EMPOWERMENT, FEMINISM AND SELF-EFFICACY: RELATIONSHIPS WITH
DISORDERED BODY IMAGE AND EATING

A Thesis
by
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FOREWORD

This thesis is written in accordance with the style of the *Publication Manual of the American Psychological Association (5th Edition)* as required by the Department of Psychology at Appalachian State University

I would like to thank my thesis chair, Dr. Curtin, for being supportive in a big way with this process, as she made it all seem quite manageable. Truly, I cannot say enough good things about her, and I am very grateful for the opportunity to work together. I would also like to thank my committee who made this process possible and were supportive throughout. Additional thanks go out to my cohort (Laura, Greg, Martha, Chelsea, Michael, Jared and Ina -- potentially the greatest cohort a person could have), who helped me to keep heart and who listened to my frequent ranting with little complaint. Thanks to my research assistants Jenny and Marie for filling out the many, many, many pink and yellow slips so that I didn't have to. Certainly, my parents and Meghan made a pretty awesome contribution with regard to emotional support and interest in my topic. Also thanks to my Raleigh family, for giving me a home away from home, and a place to go decompress while soaking up the air conditioning. Lots of love to my friends for reminding me that grad school isn't my life (no matter how it feels), which I needed to be reminded of often. Further appreciative statements go out to Krycek for sitting with me through most of this, and only distracting me a little. And, of course, my utmost appreciation goes to John for all the support and all the dinners he made, and for making it all so much easier for me. He's the best around!

Empowerment, Feminism and Self-Efficacy:

Relationships with Disordered Body Image and Eating

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Abstract

Eating disorders are prevalent in the United States, relate to significant psychological and health problems, and primarily affect women. Sociocultural norms pertaining to an ideal of thinness for women are considered central in the development of disordered eating and disturbed body image. On the other hand, adoption of a feministic ideology, empowerment and self-efficacy are thought to have protective value with regards to body image and eating behavior. Undergraduate women ($n = 184$) enrolled in psychology classes completed self-report measures of feminism, empowerment, self-efficacy, body image and eating attitudes/behavior. Inconsistent with hypotheses, there was no relationship between feminism and disordered eating. However, as hypothesized, positive perceptions of personal body image related positively with later stages of feminism. Negative body image and disordered eating were associated with lower self-efficacy, and, consistent with hypotheses, self-efficacy predicted disordered eating and body image beyond what was predicted by empowerment. Self-efficacy may serve as a protective factor for college aged women from disordered eating and negative body image, although the present study is limited by reliance on correlational rather than longitudinal data. Increased self-efficacy appears to be a promising treatment target in the context of eating and body image disorder treatment.

Empowerment, Feminism and Self-Efficacy: Relationships with

Disordered Body Image and Eating

Eating disorders are severely debilitating disorders experienced by a growing number of people in the United States. Each successive generation of people growing up in the United States is at a greater risk of an eating disorder than the generation before (Hudson, Hiripi, Pope, & Kessler, 2007). The prevalence of eating disorders among women is significantly greater than the prevalence among men, and this gender difference is potentially related to sociocultural factors of the Western culture (American Psychiatric Association [APA], 2000). Body image disturbance distinguishes eating disorders from other psychological conditions associated with eating disturbance and weight loss (Rosen, 1990). Disturbance in body image and undue self-evaluation related to body shape, such as unwarranted attention paid to appearance, are defining features of both Anorexia Nervosa and Bulimia Nervosa (APA, 2000). In addition to being a core feature of eating disorders, disturbed body image has independent health risks. For example, women's concerns about their appearance relate to anxiety, shame, external body monitoring that occupies vital cognitive functioning, and depression (Fredrickson & Roberts, 1997). Negative body image can also affect behavior in that individuals concerned about their physical appearance may avoid situations in which they feel their body will be evaluated such as social outings (Rosen, 1990).

In Western cultures, dissatisfaction with personal appearance and body image is a common experience for women (Fredrickson & Roberts, 1997; Malson & Swann, 1999). Body image is defined as "the way people perceive themselves and, equally important, the way they think others see them" (Fallon, 1990, p. 80). The culture in the United States stresses the ideal female body as thin, toned and perfect (Malson & Swann, 1999). While

Western culture sets the standard of a thin ideal, due to individual biology, this ideal is for some people perceived as an inevitable shortcoming (Fallon, 1990). Some argue that this thin ideal drives women to view their bodies as something to be improved using products such as diet pills and plastic surgery (Malson & Swann, 1999), and for some, cultural ideals are pursued in spite of impracticality or personal risk (Fallon, 1990). According to cognitive perspectives, one's body image may be distorted by irrational thoughts, unrealistic expectations and faulty explanations (Freedman, 1990), which may potentially lend itself to cognitive errors for many women in a society that values thinness.

The context of United States culture strongly suggests that women should adhere to a thin ideal, while men are given less indication to pursue this standard (Malson & Swann, 1999), representing a sociocultural structure, which rewards women for their physical attractiveness, and men for their physical effectiveness (Fredrickson & Roberts, 1997). In a large survey of women, half reported that they were dieting or concerned about becoming overweight, and half admitted to having an overall critical view of their appearance, with more than 45% expressing discontent concerning the appearance of their torsos and lower bodies (Cash & Henry, 1995). This finding corresponds with the proposal that a great number of women experience subclinical eating disorder syndromes. Negative body image is considered the best predictor of disordered eating (Rosen, 1990), and women living within a culture that emphasizes the thin ideal are at a heightened risk of negative body image and eating disturbance (Fallon, 1990; Malson & Swann, 1999; Rosen, 1990).

Women frequently experience the internalization of society's standards of beauty, preoccupying themselves with how they believe others view their bodies. This kind of body monitoring can result in the development of a "third person" or "looking glass" image of the

self in order to anticipate and control how the individual will be viewed by others (Roberts & Waters, 2004). This internalization of society's norms is termed self-objectification and is a part of Fredrickson and Robert's (1997) theory of objectification, which draws a connection between Western sociocultural views of the body and gender differences relative to the emphasis placed on physical appearance with regard to women. Through self-objectification, women learn that their bodies are evaluated by society and those evaluations relate to negative consequences including economic and social outcomes (Roberts & Waters, 2004). Further, the experience of growing up in the United States culture with a focus on the thin ideal may generate this objectification. Girls are socialized to attend to their bodies as objects evaluated throughout their reproductive years, which appears to relate to body objectification being an issue for the majority of a woman's life (Fredrickson & Roberts, 1997). Self-objectification involves constant awareness of how others view one's body, which is referred to as surveillance. Surveillance, in turn, may lead to body shame, or negative feelings about the body and self, and body shame can then lead to disordered eating (Hurt et al., 2007). The experience of body shame and the associated negative emotions may lead women to become more concerned with their body's appearance than the health and functioning of their bodies (Roberts & Waters, 2004).

Some situations trigger women to experiences self-objectification. For example, Fredrickson, Roberts, Noll, Quinn, and Twenge (1998) found that, among women, state self-objectification, as manipulated by trying on a bathing suit, produced body shame, more so than when the female participants tried on a sweater. Men felt shy and silly in a bathing suit while women felt shame and disgust. They also found that women who reported greater body shame engaged in restrained eating. The portrayal of a woman in society generally

emphasizes her body (Fredrickson & Roberts, 1997), which may relate to anxiety when revealing one's figure and an emphasis on conformance to societal expectations experienced by women. For instance, women are more likely to believe that their self-worth is based on appearance and how they are perceived by others than men (Fallon, 1990).

The perpetuation of cultural expectations with regard to gender and appearance may be associated with the increase in eating disorders among women over time. Research supports that a correlation between feminine norms of thinness and disordered eating exists. Women with more traditional expectations and preferences about gender roles in social relationships have a higher investment in their appearance (Cash, Ancis, & Strachan, 1997), and concerns about physical appearance and eating relate to feminine traits. Feminine norms among women are also associated with body shame and negative eating attitudes (Hurt et al., 2007). Similarly, women who prefer traditional gender roles and expectations of gender were more likely to internalize societal standards of beauty, and reported more maladaptive attitudes about their physical appearance than women whose gender role expectations were less traditional (Cash et al., 1997).

With regard to disordered eating in particular, Martz, Handley, and Eisler (1995) found that women who adhere to traditional feminine ideals are at a greater risk for eating disorders. A study by Mori, Chaiken and Pliner (1987) theorized that dieting behaviors such as light eating and appearing thin are perceived as being sex-appropriate for women in United States culture, and these attributes are viewed as signs of femininity. In an experiment manipulating the desirability of an opposite sex confederate partner, women with a desirable partner ate significantly less than women with an undesirable partner. In a similar experiment by Mori and colleagues (1987), women were given feedback on their femininity and were

then observed eating. When women were given feedback that threatened their femininity, they ate significantly less when their partner was aware of this feedback than women in the low-threat condition. This indicates that women may restrict their food intake in order to be perceived as more feminine. Many aspects of the feminine gender role, such as concern with physical attractiveness, lack of emotional relationships, fear of behaving assertively and fear of not being nurturing are found to be higher among women with eating disorders (Martz et al., 1995.) compared to women without eating disorders.

