2018

The Impact of Feminist Identity Development on the Internalization of Sociocultural Pressures and Body Dissatisfaction

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THE IMPACT OF FEMINIST IDENTITY DEVELOPMENT ON THE INTERNALIZATION OF SOCIOCULTURAL PRESSURES AND BODY DISSATISFACTION

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY

BY

JILL R. KLOTZMAN, PSY.M.

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

Dayton, Ohio **July 2019**

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June 21, 2018

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **JILL R. KLOTZMAN** ENTITLED **THE IMPCT OF FEMINIST IDENTITY DEVELOPMENT ON THE INTERNALIZATION OF SOCIOCULTURAL PRESSURES AND BODY DISSATISFACTION** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

The purpose of the present study was to examine the relationship between perceived sociocultural pressures and internalization of the thin ideal and to determine whether or not high levels of feminist identity development moderate this relationship. The study also investigated the relationship between internalization of the thin ideal and body dissatisfaction and whether or not high levels of feminist identity development moderated the relationship. Two multiple hierarchical regression analyses were performed using data collected from a female undergraduate student sample (*N*=403) from Wright State University. These data were derived from a survey containing the Perceived Sociocultural Pressure Scale (PSPS; Stice & Argas, 1998), the Body Stereotype Scale-Revised (IBSS-R; Stice, Marti, Spoor, Presnell, & Shaw, 2008), the Body Areas Satisfaction Scale-Revised (BASS-R; Petrie, Tripp, & Harvey, 2002), and the Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991). Findings showed that while pressures and internalization and internalization and body dissatisfaction were significantly and positively correlated, high levels of feminist identity development did not moderate the strength of these relationships. The findings of this study indicate that future research is necessary to pinpoint specific aspects of feminist identity that may serve to protect women from internalization and/or the development of body dissatisfaction. Furthermore, this study highlighted that further research is necessary in order to better understand how and why women with higher levels of feminist identity development tend to perceive more sociocultural pressure to be thin than their less feminist counterparts.

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Acknowledgement

Writing this dissertation in the midst of coursework, clinical work, and life in general has been a challenge unlike any other academic endeavor I have undertaken before. The marathon that is doctoral-level education has pushed me beyond my perceived limits and enabled me to learn more than I ever knew possible. If not for the love, support, and mentorship from numerous remarkable individuals in my life, this undertaking would not have been possible.

First, I would like to thank my former Dissertation Chair, Christopher Modica. Although we only had a brief time together working as advisor and advisee, I will be forever impacted by your confidence in me, your words of affirmation and guidance, and your mentorship. I am so grateful that you were a part of my doctoral journey. Additionally, I would like to give special thanks to Jeremy Schumm, who graciously stepped in to fill the role of Dissertation Chair midway through my third year at SOPP. Without your support and statistical expertise, this project would not have been possible. I would also like to thank my committee members, Daniela Burnworth and Cheryl Meyer. I have very much valued the support and feedback that I have received from you both. You have both challenged me to think critically about the execution of this project and have provided your thoughts and expertise to guide me in right direction.

Finally, I must thank my fiancé Michael. Without your love, encouragement, and stress-management tips, I do not think this project would have come to fruition. I am truly grateful to have such a patient, considerate, and supportive partner to walk through life with me. To all of those listed above and to the many others who have impacted my life in countless ways over the last four years, a sincere and heartfelt thank you.

Dedication

This project is dedicated to all of the women and girls who have ever doubted their worth, intelligence, or ability; to those who have ever felt inadequate, ugly, or undeserving of love. This project is for those who are not yet able to see that their beauty is so much deeper than the image reflected back in the mirror. No matter what you see on TV, read in the magazines, or hear from friends and family, you are beautiful and stronger than you know!

Chapter I

Statement of the Problem

Various theorists have proposed that the adoption of feminist ideology should protect women from body dissatisfaction in that women who endorse feminist ideology have a tendency to critically evaluate and resist negative sociocultural messages that promote body concern (Green et al., 2008; Murnen & Smolak, 2008). While numerous researchers have examined the association between feminist identity and body dissatisfaction and/or eating disorder outcomes, relatively few have also explored the relationship between feminist identity and internalization of sociocultural messages (e.g. Fingerat & Gleaves, 2004; Leggatt, 2004; Murnen & Smolak, 2008; Myers & Crowther, 2007). This means that while researchers have examined whether or not feminist women are protected from body image problems, few have sought to pinpoint how feminist identity disrupts or alters the process of body dissatisfaction development (see Murnen & Smolak, 2008).

In addition to being relatively understudied, the strength of the relationship between feminism, internalization, and body dissatisfaction has been variable across studies (e.g. Fingerat & Gleaves, 2004; Leggatt, 2004; Myers & Crowther, 2007; Slaviero, 2006; Beamer, 1999; Snyder & Hasbrouck, 1996). It is likely that some of this variability is attributable to methodological differences between studies; such as how variables were operationalized, which measures were used, and which theoretical model of eating disorder development guided the study. With few studies on this subject and

variable results across studies (i.e. some results statistically significant, some non-significant), the role of feminist identity within the context of body dissatisfaction development is worthy of further examination.

One problematic aspect of the extant feminist identity development/body dissatisfaction research is that feminist identity has been operationalized in various ways across studies. While some studies have focused on attitudes towards the women's movement (e.g. Fingeret & Gleaves, 2004; Ojerholm & Rothblum, 1999; Tiggemann & Stevens, 1999), others have focused on feminist self-identification (e.g. Cogan, 1999; Haines, Erhcull, Liss, Turner, Nelson, Ramsey, 2008; Hurt, Nelson, Turner, Haines, Ramsey & Erhcull, 2007) and feminist beliefs and attitudes (e.g. Cash, Ancis, & Strachan, 1997; Green et al., 2008; Snyder & Hasbrouck, 1996). While each of these researchers claim to measure feminist identity development (FID), there is clear disagreement with regard to the definition of this term (see Shibley, 2002). It is possible that the discrepant findings between the aforementioned studies may be partially attributable to the fact that researchers claimed to be measuring the same construct (i.e. FID), when they were actually measuring different features of the same construct. Theorists have suggested that women with high levels of FID are less susceptible to the internalization of negative social messages because they hold beliefs and attitudes that lead them to critically evaluate socially-constructed gender norms (Green et al., 2008). The present study will therefore measure participants' feminist attitudes and beliefs without requiring feminist self-identification or explicit endorsement of feminism.

The construct of body dissatisfaction has also been operationalized in various ways across studies. While some studies have used measures that assess satisfaction with

specific body parts (e.g. Eisele, 2007; Fingerat & Gleaves, 2004) others have explored shame and self-consciousness as it relates to body shape and weight (e.g. Haines et al., 2008; Snyder & Hasbrouck, 1996). It is possible that some of the inconsistent findings within the FID/body dissatisfaction research may be partially attributable to these differences in the operationalization of body dissatisfaction. While each of these researchers claim to measure the construct of body dissatisfaction, some focus more on the consequential attitudes related to body dissatisfaction (i.e. shame and self-consciousness) rather than the dissatisfaction itself. For the purposes of the present study, body dissatisfaction will be assessed via participant ratings of satisfaction or dissatisfaction with specific body parts.

Within the FID/body dissatisfaction literature, there are two predominant theories of eating disorder development that consider the role of internalization: Stice's (1994) dual pathway model and the self-objectification model. Both theorists assert that the internalization of sociocultural messages is central to the development of body dissatisfaction; however, the theories differ as to *why* sociocultural messages lead to body dissatisfaction. Stice proposes that body dissatisfaction and pathological eating behaviors are the result of internalization of the thin ideal and subsequent drive and struggle to attain that ideal (Stice, 1994). Self-objectification theory posits that women develop body dissatisfaction when they internalize messages about the objectification and sexualization of women's bodies, and subsequently treat themselves as objects to be evaluated based on appearance (Myers & Crowther, 2007). Each of these conceptual frameworks focuses on different aspects of internalization and body dissatisfaction, which may explain some of the mixed results across the literature base. It is likely that researchers selected different

measures of body dissatisfaction and internalization depending on which theoretical framework they chose to guide their research. The present study will utilize the framework of Stice's (1994) dual pathway model and will focus on the internalization of the thin ideal and the negative consequences that arise in pursuit of this ideal as the primary mechanism of body dissatisfaction development.

