cultures that have traditionally been dominated by a single gender such as fire departments and elementary schools? Would findings be comparable in organizations based on spiritual values and religious ideology? Would diverse religious values and/ or power relations in religious organizations impact results?

Since shame and self-objectification were statistically significant predictors of both the dieting and bulimia and food preoccupation subscales of the EAT-26, examination of these internal factors in younger populations of females is recommended to understand more about the timing of the internalization of these variables. This information could be useful in developing and implementing prevention programs. Additionally, longitudinal research that studies females' experience of sexual harassment, self-objectification, shame and disordered eating symptomatology is recommended to ameliorate treatment and prevention efforts. Research on strategies to lessen sexual harassment seems mandatory to support females' safety and self-actualization. This research should consider primary, secondary and tertiary prevention strategies on micro, mezzo and macro system levels.

Future research should expand upon the treatment model in this study which accounted for approximately 25% of the variance in predicting disordered eating symptomatology as measured by the EAT-26 full scale. Such internal factors as anger including trait anger and anger expression, anxiety, coping styles, perceived mutuality with each parent, and post traumatic stress have influenced disordered eating symptomatology in previous research (Bekker & Boselie, 2002; Ghaderi, 2003; Hahn-Smith & Smith, 2001; Harned & Fitzgerald, 2002; Pivan & Thompson, 2004; Tantillo & Sanftner, 2003; Zaitsoff, Geller, & Srikameswaran, 2002) and might add precision and predictive value to the model used in this study.

Future research on factors that promote resiliency in females with specific focus on psychological reaction to sexual harassment, self-objectification, and shame is recommended. It is expected that parental and other adult relationships of perceived mutuality will be strong influences in the model. These relationships involve mutual empathy and result in feelings of individual and relational empowerment. They are:

> characterized by and lead to (a) increased knowledge about oneself and the other(s), (b) self-worth and validation, (c) zest and vitality,
>
> (d) the ability to act on behalf of oneself and others, and (e) the desire for connection with others beyond the immediate interaction (Tantillo & Sanftner, 2003, p. 350).

Additionally based on previous research (Lieberman et al., 2001) supportive relationships among peers would be expected to promote resiliency and self-esteem in females and add further to the predictive value of the model proposed in this study.

Environments that nurture relationships of mutuality would be expected to make a significant contribution to the well-being of females. Bergman and Surrey (1997) developed a workshop entitled “New Visions of the Male-Female Relationship: Creating Mutuality.”

Although initially used in working with adults, they adapted the model for four year olds. Bergman and Surrey reported a shift in gender relationships as a result of the workshop experience. There was more interconnected play between boys and girls and "no more hierarchical patterns among the boys" (p. 284).

This study's findings contribute to previous research (Harned, 2000; Harned & Fitzgerald, 2002) in stressing the importance of investigating the influence of institutional and societal factors and their impact on individuals in relationship to both sexual harassment and disordered eating. Acts of sexual harassment flourish when three conditions are met: "risk to victims for complaining, the likelihood that their complaints will not be taken seriously, and the probability that offenders will not be sanctioned in any meaningful way," (Fitzgerald, Gelfand, & Dragow, 1995, p. 439). Research on these conditions, in specific institutions being studied including in early, secondary, and higher educational institutions, seems imperative. Finally, research on broad policy issues that relate to disordered eating symptomatology specifically and gender attitudes in general seems essential for the promotion of health and security in females.

Conclusion

In conclusion, this study's findings support and extend previous research on the prevalence of sexual harassment experience among college age women. Sexual harassment seems to be an almost universal experience. Also, this study confirmed previous researchers' findings on the prevalence of disordered eating symptomatology. Although the results of this research did not cohere with previous studies of the relationship between sexual harassment and disordered eating, the finding of the relationship between shame, self-objectification and disordered eating symptoms fit together with the results of previous research and strengthens Harned's plea to examine and change social conditions that impede self-actualization in females.

This challenge presents an opportunity for which the Social Work profession is well suited based on its social justice mission and values, its treatment model, and its client base. When social conditions do not support the self actualization of females, families, institutions, and society at large are deprived of the potential contributions ofhalf of its citizenry. Although Jane Addams was referring to the poor in her famous statement, her wise words seem equally apt here.

> The good we secure for ourselves is precarious and uncertain until it is secured for all of us and incorporated into our common life.