On the other hand, feminism potentially offers an alternative perspective to address gender differences surrounding appearance such as self-objectification. When a woman takes on the role of feminist, she rejects one societal ideal by not conforming to typical gender roles and expectations. Thus, by extension she may be more comfortable rejecting another social norm, such as the expectation of thinness that may serve a protective function with respect to negative body image and related problems (Hurt et al., 2007). Theoretically, feminism views many of the tenants of beauty and fashion propagated by popular culture as subordinating towards women (Jeffries, 2005). Instead, feminism teaches women to value themselves and to view extreme dieting methods for the attainment of the thin ideal as a means of decreasing their self-esteem (Wolf, 1991), and thereby may enable women to view this pressure to be thin as oppression to be resisted. Indeed, women who subscribe to feminist beliefs have been found to report higher ratings of physical attractiveness and lower body dissatisfaction (Dionne & Davis, 1995), and women report knowledge of feminist ideology to be useful in coping with the societal pressures to be thin (Affleck, 2000). Feminist identity may serve a protective function in that it leads to critical evaluation of societal norms, it emphasizes collective action of women, and it may empower women to act

on their own accord rather than in conjunction with societal norms that suggest women should attend heavily to their bodies (Murnen & Smolak, 2009).

Adoption of a feminist perspective traditionally is thought of as occurring in discrete, developmental stages, each with its own description of beliefs and reactions to men which coincide with that particular phase of maturation. The process is believed to be a pattern of growth described in terms of stages of membership. According to Downing and Roush (1985) there are five stages which include (1) *passive acceptance* in which the woman accepts traditional gender roles and denies or is unaware of prejudice and discrimination against women, (2) *revelation* when traditional gender roles are questioned, and women begin to experience anger towards men and guilt for participating in sexism*, (3) embeddedness-emanation* when women begin to connect with other women through liberation of their previous roles, and become open to alternate viewpoints, (4) s*ynthesis* in which a woman begins to form a positive concept of self and other women, and resolve evaluations of men on an individual basis, and (5) *active commitment* in which women begin to take action towards social change.

However, additional research has found that agreement with or even classification in a particular stage does not equate individual identification as a feminist. It has been shown that, while women may agree with some or all of the goals of feminism, many do not identify as feminist. This is thought to be a product of the stigma associated with the title of feminist (Hurt et al., 2007). Liss, O'Connor, Morosky, and Crawford (2001) found that while 81% of a sample of college undergraduate women agreed with some or all of the goals of feminism, they did not identify themselves personally as feminist and did not identify with the social group as a whole. They further found that the feminist stages *revelation* and *embeddedness*

correlated more strongly with predictions of feminist identification than the final stage, *synthesis*. This may be attributed to the negative connotations associated with feminists, and findings support that women who label themselves as feminists have varied attitudes rather than merely a belief in egalitarianism (Murnen & Smolak, 2009). Henderson-King and Stewart (1994) examined college women's group identification and found that women who highly identify with being feminist also identify highly with being a woman, but the reverse is not true. Further, they found that women who identify more strongly as women but not feminist were more likely to be in the passive acceptance stage where they are not aware of sexism and are complacent to traditional gender roles. Some research suggests that the Downing and Roush model may be better considered as different levels of experience along a continuum, rather than a sequential discrete stage progression (Henderson-King & Stewart, 1997).

Findings concerning the relationship between feminism and body image and disordered eating are inconsistent. For example, Cash et al. (1997) found no correlation between feminist identity and positive body image. Further, they did not find a relationship between egalitarian views and more positive body image, suggesting that feminism and feminist ideology had no protective role. Alternatively, Sabik and Tylka (2006) found that categorization in the *synthesis* and *active commitment* stages of feminism buffered the relationship between a perceived sexist event and disordered eating. In a meta-analysis of studies examining the relationship between feminist identity and body image and eating problems, Murnen and Smolak (2009) found that feminist identity was associated with a lower drive for thinness and lower ratings of disordered eating. This suggests that the adoption of a feminist identity may prevent self-objectification and the taking on of societal

norms, as feminists are better able to externalize cultural pressures as external rather than personalize them. They further found small effect sizes supporting feminist theory that feminist identity was associated with less internalization of media images and feminist identity was related to less body shame, although effect sizes were small. Over all, there is some indication that the relationship between feminism and body image may be more complicated than previously thought (Affleck, 2000), which may suggest that a more specific component of feminism is needed to understand the potential relationship (Peterson, Grippo, & Tantleff-Dunn, 2008).

Empowerment is a specific facet of feminism thought to serve a protective function relative to disturbed body image and eating. Empowerment has been defined as "a process by which individuals with lesser power gain control over their lives and influence the organizational and societal structures within which they live" (Segal, Silverman, & Temkin, 1995, p. 215). It involves gaining power on multiple levels and through different resources which in turn gives the individual more control within his/her environment (Segal et al., 1995). Women with higher levels of empowerment reported less negative body image and less disordered eating in a correlational study (Peterson et al., 2008). Empowerment relates to self-efficacy, self esteem, and a belief that the attainment of positive outcomes are under personal control (Segal et al., 1995).

Feminist psychology interventions challenge social stereotypes for women with body image disorders (Freedman, 1990). Empowerment is an important goal of feminist therapy, as it is associated with an increase in self-efficacy (Chrisler & Lamont, 2002). The connection between self-efficacy and empowerment has not been directly evaluated in feminist literature; however, the two are conceptually linked. Bandura (1986) defines self

efficacy as "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performance," (p. 391), and he found that empowerment is brought about by self-efficacy mechanisms.

Ozer and Bandura (1990) found positive changes in behavior related to empowerment by self-efficacy enhancement through a self-defense program which taught physical techniques to ward off an assailant. Participants were 43 women from young to older adulthood, and self-defense training was staggered in order to provide an intra-group control baseline. To assess the immediate and long-term effects of the program, self-efficacy and engagement in activities was assessed at three points in time: control, treatment and follow-up. Improved self-efficacy related to increased activity and decreased avoidance, consistent with construct of greater empowerment. Women reported being more active and present in the world around them outside of the house including recreational, social and educational activities after participating in the program compared to before the program. Overall, the program related to improved perceived coping, cognitive control efficacy, and activity levels among women who participated. Other research has examined self-efficacy in populations of women with eating disorders. Pinto, Guarda, Heinberg, and DiClemente (2006) assessed normative eating self-efficacy and body image self-efficacy among female inpatients diagnosed with an eating disorder. They found that self-efficacy to achieve normative eating was negatively associated with eating disorder pathology, with perceived difficulties sustaining positive behaviors, and with depression. Though separately evaluated, self-efficacy appears to relate positively with feminism and empowerment, and negatively with disordered eating.

Recent research has examined the construct of empowerment as a potential protective factor, more so than feminism, with regards to minimizing self-objectification in women, and empowerment is theorized to improve body image and reduce eating disturbance. Peterson et al. (2008) examined body image and eating disturbance in relation to feminism and empowerment with an emphasis on self-esteem as well as an emphasis on power/powerlessness. They recruited 276 undergraduate women from a southeastern university. The sample was 70% white, with an average age of 20.6 years. Participants completed questionnaire packets, including measures of body image, empowerment, disordered eating and feminist identity, and a demographic information sheet. Peterson and colleagues found that empowerment and feminism significantly and negatively correlated with body image disturbance and disordered eating. The empowerment scale included two subscales measuring power/powerlessness and self-esteem/self-efficacy, which are thought to be vital components of empowerment. Power/powerless predicted disordered eating and body image disturbance, and these findings remained significant after self-esteem/self-efficacy was controlled, in that greater powerlessness was associated with more disordered eating. Further interpretation of this finding concluded that the power/powerlessness scale and the self-esteem /self-efficacy scale correlated with each other thereby limiting their differential predictive relationship with body image and disordered eating.

However, it is not clear that the empowerment scale used by Peterson and colleagues (2008) assessed situationally-specific self-efficacy as defined by Bandura (1986). The factor measuring self-esteem/self efficacy posed broad questions, such as "I am able to do things as well as most other people," and "I have a positive attitude about myself" (Rogers, Chamberlin, Ellison, & Crean, 1997, p. 1044), allowing the participant to generalize about

the situation instead of asking about specific situations. Because the measure did not assess situationally-specific circumstances, it does not appear to have assessed self-efficacy, but rather general self-esteem. A more appropriate measure of self-efficacy in this context could supplement Peterson et al.'s findings and possibly clarify the previous conclusion that self-efficacy overlaps with personally reported power. The Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ) created by Pinto et al. (2006) poses specific situations such as "I can eat from a buffet without feeling anxious," and "I can wear a swimsuit in public," and appears to assess self-efficacy relative to body image and eating behaviors in a situationally specific manner. Though it was developed using a population of female inpatients receiving treatment through a behavioral eating disorder program, the measure is considered to be generalizable to the normal population as the sample contained women at various stages of recovery from eating disorders, and the attitudes and behaviors assessed are present to some degree in normal women (Pinto et al., 2006).