Overall, the present research will contribute to the literature base by providing additional data regarding the relatively understudied role of FID as it relates to internalization and body dissatisfaction within the framework of Stice's (1994) dual pathway model. Systematic research on potential moderators of body dissatisfaction has and will continue to help researchers to better understand the mechanisms that underlie successful eating disorder prevention and treatment programs (Stice & Becker et al., 2013). The results of this study may be used to inform prevention and treatment of body dissatisfaction. By enhancing the efficacy of eating disorder prevention programs and treatment, multiple comorbid public health problems, such as depression, anxiety, and suicidality, may also be addressed and minimized (Stice & Becker et al., 2013). Given the pervasiveness of body dissatisfaction in Western society, it is critical to perform research that helps to identify possible predictors, moderators, and protective factors for eating disorder development.

The aim of the present study is to examine whether or not high levels of FID moderate the relationship between sociocultural pressures and the internalization of these societal messages and/or the relationship between internalization and body dissatisfaction. This study was designed to better understand the role of FID within the context of Stice's (1994) dual pathway model of bulimia nervosa. This theoretical model

posits that body dissatisfaction arises from the internalization of sociocultural messages surrounding physical appearance. When women internalize the thin ideal and subsequently identify disparities between their own bodies and the ideal female form, they are likely to become dissatisfied with their bodies and may engage in behaviors aimed at achieving the thin ideal (Stice, 1994).

The findings of the present study may help to clarify where in the process of body dissatisfaction development (if any) FID plays a disruptive/protective role. Additionally, the results of this study may be used to help to inform and enhance eating disorder treatment and/or prevention programs.

Chapter II

Literature Review

In Western culture, there are many societal forces that promote an ultrathin body type as the epitome of female beauty. The degree to which one internalizes this societally promoted thin ideal putatively fosters a sense of body dissatisfaction due to the difficultly of attaining such an idealized appearance (Stice & Presnell, 2007). Body dissatisfaction is so pervasive among women and girls in North America, that a moderate degree of body dissatisfaction is now considered to be normative (e.g. Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). Sociocultural pressures from the media, peers, and family, coupled with unrealistic body image norms, place adolescent girls and young women at an elevated risk for developing body dissatisfaction and subsequent pathological eating behaviors (Stice, Becker, & Yokum, 2013). Due to the prevalence of pathological eating behavior among North American women, a subset of eating disorder research has focused on potential moderators of body dissatisfaction, including the role of FID (e.g. Green et al., 2008; Murnen & Smolak, 2008). The literature review that follows provides a general overview of the recent research on body dissatisfaction, eating disorders, a sociocultural framework for understanding eating disorder development, and FID.

Body Dissatisfaction and Eating Disorders

Over the last several decades, body dissatisfaction has emerged as a prominent risk and maintenance factor in eating disorder pathology (e.g Boone & Soenens, 2015; Cooley & Toray, 2001; Stice & Shaw, 2002; Thompson et al., 1999). Body

dissatisfaction refers to negative subjective evaluations of one's physical body, such as figure, weight, or specific body parts (Stice & Shaw, 2002). Body dissatisfaction is a distinct construct that should be differentiated from body image distortion, a common symptom of anorexia nervosa (AN; American Psychological Association, 2013). Body image distortion refers to the phenomenon in which an individual perceives his or her body shape to be significantly larger than it truly is (Stice & Shaw, 2002). Although body image distortion and body dissatisfaction are distinguishable constructs, they are not always mutually exclusive and can be interactional in nature (Stice & Shaw, 2002). It is also important to distinguish between body dissatisfaction and self-evaluation that is unduly influenced by body shape and weight, which is a symptom of both bulimia nervosa (BN) and AN (Stice & Shaw, 2002). While body dissatisfaction may be associated with an over-emphasis of weight and shape in determining self-worth, body dissatisfaction is not requisitely linked to self-worth (Wilksch & Wade, 2009).

Body dissatisfaction is thought to increase the risk of eating pathology through two central mechanisms: Dieting and negative affect (Stice, 1994; Stice & Shaw, 2002). Body dissatisfaction often leads to dietary restraint because of the commonly held belief that dieting is an effective weight management solution (Stice, 1994; Stice & Shaw, 2002). Numerous empirical studies have indicated that increases in body dissatisfaction are positively related to higher levels of dietary restraint and to the prediction of eating disorder pathology (e.g. Allen, Byrne & McLean, 2012; Graber, Brooks-Gunn, Paikoff, & Warren, 1994; Johnson & Wardle, 2005; Stice & Argas, 1998). Theoretically, dieting may evolve into pathologically restrictive eating when weight control efforts are reinforced by successful weight loss and/or by positive responses from valued others (e.g.

family and peers; Stice & Shaw, 2002). Dieting may also promote the development and maintenance of binge eating disorder (BED), or BN, as some individuals may engage in binge eating to counter the deleterious effects of caloric deprivation. Furthermore, disinhibited eating behaviors, such as binge eating, may also arise in the wake of strict dietary rules violation (Stice & Shaw, 2002). According to Marlatt and Gordon's (1985) abstinence-violation effect, when an individual violates a set of stringent internal rules (e.g. rigid dietary rules), they tend to engage in self-blaming attributions for abstinence violations, thereby increasing the probability of derailing further abstinence behavior. For individuals with BN or BED, this means that even small dietary lapses are often perceived as representing a complete loss of control, and when coupled with self-criticism, this often results in binge eating (Grilo & Shiffman, 1994).

In addition to the dietary pathway from body dissatisfaction to eating pathology, theorists have suggested that there may also be a negative affect regulation pathway (e.g. Grilo & Shiffman, 1994; Stice, 1994; Stice, Shaw, & Nemeroff, 1998). Within this framework, negative affectivity is defined as the tendency to experience unpleasant emotional states, such as shame, disgust, anger, sadness, frustration, or fear (Rhode, Stice, & Marti, 2015). Body dissatisfaction is thought to contribute to negative affect because of the centrality of appearance as an evaluative metric in Western society (Stice & Shaw, 2002). When women evaluate or compare their bodies to the thin ideal, the discrepancies they find may lead to the induction of negative affect. For some women, binge eating serves as a coping strategy for comforting or distracting from these negative emotions (Heatherton & Baumeister, 1991). Individuals might also utilize compensatory behaviors such as fasting, over exercising, or self-induced vomiting in an effort to reduce

anxiety about impending weight gain subsequent to binge eating (Stice & Shaw, 2002). In these ways, negative affect may serve as a mediator between body dissatisfaction and eating disorder pathology (see Fig. 1 for graphical depiction).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychological Association, 2013) has classified pathological eating behavior into three categories: Feeding and eating disorders, other specified feeding and eating disorders, and unspecified feeding and eating disorders. Threshold feeding and eating disorders include AN, BN, and BED. Some examples of other specified feeding and eating disorders include atypical AN, sub-threshold BN, sub-threshold BED, and purging disorder (PD). Stice, Marti, and Rhode (2013) found that the lifetime prevalence of any eating disorder by age 20 is 13.1%, with 0.8% lifetime prevalence for AN, 2.6% for BN, 3.0% for BED, 2.8% for atypical AN, 4.4% for sub-threshold BN, 3.6% for sub-threshold BED, and 3.4% for PD. Overall, when looking at lifetime prevalence, more individuals receive other specified feeding and eating disorder diagnoses (11.5%) than threshold eating disorders (5.2%); (Stice & Marti et al., 2013).

Eating disorders are marked by chronicity, relapse, comorbidity, functional impairments, suicide attempts, medical complications, and mortality (DSM-5, American Psychological Association, 2013). Crow et al. (2009) found that based on DSM-IV diagnostic criteria, the overall mortality rate for treatment-seeking individuals with AN, BN, and eating disorder not otherwise specified (EDNOS) was 4.5%. Nearly two-thirds of deaths were attributed to eating disorder-related medical complications, followed by completed suicide, substance-use related, and trauma-related causes (Crow et al., 2009). When each disorder is considered independently, the risk of death is notably highest for

those with AN, followed by EDNOS and BN respectively (Arcelus, Mitchell, Wales, & Nielsen, 2011). In fact, the ratio of observed to expected deaths (i.e. the standardized mortality ratio [SMR]) was found to be more than three times higher for individuals with AN (i.e. 5.86) than for individuals with EDNOS (1.92) and BN (1.93). As a point of reference, the SMR for females with schizophrenia is 2.5, 2.1 for females with bipolar disorder, and 1.6 for females with major depressive disorder (Arcelus et al., 2011). These notable mortality rates necessitate continued research on the prevention and treatment of body dissatisfaction and related pathological eating behaviors.