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APPENDIX A

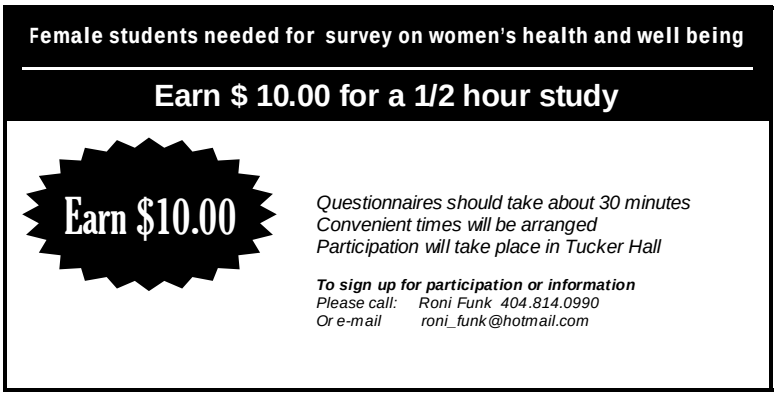
MATERIALS FOR RECRUITING PARTICIPANTS:

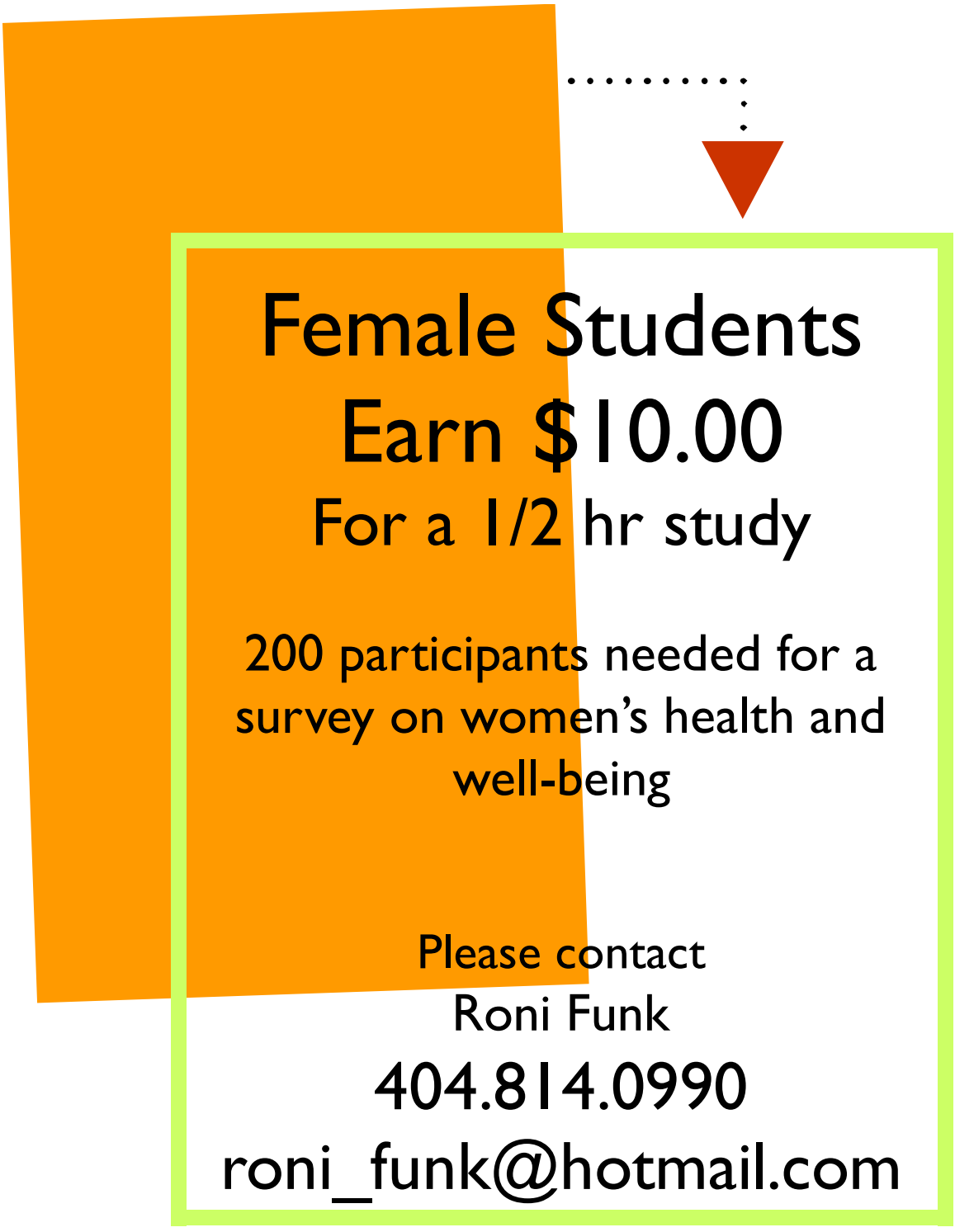
ADVERTISEMENT, POSTER, AND

SIGNUP SHEET

ADVERTISEMENT TO RECRUIT STUDY PARTICIPANTS

To be placed in Student Newspaper





Female Students Earn $10.00

For a 1/2 hr study

200 participants needed for a survey on women's health and well-being

Please contact
Roni Funk
404.814.0990
roni_funk@hotmail.com

WOMEN'S HEALTH AND WELL-BEING STUDY

SIGN UP SHEET

Date/Time		Name	E-mail address
June 1 5	2:00	1.	
June 1 5	2:00	2.	
June 1 5	2:00	3.	
June 1 5	2:00	4.	
June 1 5	2:00	5.	
June 1 5	2:00	6.	
June 1 5	2:00	7.	
June 1 5	2:00	8.	
June 1 5	2:00	9.	
June 15	2:00	10.	
June 15	2:30	11.	
June 1 5	2:30	12.	
June 15	2:30	13.	
June 1 5	2:30	14.	
June 15	2:30	15.	
June 1 5	2:30	16.	
June 1 5	2:30	17.	
June 15	2:30	18.	
June 1 5	2:30	19.	
June 1 5	2:30	20.	
June 15	3:00	21.	
June 1 5	3:00	22.	
June 1 5	3:00	23.	
June 1 5	3:00	24.	
June 1 5	3:00	25.	
June 15	3:00	26.	
June 1 5	3:00	27.	
June 1 5	3:00	28.	
June 15	3:00	29.	
June 15	3:00	30.	

APPENDIX B

INFORMED CONSENT FORM

Informed Consent Form

College Women's Health and Well-Being

Eating and body issues
Uncomfortable feelings
Potentially upsetting experiences

You are invited to participate in a study of the relationship between upsetting experiences and eating issues in college age females. The purpose of this study is to find out more about the factors that influence this relationship. Your participation will provide us with useful information on this topic, which may be helpful to college age females in the future. My name is Roni Funk and I am a doctoral student at the University Of Georgia School of Social Work. This study is in partial fulfillment of the requirements for my Ph.D. degree in Social Work.

Your participation will involve filling out a 13-page questionnaire that should take twenty – thirty minutes or less to complete. All your answers will be anonymous. Your name will not be attached to your completed questionnaire. There will be no way for questionnaire answers to be identified with any individual study participants. These consent forms will be available only to the investigator. You will receive $10.00 when your completed questionnaire is returned to me. You may complete the questionnaire in a classroom setting at one of several times during Spring or Summer semester, 2004.