The present study replicated the methods and hypotheses of Peterson et al. (2008) with relation to empowerment, feminism, body image and eating disturbance, using a similar sample of college undergraduate females and similar self-report measures. As supported by Peterson and colleagues, and in replication of their hypotheses, it was predicted that (1) feminism and empowerment would negatively correlate with disturbance in body image and eating such that higher ratings of empowerment and higher endorsement of feminism would be associated with lower body image disturbance and eating disturbance, and that (2) power/powerlessness, a subscale of the empowerment measure, would predict eating and body image disturbance and self-esteem.

However, in addition to the above hypotheses, the relationship between empowerment, as assessed by Peterson and colleagues, and self-efficacy, as measured by a scale using situationally-specific items related to eating and body image were examined. Previous research has found that greater empowerment is associated with higher self-efficacy (Chrisler, & Lamont, 2002; Ozer & Bandura, 1990; Segal et al., 1995). Thus, it was predicted that (3) self-efficacy would significantly add to the prediction of body image and disordered eating beyond what is explained by empowerment, when controlling for self-esteem.

Method

Participants

Participants were 184 undergraduate women recruited from psychology classes at Appalachian State University. On average participants were 18.64 years old (SD = .97). The majority of participants were college freshman (63.6%), single (96.7%), Caucasian (91.3%), and reported Protestant/Christian religious affiliation (55.4%). Weight, as reported by participants, ranged from 95 – 230 lbs (M = 141.96; SD = 24.84), and height ranged from 57 – 73 inches (M = 65.5; SD = 2.86). On average, participants' BMI was 23.33 (SD = 3.87), in the normal range according to the World Health Organization (2006). See Table 1 for descriptive statistics. Participants were treated in accordance with American Psychological Association ethical guidelines (2002), and the procedures were approved by the Institutional Review Board at Appalachian State University (Appendix A) on May 5, 2009.

Measures

Eating Attitudes Test (EAT; Garner & Garfinkel, 1979). The EAT is a 40-item forced choice measure used to assess self-reported attitudes related to eating. Participants respond to each question (e.g., "Am preoccupied with a desire to be thinner" and "Feel that food

controls my life") using a 6-point rating scale with 1 being "never" and 6 being "always."

Responses are converted to 3 points (indicative of most disturbed eating), 2 points or 0 points

(indicative of least disturbed eating) and total scores range from 0 to 120. Higher scores are

associated with disturbed eating habits. The EAT has a reported concurrent validity

coefficient of 0.87, and Cronbach's alpha was reported as 0.94, indicating high internal

reliability. Cronbach's alpha for the current sample was 0.84.

Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ; Pinto et al.,

*2006).*The EDRSQ is a 23-item measure used to assess self-efficacy using 2 subscales, a 14-

item Normative Eating Self-Efficacy scale and a 9-item Body Image Self-Efficacy scale.

Participants respond to items (e.g., "I can look in a full-length mirror without thinking about

where I want to lose weight," "I can buy food based on what I feel like eating, not because it

is low fat and/or low calorie.") using a 5-point scale with 1 being "not at all confident" and 5

being "extremely confident." Scores on each subscale are averaged and range from 1 to 5.

Lower scores correlate with greater disordered eating pathology, and higher scores correlate

with confidence to engage in specific behaviors that are inconsistent with disordered eating

and body image disturbance among women in treatment for an eating disorder. Cronbach's

alpha of the EDRSQ has been reported as 0.95, indicating high internal reliability (Pinto et

al., 2006). Cronbach's alpha for the current sample was 0.96.

*Empowerment Scale (ES; Rogers et al., 1997).*The ES is a 31-item measure used to

assess empowerment along 5 factors: Self-esteem/Self Efficacy, Power/Powerlessness,

Community Activism and Autonomy, Optimism and Control over the Future, and Righteous

Anger. Power/Powerlessness is a measure of one's perceived control over societal and

personal choices (e.g., "I feel powerless most of the time," "When I am unsure about

something I usually go along with the group"). Self-esteem/Self-efficacy is a measure of

one's feelings of self-worth and confidence in general abilities (e.g. "I generally accomplish

what I set out to do," "I see myself as a capable person."). Participants respond to items using

a Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). The ES total score

ranges from 28 to 112. Higher scores are indicative of greater magnitude of the construct of

empowerment. In the present study, and in keeping with the original Peterson et al. (2008)

study, the Power/Powerlessness and Self-Esteem/Self Efficacy subscales of the

empowerment scale are of most interest. Higher scores on the Power/Powerlessness subscale

and the Self-Esteem/Self-Efficacy subscale indicate greater power and greater self-esteem

respectively. Thus, the Power/Powerlessness subscale will be referred to as the Power

subscale, and the Self-Esteem/Self-Efficacy subscale will be referred to as the Self-Esteem

subscale. Power scores and scores on the Self-Esteem scale are averaged and range from 1 to

4. Cronbach's alpha of the ES is reported 0.86, indicating high internal consistency (Rogers

et al., 1997). Cronbach's alpha on the ES total for the current sample was 0.81, for the ES

Power subscale was 0.62, and for the ES Self-Esteem subscale was 0.89.

       Feminist Identity Composite (FIC; Fischer et al., 2000). The FIC is a 40-item scale

that combines the Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991) and

the Feminist Identity Scale (FIS; Rickard, 1987). The FIC is based on the Downing and

Roush (1985) feminist identity stages, and each stage is a subscale of the measure.

Participants respond to items (e.g., "I am proud to be a competent woman," "Gradually, I am

beginning to see how sexist society really is.") on a Likert scale ranging from 1 (strongly

disagree) to 5 (strongly agree), with higher scores indicating higher agreement with the

measured stage of feminism. Scores for each of the subscales are averaged and range from 1

to 5. For each of the subscales, Cronbach's alphas were reported as follows: *passive acceptance* 0.75, *revelation* 0.80, *embeddedness-emanation* 0.84, *synthesis* 0.68 and *active commitment* 0.77 (Fisher et al., 2000). For each of the subscales in the current sample, Cronbach's alphas were as follows; *passive acceptance* 0.81, *revelation* 0.88, *embeddedness-emanation* 0.86, *synthesis* 0.86 and *active commitment* 0.86.

        *Multidimensional Body-Self Relations Questionnaire (MBSRQ; Brown, Cash, & Mikulka, 1990).*The MBSRQ is a 69-item attitudinal assessment of body image and issues related to weight. As in Peterson et al. (2008), two subscales will be used: Body Area Satisfaction (BAS) and the Appearance Evaluation (AE). Participants respond to items (e.g., "It is important that I always look good," "I like the way I look without my clothes.") using a Likert scale ranging from 1 (definitely disagree) to 5 (definitely agree). Scores on the subscales are averaged, with higher scores indicating a more positive evaluation of one's body. Cronbach's alphas on the MBSRQ subscales ranged from 0.89 to 0.75 (Brown et al., 1990). Cronbach's alpha for the BAS subscale for the current sample was 0.84, and for the AE subscale was 0.89.

Procedures

        Participants were recruited through undergraduate psychology classes, and accessed the experiment through a link provided via email sent through the psychology subject pool. Participants reviewed an informed consent form (see Appendix B), electronically signed and subsequently filled out a questionnaire battery. Participants first reported basic demographic information (Appendix C), including height and weight to calculate body mass index (BMI), age, socioeconomic status, education level, and ethnicity for descriptive purposes. Participants then completed the remaining questionnaires in the following order: EAT,

EDSRQ, ES, FIC, MBSRQ. In exchange for their cooperation, participants received

experiential learning credit validation in accordance with their instructor's policies, and were

given the option to review a debriefing form (Appendix D) upon completion of the measures.

<div align="center">Results</div>

Participant data was screened to ensure that there were no outlying data points, and

that all variables were normally distributed. Missing data did not appear to follow a specific

pattern, and was handled by substituting the participants' subscale average for individual

missing items on the questionnaire scored. Participants who were missing more than12.5% of

the responses to a given subscale or measure (i.e., missing more than 1 item on an 8 item

scale) were excluded from analyses. Seventeen participants were excluded from analyses

because of missing data that could not be estimated in the above described manner.

Descriptive statistics of all measures including means, standard deviations and ranges are

presented in Table 2.

In order to test the first hypothesis that feminism and empowerment negatively

correlate with disturbance in body image and eating attitudes, a one-tailed Pearson product

moment correlation was calculated between each of the FIC subscales and both the EAT and

the MBSRQ subscales, and between the two ES subscales and both the EAT and the

MBSRQ. Contrary to the hypothesis, there was no relationship between the EAT and any of

the FIC subscales, indicating no relationship between disordered eating and any stage of

feminism (see Table 3).