In addition to mortality and morbidity, eating disorders generate significant economic and social costs (Mathers, Vos, & Stevenson, 1999). While there is a robust literature base on the economic burden of many other mental health disorders (e.g. depression), the economic burden of eating disorders has been relatively understudied (Striegel-Moore, DeBar, Wilson, Dickerson, Rosselli, Perrin, Lynch, & Kraemer, 2008). Of the existing research on eating disorder costs, the majority has focused healthcare costs and utilization. Comparatively, there is little information available about the impact of eating disorders on workplace productivity, employment status, and earnings (Samnaliev, Noh, Sonneville, & Austin, 2015). In terms of healthcare costs, a study by Samnaliev et al. (2015) revealed that annual healthcare expenses for respondents with eating disorders were on average 47% greater than the respondents without eating disorders. This notable increase in expenditure is likely attributable to the fact that those individuals with eating disorders tend to receive more services than healthy individuals. In addition to primary care and/or mental health services, individuals with eating disorders have been shown to utilize additional care in the form of telephone

consultations, specialty care, prescription medications, and emergency/urgent care (Lynch, Striegel-Moore, Dickerson, Perrin, DeBar, Wilson & Kraemer, 2010; Striegel-Moore et al., 2008). Although the full extent of healthcare costs related to eating disorders is not yet known, preliminary data highlight the need for further treatment and prevention research to minimize the economic burden of these disorders.

Lost workplace productivity associated with eating disorders has not yet been widely examined. Existing studies have utilized survey data such as the Medical Expenditure Panel Survey (MEPS) or self-report data from eating disorder samples in order to quantify lost productivity (Lynch et al., 2010; Samnaliev et al., 2015). While the conclusions from these studies are limited in their generalizability due to small sample sizes and demographic homogeneity, Samnaliev et al. (2015) reported that adult individuals with eating disorders were less likely to report earnings in the past 12 months when compared to respondents without eating disorders. Furthermore, annual earnings of working individuals with eating disorders were approximately 7% less than respondents without eating disorders (Samnaliev et al., 2015). In a study on the economic burden of BED, Lynch et al. (2010) found that the annual number of days lost from work due to BED was similar to the diminished workplace productivity of individuals with moderate depression. The preliminary evidence of diminished workplace productivity and the known functional impairments associated with eating disorders illustrate the far-reaching social, economic, and public health impact of these disorders.

The Sociocultural Model of Disordered Eating

The prevalence, mortality, and economic burden of eating disorders have prompted the development of numerous theoretical models of eating disorder

development (Stice & Becker et al., 2013). One such model is Stice's (1994) dual pathway model of BN, which has been well supported by research (e.g. Stice et al., 1998; Stice & Shaw, 2002; Stice, Shaw, Becker, & Rhode, 2008, Rohde, Stice, & Marti, 2015). While the pathogenesis of disordered eating is multidetermined, it has been theorized that sociocultural pressures play a crucial role in the development and maintenance of eating disorders (Stice, 1994; Stice & Shaw, 1994). Stice's (1994) model proposes that sociocultural pressures concerning physical appearance come from diverse sources such as the media, family, and peers. These sources promote a number of body-critical themes such as the thin ideal body image, the centrality of appearance in the female gender role, and the importance of appearance for women's societal success (Stice, 1994). According to Stice's theory, when women internalize these cultural messages and adopt the thin ideal as their own standard of beauty, they become increasingly susceptible to body dissatisfaction, dieting, and subsequent negative affect and disordered eating while in pursuit of an ultra-thin body shape (Stice, 1994). Figure 1 below presents a graphical depiction of the described model of body dissatisfaction and eating pathology development.

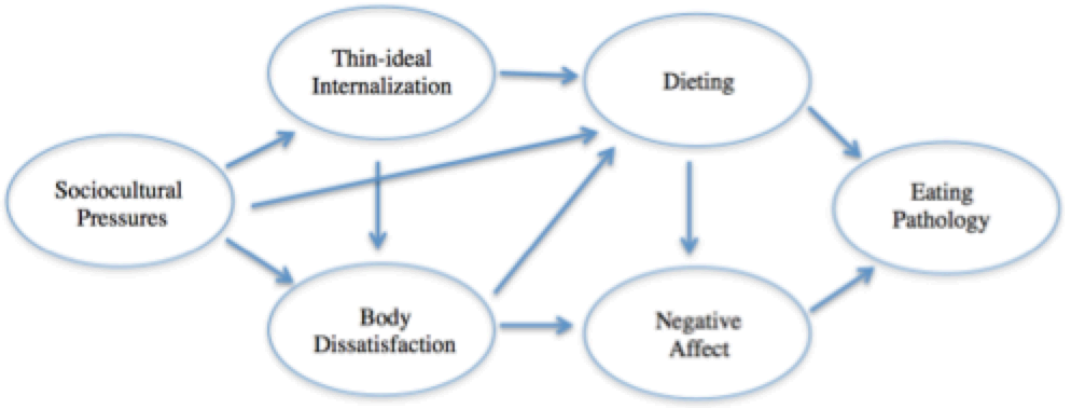

Fig. 1. Graphical depiction of precursors and consequences of body dissatisfaction. Figure recreated with expressed permission from original author.

Sociocultural pressures regarding the thin ideal are primarily transmitted to women through the messaging of mass media, family, and peers (Stice, 1994). Drawing from Bandura's (1977) social learning theory, sociocultural pressures are believed to be transmitted via two distinct mechanisms: Imitation and social reinforcement (Stice, 1994; Stice & Shaw, 2002). Imitation refers to the process in which new behaviors are learned and adopted simply by observing others perform them. For example, a young girl may learn to restrict her food intake by observing her mother or friends engage in intermittent fasting. On the other hand, social reinforcement is a more active process wherein individuals adopt beliefs and behavioral practices that are promoted and approved by respected others (Bandura, 1977; Kandel, 1980). For example, a young girl's mother encourages her child to engage in intermittent fasting and praises the girl when she successfully restricts her food intake. When young girls and women are bombarded with body critical messages and are regularly reinforced for behaviors consistent with subscription to the thin ideal, they may begin to adopt attitudes and behaviors that are

conducive to eating pathology (Stice, 1994; Stice & Argas, 1998; Thompson & Stice, 2001).

Since the proposal of Stice's (1994) dual pathway model, numerous studies have been conducted to test the theorized mechanisms of action underlying eating disorder development. Overall, the research has largely supported Stice's theoretical model. For example, multiple studies have demonstrated that individuals with eating disorders reported greater amounts of perceived pressure to be thin from family, friends, and the media than their symptom-free counterparts (Costanzo & Woody, 1984; Irving, 1990; Pyle, Mitchell, & Eckert, 1981; Reina, Shomaker, Mooreville, Courville, & Brady, 2013; Rohde et al., 2015; Shannon & Mills, 2015). While these results appear to provide support for Stice's theory, it is important to note that the aforementioned studies relied largely on cross-sectional data, which precludes the ability to differentiate a precursor from a consequence of body dissatisfaction (Stice & Shaw, 2002). In response to this methodological limitation, an increasing number of prospective and empirical studies on body dissatisfaction have emerged in recent years. A number of these independent studies have found that greater perceived pressure to be thin predicts subsequent increases in body dissatisfaction and disordered eating behavior (e.g. Field, Camargo, Taylor, Berkey, Roberts, & Colditz, 2001; Reina et al., 2013; Stice, 2001). Furthermore, several prospective and experimental studies have found that even simple exposure to thin ideal media content can lead to significant increases in thin ideal internalization, body dissatisfaction, dieting, and eating pathology (Groesz, Levine, & Murnen, 2002; Harrison & Cantor, 1997; Ogden & Mundray, 1996; Posovac, Posovac, & Weigel, 2001). It is hypothesized that perceived pressures from family, friends, and the media increase one's

risk of body dissatisfaction only when these pressures are internalized. Several studies have provided support for this hypothesis by demonstrating that higher levels of thin ideal internalization increase one's risk for subsequent body dissatisfaction (Fingeret & Gleaves, 2004; Myers & Crowther, 2007; Stice, 2001). Moreover, researchers have found that the induction of cognitive dissonance surrounding sociocultural messaging can produce reductions in both thin ideal internalization and body dissatisfaction (Stice, Marti, Spoor, Presnell, & Shaw 2008; Stice & Presnell, 2007).

Moderators of Internalization and Body Dissatisfaction

In order for sociocultural messages to adversely affect one's body image, the individual must first internalize the thin ideal. If a woman does not subscribe to these sociocultural pressures and adopt the thin ideal as her own standard of beauty, she is not likely to engage in eating behaviors aimed at achieving an ultra slender appearance (Stice, 1994). Given this prerequisite, a number of studies have examined potential factors that might moderate the degree to which one internalizes body-critical commentary. Some of these researched moderators include self-esteem, self-concept clarity, social learning, and feminist identity (Brannan & Petrie, 2011; Fingeret & Gleaves, 2004; Mitchell, Petrie, Greenleaf, & Martin, 2012; Myers & Crowther, 2007; Pelletier & Dion, 2007; Rhodes & Wood, 1992; Stice, 1994; Twamley & Davis, 1999). Overall, the results of these moderation studies have been mixed. For example, while Mitchell et al. (2012) found that self-esteem was directly and inversely related to body dissatisfaction, the interaction terms were not significant, indicating that this variable did not serve as a moderator. Conversely, empirical studies by Twamley and Davis (1999)

and Brannan and Petrie (2011) provided support for self-esteem as a moderator between thin ideal internalization and body dissatisfaction.