Although there are no foreseeable risks to study participants, the questionnaire deals with potentially uncomfortable feelings and upsetting experiences. Some people experience negative emotions when recalling these issues. If you would like to talk to someone, counselors are available at Health Services, 370 River Road (beside Ramsey), 542.2273. Full time students who have paid health fees receive six free visits. All students are seen on a walk in basis and are offered an appointment that day.

When you are reading this form, please feel free to ask me any questions you have about the study. If you have additional questions later, please contact me at 404.814.0990 or roni_funk@hotmail.com and I will be happy to answer them. My faculty advisor is Dr. Nancy Kropf, 706.542.6777.

You will be offered a copy of this form to keep. These forms will be destroyed six months after the research is complete. Then, there will be no record of the names of study participants.

You are making a decision whether or not to participate in this study. Your signature indicates that you have read the information provided above and have decided to participate. You may choose to discontinue participation at any time prior to returning the questionnaire to the investigator; however once you have turned in your questionnaire, you will not be able to decline participation, as it will not be identifiable as yours.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu

APPENDIX C

QUESTIONNAIRE

COLLEGE WOMEN'S HEALTH AND WELL-BEING

DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRES

College Women's Health and Well-Being:

Eating and body issues
Uncomfortable feelings
Potentially upsetting experiences

The following measures address various aspects of college women's attitudes, ideas, and experiences relationships, with food, eating, their bodies, and distressing experiences. All information will be used for research purposes only and will be anonymous. There will be no way to associate individual questionnaires with individual participants. Please fill out all questions.

This part of the questionnaire addresses the ways in which you think about and act in the relationships you have with close friends, family, and significant others

Your Attitudes and Behaviors in Close Relationships

Please answer the following questions. Using the scale below, for each item, circle the *numerical* response that best reflects your answer to the below questions. Circle only one number for each item.

1. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

2. When my partner's needs and feelings conflict with my own, I always state mine clearly.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

3. Instead of risking confrontations in close relationships, I would rather not rock the boat.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

4. I speak my feelings with my partner, even when it leads to problems or disagreements.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

5. When my partner's needs or opinions conflict with mine, rather then asserting my own point of view I usually end up agreeing with him/her.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

6. I rarely express my anger at those close to me.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

7. I think it is better to keep my feelings to myself when they do conflict with my partner's.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

8. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

Your Thoughts About Your Body

This part of the questionnaire addresses your attitudes and beliefs about your body.

INSTRUCTIONS: The below question identifies 10 different bodily attributes. We would like you to rank order these body attributes from that which has the greatest impact on your physical self-concept to that which has the least impact on your physical self-concept. Please make sure you only use each numerical rating only once.

NOTE: It does not matter how you describe yourself in terms of each attribute. For example, fitness level can have a great impact on your physical self-concept regardless of whether you consider yourself to be physically fit, not physically fit, or any level in between.

Please first read over all of the attributes. Then, record your rank by writing the letter of the attribute.

WHEN CONSIDERING YOUR PHYSICAL SELF-CONCEPT, HOW IMPORTANT IS…

a. Physical coordination?	f. Physical attractiveness?
b. Health?	g. Energy level (e.g. stamina)?
c. Weight?	h. Firm/sculpted muscles?
d. Strength?	i. Physical fitness
e. Sex appeal?	j. Measurements (e.g. chest, waist, hips)?

ATTRIBUTE RATING

Insert attribute letter, e.g. "a" for attribute "Physical coordination" next to appropriate importance rating

MOST IMPORTANT.....…….... _____	SIXTH MOST IMPORTANT..... _____
SECOND MOST IMPORTANT.. _____	SEVENTH MOST IMPORTANT... _____
THIRD MOST IMPORTANT..... _____	EIGHTH MOST IMPORTANT..... _____
FOURTH MOST IMPORTANT..... _____	NINTH MOST IMPORTANT..... _____
FIFTH MOST IMPORTANT..... _____	LEAST IMPORTANT..... _____

Your Thoughts on Food and Eating
This part of the questionnaire addresses your ideas, feelings, and beliefs re: food, eating, and weight. **Please answer the following questions. Using the scale below, for each item, circle the *numerical* response that <u>best</u> reflects your answer to the below questions. Circle only <u>one</u> number for each item.**

1. Am terrified about being overweight.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

2. Avoid eating when I am hungry.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

3. Find myself preoccupied with food.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

4. Have gone on eating binges where I feel that I may not be able to stop.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

5. Cut my food into small pieces.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

6. Aware of the caloric content of the foods that I eat.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

7. Particularly avoid food with high carbohydrate content (i.e. bread, rice, potatoes, etc.)

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

8. Feel that others would prefer I ate more.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

9. Vomit after I have eaten.

1	2	3	4	5	6

10. Feel extremely guilty after eating.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

11. Am preoccupied with a desire to be thinner.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

12. Think about burning up calories when I exercise.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

13. Other people think that I am too thin.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

14. Am preoccupied with the thought of having fat on my body.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

15. Take longer than others to eat my meals.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

16. Avoid foods with sugar in them.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

17. Eat diet foods.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

18. Feel that food controls my life.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

19. Display self-control around food.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

20. Feel that others pressure me to eat.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

21. Give too much time and thought to food.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

22. Feel uncomfortable after eating sweets.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

23. Engage in dieting behavior.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

24. Like my stomach to be empty.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

25. Enjoy trying new rich foods.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

26. Have the impulse for vomit after meals.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Usually	Always

Uncomfortable Feelings
This part of the questionnaire lists statements describing feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find these statements describe the way you feel a good deal of the time, it can be painful just reading them. Please try to be as honest as you can when responding to the below statements. **<u>INSTRUCTIONS</u>: Please read each item carefully. Using the scale below, for each item, circle the *numerical* response that <u>best</u> indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Circle only <u>one</u> number for each item and PLEASE DO NOT omit any items.**

1. I feel like I am never quite good enough.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

2. I feel somehow left out.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

3. I think that people look down on me.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

4. All in all, I am inclined to feel that I am a success.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

5. I scold myself and put myself down.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

6. I feel insecure about others opinions of me.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

7. Compared to other people, I feel like I somehow never measure up.

0	**1**	**2**	**3**	**4**
Never	Seldom	Sometimes	Often	Almost Always

8. I see myself as being very small and insignificant.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

9. I feel I have much to be proud of.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

10. I feel intensely inadequate and full of self doubt.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

12. When I compare myself to others I am just not as important.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

13. I have an overpowering dread that my faults will be revealed in front of others.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