Consistent with the hypotheses, the BAS and AE subscales of the MBSRQ negatively

correlated with the Passive Acceptance stage of feminism ($r = -.168$, $p = .011$; $r = -.184$, $p = .006$, respectively), and positively correlated with the Synthesis ($r = .208$, $p = .002$; $r = .279$,

$p < .001$) and Active Commitment ($r = .248$, $p < .001$, $r = .286$, $p < .001$) stages of feminism. Thus, greater endorsement of femininity (Passive Acceptance) related to lower Body Areas Satisfaction and lower Appearance Evaluation, while greater endorsement of later stages of feminism (Synthesis and Active Commitment) related to higher Body Areas Satisfaction and higher Appearance Evaluation.

Again, consistent with the proposed hypotheses, both subscales of the ES, Self-Esteem and Power, negatively correlated with the EAT (SE: $r = -.256$, $p < .001$; PP: $r = -.166$, $p = .012$), and both positively correlated with the AE and BAS subscales of the MBSRQ. (SE and BAS: $r = .489$, $p < .001$; PP and BAS: $r = .258$, $p < .001$; SE and AE: $r = .453$, $p < .001$; PP and AE: $r = .320$, $p < .001$). Greater eating disturbance related to lower empowerment, and more positive body image evaluations related to higher empowerment.

In order to test the second hypothesis, that the Power subscale of the ES would predict body image and eating disturbance after accounting for self-esteem, three hierarchical multiple regression analyses were conducted. The ES Self-Esteem score was entered on step 1, and the Power score was entered on step 2. See Table 4 for the results of the multiple regression analyses. For the first analysis, the criterion variable was the EAT. The ES-SE predicted approximately 7% of the variance ($R^2 = .066$, $F = 12.79$, $p < .001$) in the EAT score. Contrary to the hypothesis, the addition of the ES-PP did not significantly add to the prediction of the EAT score ($R^2 = .071$, $F = 6.88$, $p = .321$, $f^2 = 0.0053$). For the second analysis, the criterion variable was the MBSRQ-BAS. The ES-SE predicted approximately 24% of the variance in the MBSRQ-BAS scores ($R^2 = .239$, $F = 57.28$, $p < .001$). Again, contrary to the hypothesis, the addition of the ES-PP did not significantly add to the model ($R^2 = .244$, $F = 29.28$, $p = .272$, $f^2 = 0.0066$). For the third analysis, the criterion variable was

the MBSRQ-AE. The ES-SE predicted approximately 21% of the variance of the MBSRQ-AE scores (R^2= .206, F = 47.08, p < .001). Consistent with the hypothesis, the addition of the ES-PP significantly added to the model, but only accounted for an additional 2% of the variance (R^2= .229, F = 26.913, p =.019, f^2= 0.0298; see Table 4).

In order to test the third hypothesis that self-efficacy would significantly add to the prediction of disordered body image and eating beyond that explained by power and self-esteem, three hierarchical forced-entry multiple regression analyses were conducted. The ES-PP and ES-SE were entered on step 1, and the EDSRQ-NE and EDSRQ-BI were entered on step 2. The criterion variable was the EAT total score. As previously noted, the ES subscales accounted for approximately 7% of the variance in the EAT scores (R^2= .071, F = 6.88, p = .01). Consistent with the hypothesis, the EDSRQ subscales significantly added to the model, accounting for an additional 20% of the variance, increasing the total variance in the EAT total score accounted for to 27% (R^2= .270, F = 16.55, p < .001, f^2= 0.2726). For the second analysis, the criterion variable was the MBSRQ-BAS. Again, the ES subscales accounted for 24% of the variance in the model (R^2= .244, F = 29.28, p < .01). Consistent with the hypothesis, the EDSRQ subscales significantly added to the model, accounting for an additional 27% of the variance, increasing the total variance accounted for to 53% (R^2= .534, F = 51.229, p < .01, f^2= 0.6223). For the third analysis, the criterion variable was the MBSRQ-AE. As previously described, the ES subscales accounted for 23% of the variance in the model (R^2= .229, F = 26.91, p < .01). Consistent with the hypothesis, the EDSRQ subscales significantly added to the model, accounting for an additional 34% of the variance, increasing the total variance accounted in the MBSRQ-AE score to approximately 57% (R^2= .569, F = 59.17, p < .01, f^2= 0.7889).

Discussion

Among a sample of female undergraduate students, disordered eating negatively related with self-esteem and perceived power as assessments of empowerment, and showed no significant relationship with feminism. Consistent with hypotheses and theory, self-efficacy predicted disordered eating above what was predicted by self-esteem and power. Positive personal body image also related positively with empowerment, and with endorsement of beliefs consistent with later stages of a feminist identity. In addition, body image negatively related to traditional attitudes about gender or femininity. Again, self-efficacy predicted body image beyond what was predicted by self-esteem and power. These results largely replicated the findings of Peterson et al. (2008), with the exception that the present study found no relationship between eating and feminism, and assessed self-efficacy which significantly added to the prediction of body image and disordered eating above and beyond that accounted for by self-esteem and power.

Counter to Peterson and colleagues (2008) findings and counter to hypotheses, participants did not endorse a relationship between feminism and disordered eating. This finding is contrary to the literature that supports an increased risk of disordered eating among women with more traditional feminine ideals (Martz et al., 1995), that women tend to restrict food intake to be perceived as more feminine (Mori et al., 1987), and that disordered eating negatively related to feminist identity (Sabik & Tylka, 2006). This finding is also divergent from research suggesting that feminist ideology is helpful to women in resisting societal pressure to be thin (Affleck, 2000), and that feminist identity is associated with lower reports of disordered eating (Murnen & Smolak, 2009).

The lack of a significant relationship between feminism and disordered eating in the current sample may relate to a number of factors. The EAT requires that responses be scored with the response most indicative of disordered eating weighted as a 3, the adjacent response a 2, and the next adjacent response a 1 (Garner & Garfinkel, 1979). From Peterson et al.'s (2008) report of the mean scores of the EAT ($M = 55.76$), and description of scoring procedures, it does not appear that items were scored in such a fashion, thus increasing variance in EAT scores and increasing the likelihood of finding a statistically significant relationship with feminism scales. Further, the correlations between feminist revelation and disordered eating and active commitment and disordered eating reported by Peterson et al. were small ($r = .134$ and $r = -.135$). In addition, the present sample scored lower than past reported scores of normal controls on the EAT (Garner & Garfinkel, 1979), suggesting the sample was remarkably healthy in terms of eating behaviors. Thus, the current sample's comparative restriction of range on the measure of disordered eating likely reduced the ability to detect a potentially small relationship with feminist identity.

On the other hand, body image in the current sample negatively correlated with the Passive Acceptance stage of feminism associated with an acceptance of traditional gender roles (Downing & Roush, 1985). This is consistent with findings that women who prefer traditional gender roles reported more negative attitudes about their physical appearance (Cash et al., 1997), and findings that women with more traditional ideas about gender experience body shame (Hurt et al., 2007). Consistent with Peterson et al.'s (2008) finding, the two final stages of feminism, describing women who identify with a feminist identity in overcoming traditional expectations of gender (Synthesis), and women becoming active in implementing social change in line with the ideals of feminism (Active Commitment;

Downing & Roush, 1985), correlated with reports of more positive body image in the present study. Sabik and Tylka (2006), using a sample of college women, proposed a protective relationship between these stages of feminism and disordered eating, and though Sabik and Tylka did not measure body image, body image is the best predictor of disordered eating (Rosen, 1990). Hurt et al. (2007) found that though feminist identity had no direct effect on disordered eating or body image, feminist identity related to eating behaviors through intervening factors such as conformity to feminine norms and self-objectification. However, the present study failed to find a relationship between feminism and disordered eating.

Consistent with findings of Peterson et al. (2008), empowerment as reflected by self-esteem and self-perceived power also related to disordered eating and body image. Specifically, empowerment correlated negatively with disordered eating, and related positively with higher body image evaluations. Empowerment is theorized as an interpersonal process wherein the individual adopts strategies for the acquirement of knowledge and action (Carr, 2003). Previous findings by Liss et al. (2001) demonstrated that a large majority of women reported agreeing with some or all of the tenants of feminism, but did not identify as feminist, perhaps due to the stigmatization of the term "feminist." In addition, women may identify highly with being a woman, but not identify with being feminist (Henderson-King & Stewart, 1994). It would stand to reason that women can hold feminist traits without identifying as feminist, and therefore, be empowered without being feminist. The roots of empowerment lie in freedom from oppression (Freire, 1968), and therefore appear to be somewhat independent from feminism, though empowerment as a woman for some may be consistent with feminism.