While the literature base on potential moderators has expanded over the last several decades, relatively few studies have focused on the relationship between feminist identity, perceived sociocultural pressures, and internalization of the thin ideal (Murnen & Smolak, 2008). For perspective, a PsycINFO search of the terms "sociocultural pressures" and "feminism" yielded eight results, "internalization" and "feminism" yielded 48 results, while a search of "internalization" and the potential moderator of "self-esteem" yielded 436 results. Of the few existing studies that have examined the role of FID within the framework of a sociocultural model, the results have been varied. For example, while an empirical study by Fingeret and Gleaves (2004) did not find supporting evidence for the hypothesis that feminist ideology serves as a moderator of the relationship between internalization and body dissatisfaction, a 2007 study using a similar methodology and population found supporting evidence for the hypothesis (Myers & Crowther, 2007). A meta-analytic review of these and 24 similar studies also revealed variable results (Murnen & Smolak, 2009). For instance, Murnen and Smolak (2009) reported that even among some of the strongest and most numerous effect sizes, such as the relationship between feminist identity and internalization of media messages, there was significant variability in the effect sizes across studies. The authors of this meta-analysis performed several analyses of the heterogeneity in the effect sizes and found that the correlations tended to be higher when respondents were over the age of 20 and when the sample was not a convenience sample of introductory psychology students, but rather a more purposeful sample of students taking women, gender, and sexuality courses

(Murnen & Smolak, 2009). Furthermore, while some individual studies found significant differences between minority and non-minority respondents (e.g. Linnebach, 2004), the analysis of heterogeneity of effect sizes revealed no significant difference between studies utilizing a larger proportion of minority participants than studies with a smaller proportion (Murnen & Smolak, 2009). While these preliminary findings appear to indicate that FID plays a role in the process of internalization and body dissatisfaction development, the mixed results across studies suggest that further investigation and replication is warranted.

Feminist Identity Development

Within the current body of research on feminism and eating disorders, it remains largely unclear which specific aspects of feminist identity impact body dissatisfaction and internalization of sociocultural messages. Theorists have posited that unlike traditionally identified women, feminist-identified women are likely to be more aware of the subtle and insidious cultural messages about female beauty and may therefore be more resistant to internalizing such messages (Cash et al., 1997). It has also been proposed that the development of a feminist consciousness can help women and girls to resist gender-based sociocultural pressures that contribute to body dissatisfaction and eating pathology (e.g. Kelson, Kearney-Cooke, & Lansky, 1990; Snyder & Hasbrouck, 1996). While a number of studies have found evidence that feminist identity is associated with lower drive for thinness and lower scores on eating disorder inventories, researchers are limited to only a handful of existent FID measures and there is ongoing debate as to whether or not these measures adequately capture the nuances of FID (see Hyde, 2002; Murnen & Smolak, 2009). Historically, FID was conceptualized by Downing and Roush (1985) in a five-

stage theoretical model. As outlined below, this model specifies progression through five successive stages of FID that culminates in feminist self-identification.

The five stages of Downing and Roush's (1985) model are passive acceptance (PA), revelation (REV), embeddedness-emanation (E-E), synthesis (SYN), and active commitment (AC). These stages were established based on the premise that women who live in contemporary society must first acknowledge, then struggle with, and repeatedly work through their feelings about, the prejudice and discrimination they experience as women in order to achieve an authentic and positive feminist identity. This model assumes that FID follows a sequential, and hierarchical trajectory, with each stage building upon its precedent (Downing & Roush, 1985). The model itself was adapted, in part, from Cross's (1971) model of black identity development. Although the stages have different names, both identity development models examine where the individual locates him or herself within the broader context of societal oppression.

The first stage of PA, describes the phase in which women are either unaware or in denial of the individual, institutional, and cultural prejudice and discrimination against women. Women in this stage are likely to accept and subscribe to societally pervasive patriarchal ideology (Downing & Roush, 1985). The second stage, REV, is typically preceded by one or more contradictions that lead women to question and reject the oppression they face by living under patriarchal standards. During this stage, women will likely experience feelings of anger and resentment and may feel as though they have been deceived or manipulated. Women may also experience feelings of guilt for having participated in their own gender-based oppression (Downing & Roush, 1985).

The third stage, E-E, is characterized by the desire for emotional connectedness with other women and may be marked by a growing network of female social support. During this stage, individuals often experience a cognitive shift wherein they become open to alternative viewpoints and to a more relativistic, rather than dualistic, perspective. At this stage of FID, women may begin to experience dissonance between their newly emerging identities and the repeated experience of being treated as subordinate (Downing & Roush, 1985). Women in the fourth stage, SYN, increasingly value the positive aspects of womanhood and are able to integrate these qualities into a positive value system and self-concept. They are able to transcend traditional gender roles and to evaluate others on an individual, rather than stereotypic or gendered, basis. The final stage, AC, involves the translation of the newly developed feminist identity into meaningful and effective sociopolitical action. Women in this stage tend to have confidence in themselves and possess a strong sense of female identity and group consciousness (Downing & Roush, 1985).

Although Downing and Roush's (1985) model is the standard within the psychological research on FID, it has been criticized for its classification as a "stage model." Within developmental psychology, *stage* is a precise and technical term. According to stage theory, once a person enters a new stage, their newly acquired strategies and knowledge displace prior ways of interacting with the world (Hetherington, Parke, Gauvain, & Locke, 2004). This definition suggests that stages are sequential and unidirectional and that cognitive and behavioral strategies do not overlap between stages, except perhaps during the transition from one stage to the next. While on the surface this does not appear to be a problem for Downing and Roush's (1985) model, to date, no

empirical study has been performed to specifically examine whether this model meets criteria to be classified as a true stage model (Hyde, 2002). Even though all three of the extant FID measures have been found to demonstrate dimensions (in the factor-analytic sense), there is no evidence that these dimensions follow a hierarchical or sequential progression (Hyde, 2002). In an effort to address this issue, Bargad and Hyde (1991) measured the FID of female students as they progressed through their first women's studies course. While the study revealed that the group means changed in the predicted direction, it failed to demonstrate the hierarchical progression through the distinct stages (Bargad & Hyde, 1991; Hyde, 2002). For this reason, researchers should use caution when using an individual's current stage of FID to make qualitative assumptions about the genesis of her feminist identity.

Chapter III

Method

This study is an original survey conducted through the Wright State University Department of Psychology Research Participation System. All data were collected between September and December of 2017.

Participants

Demographic information is presented in Table 1. The participants in this study were 403 Wright State University students enrolled in undergraduate-level psychology courses. The sample was comprised entirely of cisgender females, as assessed by alignment between self-reported sex and self-reported gender identity. When asked to identify current academic year of enrollment, the majority (80.6%) of participants self-identified as freshman, followed by sophomores (11.7%), juniors (4.5%), other (2.2), and seniors (1.0%). The mean age of the participants was 19.00 (*SD* = 3.05), but they ranged from 17 to 46 years old. When asked about sexual orientation, 88.1% of participants identified as heterosexual, 9.2% identified as bisexual, 1.2% identified as asexual, 1.0% identified as other, and .5% identified as lesbian. The majority (74.7%) of participants self-identified as White/Caucasian, followed by Black/African American (14.6%), Multiracial (6.0%), Hispanic, Latina, or Spanish Origin (2.2%), and Asian, Native Hawaiian, or Pacific Islander (2.0%), and other (.5%).

Materials

Perceived Sociocultural Pressures Scale. Perceived sociocultural pressure to be thin from family, peers, and the media was assessed using the 10-item Perceived Sociocultural Pressure Scale (PSPS; Stice & Argas, 1998). Each item is rated on a 5-point Likert-type scale ranging from *none* to *a lot* (1 = *none*, 5 = *a lot*), with higher mean scores indicating greater perceived pressure to be thin. Sample items include "I have felt pressure from my family to lose weight," and "I've noticed a strong message from the media to have a thin body" (Stice & Argas, 1998). Psychometric assessment of this scale indicated that it possess adequate internal consistency (α = .88), test-retest reliability (*r* = .93), and predictive validity (Stice & Argas, 1998).