14. I feel I have a number of good qualities.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

15. I see myself striving for perfection only to continually fall short.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

16. I think others are able to see my defects.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

17. I could beat myself over the head with a club when I make a mistake.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

18. On the whole I am satisfied with myself.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

19. I would like to shrink away when I make a mistake.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

20. I replay painful events over and over in my mind until I am overwhelmed.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

21. I feel I am a person of worth at least on an equal plane with others.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

22. At times I feel like I will break into a thousand pieces.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

23. I feel as if I have lost control over my body functions and my feelings.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

24. Sometimes I feel no bigger than a pea.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

25. At times I feel so exposed that I wish the earth would open up and swallow me.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

26. I have this painful gap within me that I have not been able to fill.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

27. I feel empty and unfulfilled.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

28. I take a positive attitude toward myself.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

29. My loneliness is more like emptiness.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

30. I feel like there is something missing.

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

Uncomfortable Experiences
In this part of the questionnaire, we would like to know more specifically about your experiences. These experiences could have occurred in the work place, academic, and/or social settings at any time during or since Junior high school. Moreover, these experiences could have been initiated by: male supervisors, coworkers, teachers/professors, and/or peers. Please answer as frankly and completely as you can. ***Again, all your answers are anonymous.*** **Please read each item carefully. Using the scale below, for each item, circle the *numerical* response that most closely describes your own experience. Circle only <u>one</u> number for each item and DO NOT omit any items.**
AT ANY TIME, SINCE AND INCLUDING JUNIOR HIGH SCHOOL, have you been in a situation where any of your male supervisors, coworkers, teachers/professors, and/or peers:

a) Habitually told suggestive stories or offensive jokes?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

b) Made unwanted attempts to draw you into a discussion of personal or sexual matters (e.g., attempted to discuss or comment on your sex life)?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

c) Made crude and offensive sexual remarks, either publicly or to you privately?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

d) Made offensive remarks about your appearance, body, or sexual activities?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

e) Gave you unwanted sexual attention?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

f) Was staring, leering, or ogling you in a way that made you feel uncomfortable?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

g) Attempted to establish a romantic or sexual relationship despite your efforts to discourage him?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

h) Displayed, used, or distributed sexist or suggestive materials (e.g., pictures, stories, or pornography)?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

i) Frequently made sexist remarks (e.g. suggested that women are too emotional to be scientists, or to assume leadership roles)?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times

IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

j) Have continued to ask you for dates, drinks, dinner, etc. even though you have said no?

0	1	2	3	4
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

k) Made you feel like you were being subtly bribed with some sort of reward or special treatment to engage in sexual behavior?

0	1	2	3	4
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

l) Made you feel subtly threatened with some sort of retaliation for not being sexually cooperative (e,g., the mention of an upcoming evaluation review, etc.)?

0	1	2	3	4
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

m) Touched you (e.g., laid a hand on your bare arm, put an arm around your shoulders, etc.) in a way that made you feel uncomfortable?

0	1	2	3	4
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

n) Made unwanted attempts to stroke or fondle you (e.g., stroking your leg or neck, touching your breast, etc.)?

0	1	2	3	4
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

o) Made unwanted attempts to have sex with you that resulted in your pleading or physically struggling?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

p) Implied faster promotions or better treatment if you were sexually cooperative?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

q) Made it necessary for you to respond positively to sexual or social invitations?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

r) Made you afraid that you would be treated poorly if you didn't cooperate sexually?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

s) Treated you badly for refusing to have sex with a coworker or supervisor?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times
IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

t) Have you ever been sexually harassed?

0	**1**	**2**	**3**	**4**
Never	Once or twice	Sometimes	Often	Many times

IF AT LEAST ONCE, how much did this bother you?				
1	2	3	4	5
Not at all	Slightly	Somewhat	Very Much	Extremely

APPENDIX D

BEHAVIORAL SCREENING QUESTIONS

Please answer the following demographic questions. For each item, fill in the blank or check your response choice. Check only one choice for each item.

All information will be anonymous.

1. What is your age? _____ years

2. Education: (Please check one)

O Freshman	O Sophomore	O Junior	O Senior	O Grad Student	O Other _____

3. Ethnic/Racial Group: (Please check one and describe if Other)

O African American	O Asian American	O Caucasian	O Hispanic	O American Indian	O Other _____

4. What is your current weight _____ pounds

5. What is your current height _____ feet _____inches

6. Have you ever been treated for an eating disorder? ____yes ____no

7. Are you currently being treated for an eating disorder ____yes ____ no