However, counter to the findings of Peterson et al. (2008), power was not a significant predictor of disordered eating or body areas satisfaction after controlling for self-esteem. Body areas satisfaction is an aspect of body image pertaining to dissatisfaction with specific areas of the body. The high degree of overlap between self-esteem and power suggests that these constructs do not differ greatly from one another enough to offer a unique contribution to the prediction of disordered eating or body image. Power did contribute minimally to the prediction of the appearance evaluation aspect of body image above and beyond what was accounted for by self-esteem. The appearance evaluation piece of body image appears to tap into general investment in one's appearance while the body areas satisfaction piece is geared towards more specific areas of the body (Cash, 2000).

On the other hand, self-efficacy significantly contributed to the prediction of disordered eating and body image beyond what was accounted for by self-esteem and self-perceived power. Peterson and colleagues (2008) described potential overlap between self-efficacy and power, as they indicated that the self-efficacy piece of the Self-Esteem/Self-Efficacy subscale might be too highly related to power to show a distinct effect. However, the Self-Esteem/Self-Efficacy scale used did not assess self-efficacy as defined by Bandura (1986). Therefore the assumption that the construct of self-efficacy was too highly related to power to show a significant effect was countered in the present study. Findings of the current study indicate that self-efficacy is a better predictor of disordered eating and body image than power. This was somewhat consistent with findings by Pinto, Heinberg, Coughlin, Fava and Guarda (2008) who found that among hospitalized women, greater self-efficacy was associated with shorter hospital stays, and lower self-reported drive for thinness and body dissatisfaction. Unlike general self-esteem and perceptions of personal power, self-efficacy is

situationally specific and therefore more proximal to specific behaviors and self-perceptions than general concepts of self-esteem. In addition, researchers theorize that feminism (Affleck, 2000; Dionne & Davis, 1995; Murnen & Smolak, 2009), and empowerment may be protective factors with regard to body image and eating behaviors (Peterson et al., 2008). Since self-efficacy is considered a particular component of empowerment (Ozer & Bandura, 1990; Segal et al., 1995), it may serve as a more modifiable goal, as it allows for specific targeting of behavioral interventions.

In the current study, self-efficacy explained significantly more variance in body image compared to variance in disordered eating. This is likely related to the use of a relatively healthy sample of college females, as reported disordered eating behaviors were below those of normal controls (Garner & Garfinkel, 1979). In addition, self-efficacy and body image are both concepts related to self-perceptions, whereas disordered eating pertains to specific behaviors that may be used to alter appearance.

Negative body image and disordered eating were associated with lower self-efficacy in the current study. Disordered eating is predicted by poor body image (Rosen, 1990), and both can lead to serious physical and mental health consequences (Fredrickson & Roberts, 1997). Therefore, it stands to reason that future treatment interventions should attempt to improve self-efficacy related to perceived body image and healthy eating behavior. According to Bandura (1997) improvement of self-efficacy is accomplished through 4 principle sources: vicarious experience, verbal persuasion, enactive mastery, and physiological and affective states. Enactive mastery experiences are considered the most influential source of information in relation to increased self-efficacy expectancies.

Future interventions may focus on enhancing body image and eating self-efficacy to decrease negative opinions of self and disordered eating. Interventions have demonstrated improvements in reported self-efficacy and related behaviors on populations with diabetes and cardiovascular disease (Luszczynska & Tryburcy, 2008), women in a self-defense course (Ozer & Bandura, 1990), and first time stroke sufferers (Jones, Mandy & Partridge, 2009). This may be done for targeting body image and eating behaviors by initially building enactive mastery, the most important contributor to self-efficacy perceptions. Interventions to enhance self-efficacy might utilize assignments, such as practicing healthy eating behaviors and adopting more positive body image attitudes. Assignments should start simply in order to ensure success, thereby creating an enactive mastery experience. Sallit, Ciccazzo and Dixon (2009) designed and tested an intervention to improve weight-control and smoking-cessation self-efficacy used cognitive behavioral assignments such as self-monitoring, setting goals, and cognitive restructuring to challenge or modify existing beliefs that were unrealistic or harmful. Results from Salit, Ciccazzo and Dixon found improvement in self-efficacy for both smoking cessation and weight control. Further interventions may provide psycho-education to establish a base of knowledge about basic strategies for healthy eating and body size and employ verbal persuasion or encouragement, another factor related to self-efficacy enhancement. Group treatment might be effective as well, as it would demonstrate the vicarious experience component of self-efficacy by offering the opportunity to learn from the experiences of others. Furthermore, using psychometric measures to track changes in mood and weight may be helpful to treatment progress (Bandura, 1997). Use of a brief intervention style model may also be considered. Nairn (2004) used a brief intervention, defined as 4 sessions total, to improve coping self-efficacy for individuals with cancer. This intervention

showed significant improvement in self-efficacy at a 3-month follow-up, indicating that self-efficacy may be meaningfully affected within a short time frame.

However, with regard to disordered eating, Cain, Bardone-Cone, Abramson, Vohs and Joiner (2008) suggests that when targeting self-efficacy in treatment, the individual's level of interpersonal perfectionism should be taken into consideration. Elevated perfectionism and stress in combination with low interpersonal self-efficacy and high self-efficacy related to weight and shape (the belief that one is able to control their weight and shape) are associated with increased levels of dieting (Cain et al., 2008). These findings further suggested that targeting reductions in interpersonal perfectionism and stress and increasing interpersonal self-efficacy may reduce restricted eating. Therefore, this finding may serve as an important tool to monitor and prevent self-efficacy from being used in a negative fashion.

Although in the present study, there was no relationship between feminism and disordered eating, the findings suggest feminism may serve as a minor protective factor with regard to negative body image. Peterson, Tantleff-Dunn and Bedwell (2006) found that exposure to a feminist intervention increased feminist identification and decreased anxiety related to appearance. This is consistent with the appearance evaluation construct evaluated in the present study, and supports the present findings that appearance evaluation positively relates to later stages of feminism. Additionally, the inter-relatedness of the constructs in the current study, such that feminism is a broad concept, with empowerment being a specific aspect of it, and efficacy a still more specific aspect, may be demonstrated in the findings of the present study where the statistical relationships on the broad level are small to non-existent, and become stronger with specificity. Specifically, the earliest stages of feminism,

Passive Acceptance and Revelation, negatively correlated with empowerment and self-efficacy, while the Synthesis stage of feminism correlated positively with empowerment and self-efficacy. Active Commitment had a positive relationship with empowerment and body image self-efficacy. Eisele and Stake (2008) who used a longitudinal design with college students and found that engagement in activism associated with greater performance self-efficacy. However, their findings did not support the idea that increased feminism predicts greater personal self-efficacy for performance.

Limitations

There were several limitations to the present study. Most prominently, the current analyses were based on cross-sectional data and correlational analyses, thus preventing causal interpretations of findings. In addition, the measure of self-efficacy was validated on individuals in different stages of recovery from an eating disorder, not on the normal population. On the other hand, the current findings and previous research suggest that the measure may indeed be applicable to the general population (Pinto et al., 2006). The present sample was also restricted to female college students, most of whom were freshman, Caucasian and 18 years of age. However, teenage women (between the ages of 13 and 19) are at 5 times greater risk of eating disorder than other women (Pawluck & Gorey, 1998), and conclusions by Hoek and Von Hoeken (2003) affirm that eating disorders, though rare in general populations, are common in young women, particularly adolescent girls. Thus, the age of this sample may be justified in that it offers information about women who are at risk of disordered eating and body image problems (APA, 2000; Hoek & Von Hoeken, 2003)

Another limitation is the use of a primarily Caucasian sample. Research suggests that eating disorders occur in growing numbers in the minority populations. Native American

females are more likely than Caucasian and Latina women to engage in disturbed eating, and African-American and Asian women were less likely (Crago, Shisslak & Estes, 1996). Studies have found that Latino women are more likely to have body dissatisfaction than African-Americans or Asian-Americans, and also found Latinos to be just as likely as Caucasians to be dissatisfied with their figure (Altabe, 1998). That said, current research still supports the finding that being female and Caucasian puts one at greater risk for developing an eating disorder (Striegel-Moore & Bulik, 2007), thus supporting the use of the current sample.

Future studies employing a more diverse sample may be helpful in understanding the relationships between empowerment, feminism, self-efficacy and disordered eating and body image. Findings of the current study are unsupportive of past research indicating a relationship between disordered eating and feminism. Perhaps a different measure of the construct of feminism is warranted, emphasizing a woman's adherence to the female gender role, rather than the often stigmatized "feminist" concept. The Downing and Roush developmental model of feminist stages has been criticized for its lack of longitudinal studies to asses for a developmental progression. Research further suggests that the model is less relevant to modern day women and the experiences of the next wave of feminism (Moradi & Subich, 2002). Thus, it remains unclear as to whether women progress through the stages of feminism in a sequential fashion as is theorized by the Downing and Roush model (Erchull et al., 2009).