Ideal Body Stereotype Scale-Revised. Thin ideal internalization was assessed using the 6-item Body Stereotype Scale-Revised (IBSS-R; Stice, Marti, Spoor, Presnell, & Shaw, 2008). This measure assesses an individual's level of agreement with statements regarding what attractive women ought to look like. Each item is rated on a 5-point Likert-type scale ranging from *strongly disagree* to *strongly agree* (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*), with higher mean scores indicating higher levels of thin ideal internalization. Sample items include "slender women are more attractive," and "tall women are more attractive" (Stice et al., 2008). Examination of the psychometric properties of this scale indicated adequate internal consistency (α = .89), 2-week test-retest reliability (*r* = .80), and predictive validity for future disordered eating (α = .81 at T1; Stice et al., 2008).

Body Areas Satisfaction Scale. The Body Areas Satisfaction Scale-Revised (BASS-R; Petrie, Tripp, & Harvey, 2002) is a measurement of body

dissatisfaction/satisfaction. This measure is a subscale of the Multidimensional Body-Self Relations Questionnaire (MBSRQ; Cash et al., 1986). The BASS-R assesses an individual's satisfaction with specific body parts, such as the legs, arms, and buttocks. Each of the 7 items is rated on a 6-point Likert-type scale ranging from *extremely dissatisfied* to *extremely satisfied* (1 = *extremely dissatisfied*, 6 = *extremely satisfied*), with higher mean scores indicating greater body satisfaction. Petrie et al. (2002) examined the psychometric properties of the BASS-R and found adequate internal consistency ($\alpha = .90$) in a sample of undergraduate females.

Feminist Identity Development Scale. The Feminist Identity Development Scale (FIDS; Bargad & Hyde, 1991) is a 39-item self-report measure used to assess an individual's level of FID, with five subscales corresponding to the five stages of the Downing and Roush (1985) model. Each item is rated on a 5-point Likert-type scale ranging from *strongly disagree* to *strongly agree* (1 = *strongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, 5 = *strongly agree*), with higher mean subscale scores indicating stronger identification with that particular stage. Sample items include "I care very deeply about men and women having equal opportunities in all respects," and "It only recently occurred to me that I think that it's unfair that men have the privileges they have in this society simply because they are men" (Bargad & Hyde, 1991). Gerstmann and Kramer (1997) examined the psychometric properties of this measure and found the internal reliability coefficients for each subscale ranged from .65 to .85 with a mean of .77.

Demographics Questionnaire. This general demographics questionnaire was used to assess each individual's sex, gender identity, sexual orientation, age, current year

of enrollment, and race/ethnicity. The measure consisted of six multiple-choice questions corresponding to each demographic variable.

Procedure

After reviewing a comprehensive research proposal, the Wright State University Institutional Review Board (IRB) determined the present study to be exempt from IRB oversight per 45 CFR 46.101 and WSU IRB policies. With IRB approval, the Primary Investigator was granted approval and access to the Wright State University Department of Psychology Research Participation System (SONA). With expressed and written permission from the authors of each assessment measure (see Materials), the materials were converted to a digital format compatible with the SONA system. The survey study was made accessible to all WSU students registered through the SONA system in September of 2017. Students were given the option to complete the electronic survey for one class credit.

After selecting a credit option, and reviewing and accepting the terms of informed consent, participants were asked to complete the five electronic measures using a multiple-choice format. All responses were voluntary and therefore all participants were given the option to leave responses blank/unanswered. The mean duration of survey completion was 12.96 minutes (SD=6.54), and no time constrains were placed on participants. In order to ensure that participants appropriately read and comprehended the survey materials, data from respondents who completed the survey in five minutes or less were excluded from the final analysis (n=14). Once participants completed the online survey, the de-identified results (with randomly assigned participant identification numbers) were made electronically accessible to the Primary Investigator.

Analytic Plan

This study used two separate hierarchical multiple regression analyses to examine the following four hypotheses:

1. Women who endorse higher levels of perceived sociocultural pressures will also endorse higher levels of thin ideal internalization. That is, perceived sociocultural pressures will significantly positively predict thin ideal internalization.
2. FID will significantly moderate the association between perceived sociocultural pressures and thin ideal internalization. That is, when FID is high, as opposed to low, the relationship between pressures and internalization will be weaker.
3. Women who endorse higher levels of thin ideal internalization will also endorse higher levels of body dissatisfaction. That is, thin ideal internalization will significantly positively predict body dissatisfaction.
4. FID will significantly moderate the association between thin ideal internalization and body dissatisfaction. That is, when FID is high, as opposed to low, the relationship between internalization and body dissatisfaction will be weaker.

Hypotheses 1 and 3 are preconditions for hypotheses 2 and 4 respectively. Hypotheses 1 and 3 have been widely researched and numerous studies have yielded evidence in support of these predictive relationships (see Stice & Shaw, 2002). In regards to hypotheses 2 and 4, researchers have suggested that women with feminist beliefs are more likely to critique and reject the thin ideal, and are therefore likely to have more positive body image than their non-feminist counterparts (Ojerholm & Rothblum, 1999; Rubin, Nemeroff, & Russo, 2004; Tiggemann & Stevens, 1999). From a conceptual perspective, feminist beliefs may serve as a moderator between perceived sociocultural

pressures and internalization of the thin ideal, as women who hold feminist beliefs tend to be more aware and critical of societal pressures placed on women. It has been suggested that feminist beliefs may enable women to carefully evaluate the validity of the perceived pressures from family, peers, and the media, therefore reducing thin ideal internalization and subsequent body dissatisfaction (Myers & Crowther, 2007). It is hypothesized that relationship between these latter two variables will be moderated by feminist beliefs as feminist women may be better able to resist appearance-related self-evaluations than their non-feminist counterparts. While feminist women are not immune to messages about the centrality of appearance in Western society, it is hypothesized that feminist beliefs may provide women with a protective and well-balanced lens through which to interpret sociocultural pressures (Myers & Crowther, 2007).

For the first regression analysis, the independent variables were sociocultural pressures and FID and the dependent variable was internalization of the thin ideal. Following recommendations from Aiken and West (1991), sociocultural pressures and FID variables were mean centered before being input into the regression analysis. Aiken and West recommend mean centering to reduce multicolinearity between the main effects and interaction terms. The mean centered variables of FID and sociocultural pressures were multiplied to create an interaction term. Such an analysis enabled the assessment of the relationship between sociocultural pressures and thin ideal internalization (hypothesis 1) as well as determining whether or not FID moderates this relationship.

The second regression analysis used internalization of the thin ideal and FID as the independent variables and body dissatisfaction as the dependent variable. Internalization of the thin ideal and FID were mean centered and multiplied to create an

interaction term. This interaction term was used to assess whether or not FID moderates the relationship between internalization of the thin ideal and body dissatisfaction. The analysis also assessed the relationship between internalization of the thin ideal and body dissatisfaction (hypothesis 3).

Power Analysis

A power analysis was done using G*Power 3.1.9.2 (Faul, Erdfelder, Buchner, & Lang, 2009) with regard to the second step of the linear regression models. The power analysis was performed using a Cohen's f^2 of .02 (small effect size), $\alpha = .05$, and $\beta = 0.8$. There was one tested predictor (the interactions term) and three total predictors in the model. For each of the models, the three predictors were the two main effects and the interaction term. Using these parameters, a total sample size of 395 was needed in order to achieve a power of 0.8.

Chapter IV

Results

Means, standard deviations, and bivariate correlations for each measure are presented in Table A2. Statistically significant associations were defined as $p < .05$. Perceived sociocultural pressures showed a significant positive correlation with thin ideal internalization. Additionally, thin ideal internalization showed a significant positive correlation with body dissatisfaction. Sociocultural pressures, thin ideal internalization, and body dissatisfaction showed correlations in expected directions.

Prior to calculating regression equations, the distributions of the variables were examined. None of the variables were shown to have substantial deviation from normality in regards to skew and kurtosis. For the hierarchical multiple regression analyses, predictor variables (i.e., sociocultural pressures and feminist identity) were mean-centered, and then used to calculate a mean-centered interaction variable (i.e., sociocultural pressures x feminist identity). For the purposes of this analysis, feminist identity was represented using FIDS Scale 5 (AC). The first multiple regression was performed by regressing thin ideal internalization on sociocultural pressures and feminist identity in the first step and adding sociocultural pressures x feminist identity in the second step. Results can be seen in Table A3. Results showed that step one of the model was significant in predicting internalization ($R = .248$, $R^2 = .062$, $F(2, 358) = 11.75$, $p < .001$). In step one of the model, pressures, but not feminist identity, were significantly related to internalization (see Table A3). Therefore, these results support hypothesis one.