Results of the current study are consistent with the use of self-efficacy enhancing interventions. Future interventions may be designed to enhance self-efficacy, by cultivating generalizable coping skills for societal expectations and pressures related to appearance and

eating through mastery-oriented treatment (Bandura, 1997). Successful past experiences are vital to the development of self-efficacy. A longitudinal study using a controlled experimental design with pre-test and post-test measures before and after a self-efficacy enhancing intervention may provide a better test of self-efficacy's relationship to disordered body image and eating.

In summary, the current study found that self-efficacy predicts disordered eating and negative body image among college women. Many studies have shown that self-efficacy may be manipulated through targeted interventions (Jones et al., 2009; Luszczynska & Tryburcy, 2008; Ozer & Bandura, 1990; Saksvig et al., 2005; Sallit, Ciccazzo, & Dixon, 2009; Simonavice & Wiggins, 2008; Tuuri et al., 2009). Future research should develop and test self-efficacy building interventions, and test the potential impact of incorporating feminist principles, such as challenging traditional gender role beliefs and expectations, as feminism is also associated with higher ratings of body image (Dionne & Davis, 1995; Peterson et al., 2008).

References

Affleck, D. J. (2000). Women's experiences of their bodies: Understanding the connection between feminist consciousness, body image and eating disorders [Abstract]. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 61,* 94.

Altabe, M. (1998). Ethnicity and body image: Quantitative and qualitative analysis. *International Journal of Eating Disorders, 23*, 153-159.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington DC: American Psychiatric Association.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

Bargad, A., & Hyde, J. (1991). Women's studies: A study of feminist identity development in women. *Psychology of Women Quarterly, 15,* 181-201.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* New Jersey: Prentice-Hall.

Bandura, A. (1997). The nature and structure of self-efficacy. In A. Bandura (ed.), *Self-efficacy: The exercise of control.* New York: W. H. Freeeman and Company.

Brown, T. A., Cash, T. F., & Mikulka, P. J. (1990). Attitudinal body-image assessment: Factor analysis for Body-Self Relations Questionnaire. *Journal of Personality Assessment, 55,* 135-144.

Cain, A. S., Bardone-Cone, A. M., Abramson, L. Y., Vohs, K. D., & Joiner, T. E. (2008). Refining the relationships of perfectionism, self-efficacy, and stress to dieting and binge eating: Examining the appearance, interpersonal, and academic domains. *International Journal of Eating Disorders, 41,* 713-721.

Carr, E. (2003). Rethinking empowerment theory using a feminist lens: The importance of process. *Affilia: Journal of Women & Social Work*, *18*, 8-20

Cash, T. F. (2000). *The Multidimensional Body-Self Relations Questionnaire.* MBSRQ Users Manual 3rd Revision.

Cash, T. E., Ancis, J. R., & Strachan, M. D. (1997). Gender attitudes, feminist identity, and body images among college women. *Sex Roles, 36,* 433-448.

Cash, T. F., & Henry, P. E. (1995). Women's body images: The results of a national survey in the U.S.A. *Sex Roles, 33,* 19-29.

Chrisler, J., & Lamont, J. (2002). Can exercise contribute to the goals of feminist therapy? *Women and Therapy*, *25*, 9-22.

Crago, M., Shisslak, C. M., & Estes, L. S. (1996). Eating disturbances among American minority groups: A review. *International Journal of Eating Disorders*, *19,* 239-248.

Downing, N., & Roush, K. (1985). From passive acceptance to active commitment. A model of feminist identity development for women. *The Counseling Psychologist, 13,* 695-709.

Dionne, M., & Davis, C. (1995). Feminist ideology as a predictor of body dissatisfaction in women. *Sex Roles*, *33*, 277-287.

Eisele, H., & Stake, J. (2008). The differential relationship of feminist attitudes and feminist identity to self-efficacy. *Psychology of Women Quarterly, 32,* 233-244.

Erchull, M. J., Liss, M., Wilson, K. A., Bateman, L., Peterson, A. & Sanchez, C. E. (2009). The feminist identity development model: Relevant for young women today? *Sex Roles, 60,* 832-842.

Fallon, A. (1990). Culture in the mirror: Sociocultural determinants of body image. In T.F. Cash & T. Pruzinsky (Eds.), *Body images development, deviance and change* (pp. 80-109). New York: Guilford Press.

Fischer, A. R., Tokar, D. M., Mergl, M. M., Good, G. E., Hill, M. S., & Blum, S. A. (2000). Assessing women's feminist identity development: Studies on convergent, discriminant and structural validity. *Psychology of Women Quarterly, 24,* 15-29.

Fredrickson, B. L., & Roberts, T. A. (1997). Objectification theory: Towards understanding women's lived experiences and mental health. *Psychology of Women Quarterly, 21,* 173- 206.

Fredrickson, B. L., Roberts, T. A., Noll, S. M., Quinn, D. M., & Twenge, J. M. (1998). That swimsuit becomes you: Sex differences in self-objectification, restrained eating, and math performance. *Journal of Personality and Social Psychology, 75,* 269-284

Freedman, R. (1990). Cognitive-behavioral perspectives on body-image change. In T.F. Cash & T. Pruzinsky (Eds.), *Body images development, deviance and change* (pp. 272-295). New York: Guilford Press.

Freire, P. (1968). *Pedagogy of the oppressed.* New York: Continuum.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9,* 273-279.

Henderson-King, D. H., & Stewart, A. (1994). Women or feminists? Assessing women's group consciousness. *Sex Roles, 31,* 505-516.

Henderson-King, D., & Stewart, A. J. (1997). Feminist consciousness: Perspectives on

women's experience. *Personality and Social Psychology Bulletin, 23,* 415-427.

Hoek, H., & van Hoeken, D. (2003). Review of the prevalence and incidence of eating

disorders. *International Journal of Eating Disorders*, *34*, 383-396.

Hudson, J., Hiripi, E., Pope, H., & Kessler, R. (2007). The prevalence and correlates of

eating disorders in the National Comorbidity Survey Replication [Abstract].

Biological Psychiatry, *61*, 348-358.

Hurt, M., Nelson, J., Turner, D., Haines, M., Ramsey, L., Erchull, M., et al. (2007).

Feminism: What is it good for? Feminine norms and objectification as the link

between feminist identity and clinically relevant outcomes. *Sex Roles*, *57*, 355-363.

Jeffries, S. (2005). *Beauty and misogyny: Harmful cultural practices in the West.* New

York: Routledge.

Jones, F., Mandy, A., & Partridge, C. (2009). Changing self-efficacy in individuals following

a first time stroke: Preliminary study of a novel self-management intervention.

Clinical Rehabilitation, 23, 522-533.

Liss, M., O'Connor, C., Morosky, E, & Crawford, M. (2001). What makes a feminist?

Predictors and correlates of feminist social identity in college women. *Psychology of

Women Quarterly, 25,* 124-133.

Luszczynska, A. & Tryburcy, M. (2008). Effects of a self-efficacy intervention on exercise:

The moderating role of diabetes and cardiovascular diseases. *Applied Psychology: An

International Review, 57,* 644-659.

Malson, H., & Swann, C. (1999). Prepared for consumption: (Dis)orders of eating and

embodiment. *Journal of Community & Applied Social Psychology, 9,* 397-405.

Martz, D. M., Handley, K. B., & Eisler, R. M. (1995). The relationship between feminine gender role stress, body image, and eating disorders. *Psychology of Women Quarterly, 19,* 493-508.

Moradi, B., & Subich, L. M. (2002). Feminist identity development measures: Comparing the psychometrics of three instruments. *The Counseling Psychologist, 30,* 66-86.

Mori, D., Chaiken, S., & Pliner, P. (1987). "Eating lightly" and the self-presentation of femininity. *Journal of Personality and Social Psychology, 53,* 693-7012.

Murnen, S. K,, & Smolak, L. (2009). Are feminist women protected from body image problems? A meta-analytic review of relevant research. *Sex Roles, 60,* 186-197.

Nairn, R. (2004). Improving coping with cancer utilizing mastery enhancement therapy [Abstract]. *Dissertation Abstracts International*, 65.

Ozer, E., & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-efficacy analysis. *Journal of Personality and Social Psychology, 58,* 472-486.

Pawluck, D., & Gorey, K. (1998). Secular trends in the incidence of anorexia nervosa: Integrative review of population-based studies. *International Journal of Eating Disorders*, *23*, 347-352.

Peterson, R. D., Grippo, K. P., & Tantleff-Dunn, S. (2008). Empowerment and Powerlessness: A closer look at the relationship between feminism, body image and eating disturbance. *Sex Roles, 58,* 639-648.

Peterson, R. D., Tantleff-Dunn, S., & Bedwell, J. S. (2006). The effects of exposure to feminist ideology on women's body image. *Body Image, 3*, 237-246.

Pinto, A. M., Guarda, A. S., Heinberg, L. J., & DiClemente, C. C. (2006). Development of the Eating Disorder Recovery Self-Efficacy Questionnaire. *International Journal of Eating Disorders, 39,* 376-384.

Pinto, A. M., Heinberg, L. J., Coughlin, J. W., Fava, J. L., & Guarda, A. S. (2008). The Eating Disorder Recovery Self-Efficacy Questionnaire: Change with treatment and prediction of outcome. *Eating Behavior, 9,* 143-153.

Rickard, K. M. (1987, March). *Feminist Identity Development: Scale development and initial validation studies.* Paper presented at the annual meeting of the Association of Women in Psychology, Denver, CO.

Roberts, T. A., & Waters, P. L. (2004). Self objectifications and that "not so fresh feeling": Feminist therapeutic interventions for healthy female embodiment. *Women & Therapy, 27,* 5-21.

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services, 48,* 1042-1047.

Rosen, J. C. (1990). Body image disturbance in eating disorders. In T.F. Cash & T. Pruzinsky (Eds.), *Body images development, deviance and change* (pp. 190-214). New York: Guilford Press.

Sabik, N. J., & Tylka, T. L. (2006). Do feminist identity styles moderate the relation between perceived sexist events and disordered eating? *Psychology of Women Quarterly, 30,* 77- 84.

Saksvig, B., Gittelsohn, J., Harris, S., Hanley, A., Valente, T., & Zinman, B. (2005). A pilot school-based healthy eating and physical activity intervention improves diet, food knowledge, and self-efficacy for native Canadian children. *Journal of Nutrition*, *135*, 2392-2398.

Sallit, J., Ciccazzo, M., & Dixon, Z. (2009). A cognitive-behavioral weight control program improves eating and smoking behaviors in weight-concerned female smokers. *Journal of the American Dietetic Association*, *109*, 1398-1405.

Segal, S. P., Silverman, C., & Temkin, T. (1995). Measuring empowerment in client-run self-help agencies. *Community Mental Health Journal, 31,* 215-227.

Simonavice, E., & Wiggins, M. (2008). Exercise barriers, self-efficacy, and stages of change. *Perceptual & Motor Skills, 107*, 946-950.

Striegel-Moore, R., & Bulik, C. (2007). Risk factors for eating disorders. *American Psychologist*, *62*, 181-198.

Tuuri, G., Zanovec, M., Silverman, L., Geaghan, J., Solmon, M., Holston, D., et al. (2009). "Smart Bodies" school wellness program increased children's knowledge of healthy nutrition practices and self-efficacy to consume fruit and vegetables. *Appetite*, *52*, 445-451.

Wolf, N. (1991). *The beauty myth*. New York: Harper Collins.

World Health Organization. (2006). BMI Classifications. Retrieved from http://apps.who.int/bmi/index.jsp?introPage=intro_3.html.

Table 1

Demographic Distribution of the Sample (n = 184)

Age	Percent
18	57.6
19	19.6
20	12.5
21	3.3
22	.5
24	.5

Race/Ethnicity	Percent
White	91.3
Black	4.3
Latino	3.3
Asian	1.1

Marital Status	Percent
Single	96.7
Cohabitating	3.3

College Year	Percent
Freshman	63.6
Sophomore	19.0
Junior	14.1
Senior	2.2
More than 4 years	.5

Table 1(continued)

Descriptive Distribution of the Sample

Religious Affiliation	Percent
Protestant	55.4
Catholic	15.8
Jewish	1.1
Hindu	.5
Buddhist	1.1
Other	25.0
BMI Categories	Percent
Underweight	2.2
Normal	70.7
Overweight	20.7
Class I Obese	2.7
Class II Obese	2.2

Table 2

Descriptive Statistics on Demographic, Self-Efficacy, Empowerment, Feminism, Body Image, and Eating Behaviors Measured.

	N	Min	Max	Mean	SD
Age	173	18	24	18.64	.97
Weight	182	95	230	141.96	24.84
Height_Inches	183	57.00	73.00	65.47	2.86
BMI	181	16.83	40.74	23.33	3.87
EDSRQ_NE	184	1.57	5.00	3.82	.82
EDSRQ_BI	184	1.11	4.89	2.95	.90
ES_SE	184	2.33	4.00	3.25	.41
ES_PP	184	1.50	4.00	2.84	.38
FIC_PA	184	1.00	4.38	2.85	.67
FIC_REV	184	1.00	4.88	2.46	.75
FIC_EMBED	184	1.00	4.86	2.74	.70
FIC_SYN	184	1.00	5.00	3.95	.56
FIC_AC	184	1.00	5.00	3.50	.66
MBSRQ_BAS	184	1.00	5.00	3.42	.69
MBSRQ_AE	184	1.00	5.00	3.33	.76
EAT_Total	184	2.00	59.56	11.20	9.51

Note. BMI = Body Mass Index; EDSRQ_NE = Eating Disorder Recovery Self-Efficacy

Questionnaire Normative Eating Self-Efficacy subscale; EDSRQ_BI = Eating Disorder

Recovery Self-Efficacy Questionnaire Body Image Self-Efficacy subscale; ES_SE = Empowerment Scale Self-Esteem/Self-Efficacy subscale; ES_PP = Empowerment Scale Power/Powerlessness subscale; FIC_PA = Feminist Identity Composite Passive Acceptance; FIC_REV = Feminist Identity Composite Revelation; FIC_EMBED = Feminist Identity Composite Embeddedness; FIC_SYN = Feminist Identity Composite Synthesis; FIC_AC = Feminist Identity Composite Active Commitment; MBSRQ_BAS = Multidimensional Body-Self Relations Questionnaire Body Area Satisfaction; MBSRQ_AE = Multidimensional Body-Self Relations Questionnaire Appearance Evaluation ; EAT_Total = Eating Attitudes Test Total

Table 3

Correlations of Body Image, Disordered Eating, Feminism and Empowerment Scales

	EAT	MBSRQ-AE	MBSRQ-BAS
FIC_PA	.045	-.184**	-.168*
FIC_REV	.037	-.088	-.04
FIC_EMBED	.097	-.020	.018
FIC_SYN	.003	.279**	.208**
FIC_AC	-.021	.288**	.248**
ES_SE	-.256**	.453**	.489**
ES_PP	-.166*	.320**	.258**

Note. EAT = Eating Attitudes Test; MBSRQ_AE = Multidimensional Body-Self Relations Questionnaire Appearance Evaluation; MBSRQ_BAS = Multidimensional Body-Self Relations Questionnaire Body Area Satisfaction; FIC_PA = Feminist Identity Composite Passive Acceptance; FIC_REV = Feminist Identity Composite Revelation; FIC_EMBED = Feminist Identity Composite Embeddedness; FIC_SYN = Feminist Identity Composite Synthesis; FIC_AC = Feminist Identity Composite Active Commitment; ES_SE = Empowerment Scale Self-Esteem/Self-Efficacy subscale; ES_PP = Empowerment Scale Power/Powerlessness subscale.

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

Table 4

Regression Model of Disordered Eating and Body Image Predicted by Empowerment

Criterion	Step	Predictors	R^2	R^2 Change
EAT Total	1	ES_SE	.066	.066**
	2	ES_SE + ES_PP	.071	.005
MBSRQ_BAS	1	ES_SE	.239	.239**
	2	ES_SE + ES_PP	.244	.005
MBSRQ_AE	1	ES_SE	.206	.206**
	2	ES_SE + ES_PP	.229	.024*

Note. EAT = Eating Attitudes Test; MBSRQ_BAS = Multidimensional Body-Self Relations Questionnaire Body Area Satisfaction; MBSRQ_AE = Multidimensional Body-Self Relations Questionnaire Appearance Evaluation.

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

Table 5

Regression Model of Disordered Eating and Body Image Predicted by Empowerment and Self-Efficacy

Criterion	Step	Predictors	R^2	R^2 Change
EAT Total	1	ES_SE + ES_PP	.071	.071**
	2	ES_SE + ES_PP + EDSRQ_NE + EDSRQ_BI	.270	.199**
MBSRQ_BAS	1	ES_SE + ES_PP	.244	.244**
	2	ES_SE + ES_PP + EDSRQ_NE + EDSRQ_BI	.534	.289**
MBSRQ_AE	1	ES_SE + ES_PP	.229	.229**
	2	ES_SE + ES_PP + EDSRQ_NE + EDSRQ_BI	.569	.340**

Note. EAT = Eating Attitudes Test; MBSRQ_BAS = Multidimensional Body-Self Relations Questionnaire Body Area Satisfaction; MBSRQ_AE = Multidimensional Body-Self Relations Questionnaire Appearance Evaluation.

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

Appendix A

To: Lisa Grizzard
Psychology
CAMPUS MAIL

From:_____
        Jay Cranston, MD, Chair, Institutional Review Board

Date: 5/05/2009

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

Study #: 09-0244
Study Title: Empowerment, Feminism and Self-Efficacy: Relationships with Disordered Body Image and Eating
Submission Type: Initial
Expedited Category: (7) Research on Group Characteristics or Behavior, or Surveys, Interviews, etc.