In step two of the model, an interaction between feminist identity and pressures was added and this interaction term did not significantly improve the model ($\Delta R^2 = .001$, F (3, 357) = .365, $p = .55$). This finding does not support the second hypothesis proposed for this study.

A second hierarchical multiple regression was performed by regressing body dissatisfaction on internalization and feminist identity in step one and adding and internalization x feminist identity in the second step. Results showed that internalization was significant in predicting body dissatisfaction (See Table A3, $R = .187$, $R^2 = .035$, $F(2, 360) = 6.54$, $p < .01$). Therefore, these results supported hypothesis three. In step two of the model, adding the interaction term between feminist identity and internalization was found to not significantly improve the model ($\Delta R^2 = .008$, $F(3, 359) = 5.36$, $p = .087$). This finding does not support the fourth hypothesis proposed for this study.[1, 2]

Chapter V

Discussion

The first purpose of this study was to examine the well-supported relationship between perceived sociocultural pressures and thin ideal internalization as well as the relationship between thin ideal internalization and body dissatisfaction (see Groesz, Levine, & Murnen, 2002; Murnen & Smolak, 2009). In line with previous findings, the present study showed that college-aged women who endorsed higher levels of perceived sociocultural pressures also experienced higher thin ideal internalization and lower body satisfaction. These findings support the notion that exposure sociocultural pressures can be viewed as a risk factor for both internalization the thin ideal as well as for the development of body image concerns. This concept corresponds to Stice's (1994) sociocultural model of eating pathology, which posits that eating disorders are a product of widespread societal pressure for women to achieve an ultraslender body shape. According to this theory, thin ideal internalization occurs when individuals adopt and accept idealistic body image standards that are promoted by socializing agents such as family, peers, and the media (Stice, 1994; Stice & Shaw, 2002; Thompson & Stice, 2001). Once the thin ideal has been internalized, many women subsequently attempt, and often fail, to achieve this idealistic standard of beauty. The perceived incongruence between one's own body and the thin ideal is thought to be the primary mechanism through which body dissatisfaction arises (Stice, 1994; Stice, 2001; Thompson et al., 1999). The findings of the present study provide support for this theoretical assertion by

demonstrating a significant inverse relationship between thin ideal internalization and body satisfaction. In other words, the more participants internalized the thin ideal, the less satisfied they were with their bodies.

The second purpose of this study was to investigate whether FID would moderate the strength of the relationships between sociocultural pressures, internalization of the thin ideal, and body dissatisfaction. Specifically, the study's purpose was to determine whether high levels of FID would moderate the relationship between sociocultural pressures and thin ideal internalization and/or the relationship between sociocultural pressures and body dissatisfaction. Based upon several previous research studies, it was hypothesized that for women who endorsed high levels of FID, as opposed to low, the relationship between pressures and internalization and the relationship between internalization and body dissatisfaction would be weaker (e.g. Myers & Crowther, 2007; Snyder & Hasbrouck, 1996; Tiggeman & Stevens, 1998). However, the results of the present study did not support these hypotheses.[3] Rather, the data in this study showed that the effect of sociocultural pressures on thin ideal internalization and the effect of internalization on body dissatisfaction do not depend on an individual's level of FID. These results were consistent with several previous studies that also failed to find evidence for the moderating role of FID on body dissatisfaction and/or internalization of the thin ideal (e.g. Cash et al., 1997; Fingeret and Gleaves 2004; Ojerholm & Rothblum, 1999).

For the purposes of this study, high levels of FID were represented using the AC scale of the FIDS. However, it is worth noting that the researcher performed several additional regression analyses in which high levels of FID were represented by grouping

the AC and SYN stages and by grouping the AC, SYN, and E-E stages. These additional regression analyses showed that grouping the higher-level stages of FID, as opposed to using individual stages, did not change the original findings. That is, high levels of FID did not moderate the strength of the relationships between sociocultural pressures, internalization of the thin ideal, and body dissatisfaction, despite attempts to represent FID in different ways. In the present sample, 62.8% (n = 253) of respondents were in the PA stage of FID, 0.7% (n = 3) of respondents were in the REV stage of FID, 4.0% (n = 16) of respondents were in the E-E stage of FID, 1.5% (n = 253) of respondents were in the SYN stage, and 30.3% (n = 122) of respondents were in the AC stage of FID.

Although the results of this study indicate that high levels of FID do not moderate the relationships between perceived sociocultural pressures, internalization, and body dissatisfaction, this does not invalidate the claim that feminist identity may serve to protect women from negative body image. Rather, it is possible that one's specific feminist ideology, rather than their stage of FID, serves to moderate these relationships. This distinction may explain why findings about the moderating role of feminist identity have been mixed across the literature. Feminist identity is a difficult construct to accurately operationalize because each individual may define and enact her feminist attitudes in different ways. For this reason, measuring one's stage of FID may fail to adequately capture the nuances of what it means to be a feminist. For example, while a liberal feminist and a radical feminist may both be in the AC stage of FID, they are likely to hold disparate views about how to best combat sexism as well as how they define the problem of sexism overall. A liberal feminist is likely to argue for political reform, which allows women equal access in the public sphere, and therefore the ability to maintain

equality to men by way of freedom of choice. On the other hand, a radical feminist is likely to argue for the complete reordering of society in order to wholly eradicate male supremacy in all contexts (e.g. socially, politically, economically). While these women may both be in the latter stages of FID, their attitudes, perceptions, and ideologies are markedly different. This example illustrates how the stage model of FID may fail to accurately capture specific protective aspects of feminist identity. Future research on precise ideological aspects of feminism, such as the focus on individualism or the freedom of choice, may better capture how and why a feminist identity may protect women from thin ideal internalization and body-related concerns.

Beyond investigating the study's original hypotheses, the present study revealed an unexpected finding regarding the correlational relationship between perceived sociocultural pressures and level of FID. Specifically, the findings of this study indicate that women in the Passive Acceptance stage of FID endorsed lower levels of perceived sociocultural pressures than their counterparts in the Active Commitment stage of FID. Said another way, women in earlier stages of FID had a tendency to perceive less sociocultural pressures than women in later stages of FID. While theorists have proposed that women with feminist qualities may be better equipped than their non-feminist counterparts to critically evaluate and resist negative sociocultural messages, the present research indicates that they may also be more aware of these pressures than their non-feminist peers overall (Green et al., 2008; Murnen & Smolak, 2008). This finding is striking given that women who endorse higher levels of perceived sociocultural pressures have consistently been found to experience higher thin ideal internalization and lower body satisfaction across numerous studies (e.g. Fingeret & Gleaves, 2004; Myers &

Crowther, 2007; Stice et al., 1998; Stice & Shaw, 2002; Stice, Shaw, Becker, & Rhode, 2008, Rohde, Stice, & Marti, 2015). While it has been widely posited that feminist women possess qualities that protect them from thin ideal internalization and body dissatisfaction, this current finding may indicate that women with less feminist ideology may be protected from these outcomes by way of perceiving less sociocultural pressure than their feminist peers (Green et al., 2008; Murnen & Smolak, 2008).

Implications & Future Directions

Women in the AC stage of FID may possess certain qualities that make them more likely to perceive pressure to be thin from family, peers, and the media. For example, it is possible that women in the AC stage of FID are more susceptible than their less feminist counterparts to the frequency illusion regarding the thin ideal. The frequency illusion refers to the phenomenon in which a novel concept that one has recently encountered is subsequently observed often and repeatedly. Although the observable concept is likely occurring at the same frequency as ever, the observer's newfound awareness of the idea results in the illusion that the concept is suddenly more widespread and commonplace (Zwicky, 2006). When compared to women in the PA stage of FID, women in the AC stage have likely heard more about the concept that Western patriarchal society promotes an ultraslender body shape as the epitome of female beauty. Given their increased exposure to this concept, it is possible that women in the AC stage are more susceptible to the frequency illusion and therefore perceive greater amounts of sociocultural pressure than women in earlier stages of FID.

It is also possible that women in earlier stages of FID are less likely to notice sociocultural pressure because they do not view body-critical commentary as

problematic. Women in the PA stage of FID are generally unaware of the cultural prejudice against women and are likely to accept and subscribe to societally pervasive patriarchal ideology (Downing & Roush, 1985). This means that women in the PA stage of FID are likely to believe that they and other women should aspire to certain beauty standards in order to attain social, romantic, and career success. Since women in PA accept this ideology, they are unlikely to view pressure to be thin as incongruent with their view of self and others. This is consistent with the schema congruity theory, which asserts that individuals are less likely to notice and remember situations that are congruent with their existing schema (e.g. Mandler, 1982).