Approval Date: 5/05/2009
Expiration Date of Approval: 5/04/2010

This submission has been approved by the Institutional Review Board for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Investigator's Responsibilities:

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Should any adverse event or unanticipated problem involving risks to subjects occur it must be reported immediately to the IRB.

CC:
Jessica Kinsaul, Psychology

Appendix B

Participant Consent Statement

I. Purpose of this research/project

The purpose of the present study is to explore the relationship between thoughts and feelings about culture and women's health.

II. Procedures

You must be at least 18 years old to participate in this study. You will be asked to report demographic information (e.g., age), height, and weight, and will then be asked to answer questions about culture and personal health. Completing these questionnaires will take approximately one hour.

III. Risks

There is no foreseeable risk of harm or discomfort from participation in this study. However, if you experience negative emotions after participation in this study please contact that Appalachian State Counseling Center at (828) 262-3180.

IV. Extent of confidentiality

All information provided will be kept confidential. Your name will only be on your consent form which will not be linked to your responses on the questionnaires.

V. Compensation

Participants will receive proof of participating in research which may be used for extra credit in participating undergraduate psychology classes in accordance with the policies of your instructor.

VI. Freedom to withdraw

Participation is completely voluntary and refusal to participate involves no penalty. You may choose not to answer all questions and you may discontinue participation at any time.

VII. Approval of research

This research project has been approved by the Institutional Review Board at ASU. For further information about this research study and/or the rights of research subjects, please contact: Jessica Kinsaul by calling 404-735-7078 or emailing kinsaulj@appstate.edu; Dr. Lisa Curtin by calling 828-262-2729 or emailing curtinla@appstate.edu; or IRB Chairperson Dr. Jay Cranston at 828-262-2692.

VIII. Subject's Responsibilities

I voluntarily agree to participate in this study. This statement certifies that I am eighteen years of age or older, have had all of my questions answered, and have read and agreed to the terms of the consent.

_____   _____

Signature of Participant   Date

Appendix C

Demographics Questionnaire

Age _____

Race Ethnicity ___
1. Caucasian/White
2. African American/Black
3. Hispanic/Latino
4. Asian/Asian American
5. Hawaiian/Pacific Islander
6. American Indian/Alaska Native
7. Other

Marital Status ___

1. Single
2. Married
3. Divorced
4. Separated
5. Widowed
6. Cohabitating with significant other

College Year ___

1. Freshman
2. Sophomore
3. Junior
4. Senior
5. More than 4 years

GPA _____

Religious Affiliation ___

1. Protestant Christian
2. Roman Catholic
3. Jewish
4. Muslim
5. Hindu
6. Buddhist
7. Other _____

Yearly Household Income ___

(If claimed as a dependent for tax purposes, use family income)

1. Less than 10,000 a year
2. 10,000 to 25,0000 a year
3. 26,000 to 40,0000 a year
4. 41,000 to 75,000 a year
5. 76,000 to 100,000 a year
6. More than 100,000 a year

Involved in college sports? ___

1. Yes
2. No

Height ___ feet ___ inches

Weight ____ lbs

Appendix D

Written Debriefing Form

Empowerment, Feminism and Self-Efficacy : Relationships with Disordered Eating and Body Image

Thank you for participating in this study. Theoretically, it is likely that identification with feministic beliefs and personal empowerment and self-efficacy may protect women from disorder eating behaviors and negative body image. By participating in this study, you answered questions assessing each of these areas. We will explore the relationships between feminism, self-efficacy and empowerment with eating behavior and body image among a large sample of undergraduate women. All of the relationships will be described for the entire sample on average (e.g., no reports of individual responses). As mentioned in the consent form, there is no foreseeable risk of harm or discomfort from participating in this study. However, if you experience negative emotions after participation in this study please contact that Appalachian State Counseling Center at (828) 262-3180.

Jessica Kinsaul

174 Carolina Avenue
Boone, NC 28607
Phone: 404-735-7078
E-mail: kinsaulj@appstate.edu

EDUCATION   Appalachian State University, Boone, North Carolina
Master of Arts Candidate, Clinical Health Psychology
August, 2010 (expected)
GPA 3.75/4.0
Thesis: Empowerment, Feminism and Self-Efficacy: Relationships with Disordered Body Image and Eating
Supervisor: Dr. Lisa Curtin (curtinla@appstate.edu)

University of Georgia, Athens, Georgia
Bachelor of Science, Psychology – Magna Cum Laude
December, 2006
GPA 3.7/4.0

Georgia Perimeter College, Lawrenceville, Georgia
Core Curriculum, August 2002 – May 2004
GPA 3.94/4.0

HONORS   Phi Theta Kappa, *Member*
Dean's list, *Fall 2002 – Spring 2005*
Presidential Scholar, *Summer 2005*
HOPE Scholarship, *Recipient*

CLINICAL EXPERIENCE

Community Support Worker
HomeCare Management Corporation   Boone, North Carolina
Supervisor: Claudia Gross, MS – 828-264-1021
June 2009-August 2009
- Assist consumers in increasing skills to address mental health needs in coordination with treatment goals
- Provide consumer with access to the community
- Participate in one-on-one interventions as well as team treatment planning meetings

Graduate Research and Teaching Assistant
Appalachian State University   Boone, North Carolina
Supervisor: Dr. Lisa Curtin – 828-262-2729
August 2008 – May 2009; August 2009 - Present
- Review literature and organize research for grant proposals
- Organize, schedule and keep minutes for research team meetings
- Data collection
- Aid in the grading process for undergraduate psychology classes (Addictive Behaviors, Contemporary Issues in Psychology)
- Supplemented instruction and supervision in graduate level psychology class (Psychotherapy Interventions I)

Mental Health Assistant
Peachford Behavioral Health System   Atlanta, Georgia
Supervisor: Rebecca Hayes, RNC – 770-455-3200
April 2008 – August 2008
- Monitored unit patients and completed rounds
- Participated in treatment planning
- Assisted in admissions process, taking vital signs and conducting safety searches
- Prepared and conducted group sessions

OTHER PROFESSIONAL EXPERIENCE
Master's Level Extern
Appalachian State University Counseling Center   Boone, NC
Supervisor(s): Dr. Sheri Clark, Dr. Denise Lovin and Dr. Leslie Martin – (828)262-3180
Goal of 500 hours currently in progress
January 2010 – August 2010
- Conducted individual therapy sessions with clients
- Participated in treatment planning and goals as well as diagnosis
- Wrote therapy notes
- Process observed and co-led complex trauma group and body image group
- Observed and conducted walk-in interviews

Practicum Student Clinician in Training
Appalachian State University Counseling Center   Boone, NC
Supervisor(s): Dr. Sheri Clark and Dr. Amber Lyda - (828)262-3180
Individual Therapy Acquired: 44 hours
Supervision Acquired: 38 hours
August 2009 – December 2009; January 2010 – Present
- Conducted individual therapy sessions with clients
- Participated in treatment planning and goals as well as diagnosis
- Wrote therapy notes

Practicum Student Clinician in Training
Appalachian State University Psychology Clinic   Boone, NC
Supervisor(s): Dr. Josh Broman-Fulks and Dr. Hank Schneider – 828-268-2713
Psychological Assessment Experience Acquired: 27 hours
Supervision Acquired: 22 hours
January 2009 – May 2009; September 2009 – December 2009
- Conducted clinical evaluations for clients with mental disorders
- Provided academic coaching to clients according to established protocol
- Wrote psychological evaluation reports
- Provided client feedback on diagnosis

PTSD Group Facilitator
Grandfather Home for Children   Banner Elk, NC
Supervisor: Dr. Robert Hill – 828-262-2723
September 2008 – January 2009
Group Therapy Acquired: 6 hours

Supervision Acquired: 3 hours
- Led group according to established protocol
- Guided children in expression of feelings and thoughts
- Prepared crafts and exercises for activities

PRESENTATIONS

Kinsaul, J., Curtin, L., Bazzini, D., & Martz, D. (2010, March). *Feminism and Self-Efficacy:*

Relationships with Disordered Body Image and Eating. Poster session presented at the

annual conference of the Southeastern Psychological Association, Chattanooga, TN.

Curtin, L., Barker, M., Domanico, P., Bryant, J., Kinsaul, J., & Tamamura, A. (2010, March).

Analysis of College Student Drinking Discussion. Poster session presented at the annual

conference of the Southeastern Psychological Association, Chattanooga, TN.

Barker, M., Bryant, J., Domanico, P., Tamamura, A., & Kinsaul, J. (2009, April). *Analysis of*

College Student Drinking Discussion. Poster session presented at the annual

conference of the Celebration of Student Research and Creative Endeavors, Boone, NC.

Crawford, M. E., Calhoun, K. S., Kinsaul, J., & Williams, E.A. (2007, November). *Sexual*

Revictimization: The role of interpersonal effectiveness in protecting against repeated

sexual assault. Poster session presented at the annual conference of the Association for

Behavioral and Cognitive Therapies, Philadelphia, PA.