Another possible explanation for this trend is that women in the AC stage of FID are more likely to be targets of public criticism than their PA counterparts due to their activism on the sociopolitical stage. By definition, women in the AC stage of FID are activists who are committed to ending the societal problem of sexism (Bargad & Hyde, 1991). Since these individuals speak out against the normative, and often controversial, issue of women's oppression within a patriarchal society, they are more likely to be criticized for their beliefs and expression of womanhood than less politically active women. Often, this criticism comes in the form of body shaming. Body shaming is defined as the act of mocking, humiliating, or undermining an individual by criticizing the person's body shape or weight (Oxford University Press, 2018). Given that feminist opponents use body shaming to dismiss or undermine the claims of feminist activists, it is perhaps unsurprising that women in AC endorse more sociocultural pressure to be thin. It is probable that by placing one's self on a sociopolitical stage, one is more likely to be body shamed than non-public figures. Ultimately, additional research is needed to test

and clarify how being in the AC stage of FID may affect women's susceptibility to harmful sociocultural influences.

Understanding the causes and correlates of body dissatisfaction is a scientific endeavor of clinical significance. The data derived from studies on body dissatisfaction can be used to help generate and support effective interventions aimed at preventing or ameliorating body image concerns. In this regard, cognitive behavioral and dissonance-based forms of treatment have shown substantial promise (e.g. Cash et al., 1997; Stice et al., 2000; Stice et al., 2008, Stice et al., 2013). Specifically, the dissonance-based *Body Project* intervention, in which women critique the thin ideal through a series of written, verbal, and behavioral exercises, has shown statistically significant 60% reductions in eating disorders over a three-year follow-up when compared to controls (Stice et al., 2008; Stice et al., 2013). The present results suggest that such programs may also need to address how to combat body shaming that occurs both in-person and via social media. One suggested approach is to include elements of stress inoculation therapy into the *Body Project* protocol in order to prepare women to handle body-shaming events successfully and with minimal distress (Meichenbaum & Novaco, 1978).

Strengths & Limitations

The present study extended upon past research by investigating previously examined hypotheses using a novel combination of assessment materials. A widely accepted statistical analysis and design was employed to investigate the hypotheses offered in this study. This study also utilized well-established measures with sound psychometric properties.

This study is not without its own set of limitations. In particular, the study utilized a convenience sample of female undergraduate students from Wright State University. Generalizing the results of this study beyond female college students is therefore ill advised. In order to enhance the generalizability of significant findings beyond the female college student population, future research is warranted. Since it has been well established that ideals concerning beauty vary cross-culturally (e.g. Allen, Mayo, & Michel, 1993; Frisbey, 2004) and between age groups (e.g. Algars et al., 2009; Tiggeman, 2004), further examination of the research hypotheses in this study among different age cohorts and racial/ethnic groups may provide unique insights. Further support for future research on this topic comes from Tiggeman and Stevens (1994), who demonstrated that the strength of the relationship between weight concerns and feminist attitudes change depending upon the age of the women sampled. Given this latter finding, it is possible that with a sample consisting of older women, high FID may significantly moderate the relationships between perceived sociocultural pressure, thin ideal internalization, and body dissatisfaction.

Another limitation of this study is that the survey questionnaires were administered in the same order for each participant (i.e. Demographics Form, PSPS, IBSS, BASS-R, and FIDS). It is possible that the lack of randomization of these questionnaires impacted participant response patterns due to possible priming effects and/or survey fatigue. Additionally, the respondents of this survey consisted of individuals from a non-clinical population. As such, generalizing these findings to a clinical population of women with eating disorders is not appropriate. Future investigation of the research hypotheses presented in this study within a clinical

population may be a fruitful area to explore. Additionally, this study was correlational in nature and inferences of causality between variables cannot be justified. Further research is warranted to better explain the connection between significantly correlated variables found in this study.

A final constraint of this study is the limited availability of updated and validated measures of global feminist ideology. While the FIDS has been widely used in feminist research and has been demonstrated to have sound psychometric properties, the measure has not been updated since its original creation in 1991 (Bargad & Hyde, 1991; Gerstamanm & Kramer, 1997; Moradi & Subich, 2002). Unfortunately, alternatives to the FIDS, including the Feminist Identity Scale (FIS) and Feminist Identity Composite (FIC) have also not been updated since their inception in 1989 and 2000 respectively (Fischer et al., 2000; Moradi & Subich, 2002; Rickard, 1989). Since the creation of these measures, younger generations of feminists have established their own identity, which has prompted the global cultural shift into the 'fourth wave' of the feminist movement (see Munro, 2013; Shuster, 2013; Wrye, 2009). 'Fourth wave' feminism is defined by the use of technology and social media for political activism and advocacy. Some notable 'fourth wave' feminist campaigns include the #MeToo movement and the recent trend of sexual misconduct allegations against prominent male public figures, such as Harvey Weinstein, Matt Lauer, and Bill Cosby (Cochrane, 2013; Matheson, 2017). The #MeToo movement began gaining traction and public attention in October of 2017, which is one month after data collection for this study began. It is worth considering that the political climate and widespread social media attention of the #MeToo movement may have impacted how participants responded to survey questionnaires. These factors may have

resulted in inflated responses, indicating stronger affiliation with the AC stage of FID and higher levels of perceived sociocultural pressures. Given this potential confounding variable, replication of this study within a different political climate is warranted.

Given that feminist ideology has historically shifted in meaning over time, it is important that measures of FID remain relevant and applicable to modern-day feminists. It is possible that the measures that were developed during the 'third wave' of the feminist movement inadequately represent the 'fourth wave' feminist experience, and may therefore need to be interpreted with caution. In order to better understand and operationalize FID among fourth-wave feminists, it is important that existing measures be validated and normed with this population. Depending on the findings of these future studies, researchers may need to develop new measures or expand upon existing measures to accurately reflect the ideology held by 'fourth wave' feminists.

Summary

The results of this study supported the hypothesized influence of sociocultural variables on internalization and of internalization on body dissatisfaction. Although moderation of these relationships via feminist identity was not found, the results of this study indicate several additional avenues for future research. While it was found that global feminist ideology does not protect women from the detrimental effects of perceived sociocultural pressures and internalization of the thin ideal, future studies can examine more specific feminist beliefs for modern-day women that may influence body dissatisfaction. Such future research may provide clarification regarding the specific facets of feminism that can protect against internalization of sociocultural appearance standards and the development of body dissatisfaction.

Appendix A

Table A1
Demographic features of sample

Demographic Variable	*N*	Percentage
Sex		
Female	403	100.0
Age		
Under 18	2	0.5
18-21	379	94.2
22-25	9	2.2
26-29	6	1.5
30-33	1	0.2
34-37	2	0.5
38-41	2	0.5
42-45	1	0.2
46-49	1	0.2
Sexual Orientation		
Asexual	5	1.2
Bisexual	37	9.2
Heterosexual	355	88.1
Lesbian	2	0.5
Other	4	1.0
Marital Status		
Committed Relationship	100	24.8
Divorced	2	0.5
Married	7	1.7
Separated	2	0.5
Single, Never Married	292	72.5
Race/Ethnicity		
Asian, Native Hawaiian, or Pacific Islander	8	2.0
Black/African American	59	14.6
Hispanic, Latina, or Spanish Origin	9	2.2
Multiracial	24	6.0
White/Caucasian	301	74.7
Other	2	0.5
Current Educational Enrollment		
Freshman	325	80.6
Sophomore	47	11.7

Demographic Variable	*N*	Percentage
Junior	18	4.5
Senior	4	1.0
Other	9	2.2

Table A2
Means, standard deviations, and correlations for study variables

	1	2	3	4	5
1. FIDS Scale 5	--				
2. FIDS Scale 1	-.42**	--			
3. PSPS	.17**	-.14**	--		
4. IBSS-R	.05	.01	.27**	--	
5. BASS-R	.04	.05	-.48**	-.19**	--
M	26.11	30.53	23.28	17.98	27.78
SD	5.54	7.60	8.74	4.93	6.51

Note. FIDS Scale 5 = Feminist Identity Development Scale-Active Commitment; FIDS Scale 1= Feminist Identity Development Scale-Passive Acceptance; PSPS = Perceived Sociocultural Pressures Scale; IBSS = Ideal Body Stereotype Scale-Revised; BASS-R = Body Areas Satisfaction Scale-Revised. Statistics in this table represent non mean-centered data.
** $p < .01$

Table A3
Hierarchical multiple regression analyses predicting internalization and body dissatisfaction

	B	*SE B*	*β*	*t*
Model 1-Internalization				
Step 1				
Intercept	17.91	.25		72.79***
Pressures	.14	.03	.25	4.72***
Feminist Identity	.02	.05	.02	.26
Step 2				
Intercept	17.88	.25		71.55***
Pressures	.13	.03	.24	4.59***
Feminist Identity	.01	.05	.01	.19
Pressures x Feminist Identity	.00	.01	.03	.61
Model 2- Body Dissatisfaction				
Step 1				
Intercept	27.74	.34		82.54***
Internalization	-.25	.07	-.19	-3.58***
Feminist Identity	.04	.06	.04	.68
Step 2				
Intercept	27.77	.34		82.75***
Internalization	-.24	.07	-.18	-3.38**
Feminist Identity	.04	.06	.04	.71
Internalization x Feminist Identity	-.02	.01	-.09	-1.71

Note. Model 1 = Internalization as criterion variable; Model 2 = Body dissatisfaction as criterion variable; Values represent mean-centered variables for predictor variables and derivative interaction terms.

*** $p < .001$

** $p < .01$

* $p < .05$

Appendix B

Scale B1
Demographics Form

Age: _____

Gender Identity:
- Female
- Male
- Non-binary/gender neutral/gender fluid
- Transgender
- Prefer to self-describe _____

Sex:
- Female
- Male
- Prefer to self-describe _____

Sexual Orientation:
- Straight/Heterosexual
- Gay or Lesbian
- Bisexual
- Prefer to self-describe _____

Race (check all that apply):
- Asian
- Black or African American
- Hispanic, Latino, or Spanish origin
- Native American or Alaska Native
- Native Hawaiian or other Pacific Islander
- White
- Prefer to self-identify _____

Marital Status:
- Single, never married
- Committed relationship/partnership
- Married
- Life Partner
- Divorced
- Separated
- Widowed
- Prefer to self-identify _____

Current Educational Enrollment:

Undergraduate:

- Freshman
- Sophomore
- Junior
- Senior

Graduate:

- 1st year
- 2nd year
- 3rd year
- 4th year
- 5th year

Other (please specify): _____

Scale B2
Perceived Sociocultural Pressures Scale

Please circle the response that best captures your own experience:

	none				**a lot**
1. I've felt pressure from my friends to lose weight	1	2	3	4	5
2. I've noticed a strong message from my friends to have a thin body	1	2	3	4	5
3. I've felt pressure from my family to lose weight	1	2	3	4	5
4. I've noticed a strong message from my family to have a thin body	1	2	3	4	5
5. I've felt pressure from people I've dated to lose weight	1	2	3	4	5
6. I've noticed a strong message from people I've dated to have a thin body	1	2	3	4	5
7. I've felt pressure from the media (e.g., TV, magazines) to lose weight	1	2	3	4	5
8. I've noticed a strong message from the media to have a thin body	1	2	3	4	5
9. Family members tease me about my weight or body shape	1	2	3	4	5
10. Kids at school tease me about my weight or body shape	1	2	3	4	5

Scale B3
Ideal Body Stereotype Scale-Revised

How much do you agree with these statements:

strongly disagree	**disagree**	**neutral**	**agree**	**strongly agree**
1	2	3	4	5

1. Slender women are more attractive	1	2	3	4	5
2. Women who are in shape are more attractive	1	2	3	4	5
3. Tall women are more attractive	1	2	3	4	5
4. Women with toned (lean) bodies are more attractive	1	2	3	4	5
5. Shapely women are more attractive	1	2	3	4	5
6. Women with long legs are more attractive	1	2	3	4	5

Scale B4
Body Areas Satisfaction Scale Revised (BASS-R)

Use this 1 to 5 scale to indicate how dissatisfied or satisfied you are with each of the following areas or aspects of your body:

1=Very Dissatisfied 2=Mostly Dissatisfied 3=Neither Satisfied or Dissatisfied 4=Mostly Satisfied 5=Very Satisfied

1. Face (facial features, complexion)	1 2 3 4 5
2. Hair (color, thickness, texture)	1 2 3 4 5
3. Lower Torso (buttocks, hips, thighs, legs)	1 2 3 4 5
4. Mid Torso (waist, stomach)	1 2 3 4 5
5. Upper Torso (chest or breasts, shoulders, arms)	1 2 3 4 5
6. Muscle Tone	1 2 3 4 5
7. Weight	1 2 3 4 5
8. Height	1 2 3 4 5
9. Overall Appearance	1 2 3 4 5

Scale B5
Feminist Identity Development Scale (FIDS)

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

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

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

I like to return to the same vacation spot year after year __5__

Remember to read each statement carefully and decide to what degree you think it describes you at the present time

1. I don't think there is any need for an Equal Rights Amendment; women are doing well. _____
2. Being a part of a women's community is important to me. _____
3. I want to work to improve women's status. _____
4. I feel that some men are sensitive to women's issues. _____
5. I used to think there wasn't a lot of sex discrimination, but now I know how much there really is. _____
6. Although many men are sexist, I have found that some men are very supportive of women and feminism. _____
7. Especially now, I feel that the other women around me give me strength. _____
8. I am very committed to a cause that I believe contributes to a more fair and more just world for all people. _____
9. While I am concerned that women be treated fairly in life, I do not see men as the enemy. _____
10. I share most of my social time with a few close women friends who share my feminist values. _____
11. I don't see much point in questioning the general expectation that men should be masculine and women should be feminine. _____
12. I am willing to make certain sacrifices in order to work toward making this society a non-sexist, peaceful place where all people have equal opportunities. _____

13. I would describe my interactions with men as cautious. _____
14. One thing I especially like about being a woman is that men will offer me their seat on a crowded bus or open doors for me because I am a woman. _____
15. When I think about sexism, my first reaction is always anger. _____
16. My social life is mainly with women these days, but there are a few men I wouldn't mind having a non-sexual friendship with. _____
17. I've never really worried or thought about what it means to be a woman in this society. _____
18. I evaluate men as individuals, not as members of a group of oppressors. _____
19. I just feel like I need to be around women who share my point of view right now. _____
20. I care very deeply about men and women having equal opportunities in all respects. _____
21. It makes me really upset to think about how women have been treated so unfairly in this society for so long. _____
22. I do not want to have equal status with men. _____
23. It is very satisfying to me to be able to use my talents and skills for my work in the women's movement. _____
24. If I were married and my husband was offered a job in another state, it would be my obligation as his spouse to move in support of his career. _____
25. I don't think there is one "right" way to be a feminist. _____
26. I tend to be careful when I interact with men. _____
27. I believe that when people choose a career, they should not let sex role stereotypes influence their choice. _____
28. I think that most women will feel most fulfilled by being a wife and mother. _____
29. When you think about most of the problems in the world—pollution, discrimination, the threat of nuclear war—it seems to me that most of them are caused by men. _____
30. I am angry that I've let men take advantage of me. _____
31. Being a feminist is one of a number of things that make up my identity. _____
32. It only recently occurred to me that I think that it's unfair that men have the privileges they have in this society simply because they are men. _____
33. I feel that I am a very powerful and effective spokesperson for the women's issues I am concerned with right now. _____
34. I feel angry about the way women have been left out of history textbooks. _____
35. If I were to paint a picture or write a poem, it would probably be about women or women's issues. _____
36. I think that men and women had it better in the 1950s when married women were housewives and their husbands supported them. _____
37. Some of the men I know seem more feminist than some of the women. _____
38. When I see the way most men treat women, it makes me so angry. _____
39. I can finally feel very comfortable identifying myself as a feminist. _____
40. Generally, I think that men are more interesting than women. _____
41. Men and women are equal but different. _____

42. Recently I read something or had a specific experience that sparked my greater understanding of sexism. _____
43. I think that rape is sometimes the woman's fault. _____
44. On some level, my motivation for almost every activity I engage in is my desire for an egalitarian world. _____
45. I am not sure what is meant by the phrase "women are oppressed under patriarchy." _____
46. I think it's lucky that women aren't expected to do some of the more dangerous jobs that men are expected to do, like construction work or racecar driving. _____
47. I have a lifelong commitment to working for social, economic, and political equality for women. _____
48. Particularly now, I feel most comfortable with women who share my feminist point of view. _____

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Footnotes

[1]The regression models were reexamined controlling for sexual orientation. For these analyses, a subsample of $n = 392$ was used, which excluded the small number of participants who identified as lesbian ($n = 2$), asexual ($n = 5$), or other ($n = 4$). Heterosexual individuals were coded as 0 and bisexual were coded as 1. This analysis revealed that including sexual orientation in the model did not change the nature of model findings.

[2] The regression models were reexamined controlling for race. White individuals were coded as 0 and all other racial groups coded as 1. This analysis revealed that including race in the model did not change the nature of the model findings.

[3] The relationships between FID and the dependent variables of the regression models were graphically explored. There was no graphical evidence to suggest that a curvilinear relationship exists between FID and internalization or between FID and body dissatisfaction.