DIVERSE WOMEN AGING IN AMERICA: ATTITUDES TOWARD MENOPAUSE AND SELF-OBJECTIFICATION IN MIDLIFE AND BEYOND

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF PSYCHOLOGY AND PHILISOPHY

COLLEGE OF ARTS AND SCIENCES

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AUGUST 2011

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July 29, 2011

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Martha Bergen entitled "Diverse Women Aging in America: Attitudes Toward Menopause and Self-objectification in Midlife and Beyond." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Counseling Psychology.

Debra Mollen, Ph.D., Major Professor

We have read this dissertation and recommend its acceptance:

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Accepted:

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ACKNOWLEDGMENTS

First and foremost, I would like to thank Debra Mollen, Ph.D., who has been much more than my dissertation advisor throughout my graduate school career. Thank you so much for being there every step of the way, for cheering me on, and for helping me to have faith in myself as a therapist, teacher, scholar, feminist and future psychologist. Your support throughout my graduate education has meant more to me than words can say and I am forever in your debt. It has truly been an honor and a privilege.

Many thanks also go to my committee members Sally Stabb, Ph.D., and Jenelle Fitch, Ph.D., who have also been integral to my dissertation project and graduate education. I appreciate all of your wisdom, feedback, and support throughout this process.

A very special thank you goes to David Marshall, Ph.D., my statistics consultant and dissertation committee member, for your endless patience and assistance. I am indebted to you for helping me to avoid the goose chases and make sense of my data. I value your passion for research, your no-nonsense style, and your commitment to fostering the development of new researchers. I could not have completed this project without your guidance.

I would also like to thank my grandfather, Zane Bergen, Ed.D., for forging the graduate school path and inspiring me to become the second Dr. Bergen in our family.

Thank you to all of my friends and family for your unwavering support. Theo, you are an amazing partner and husband and I could not have completed this milestone without you. Mom, Dad, Jonathan, Shannon, Matt, Vivian, and Tiffany, you give my life such joy and meaning. Thanks for supporting me in the face of constant stress and anxiety. Amanda, Wendy, and Candice, I am forever grateful to you and our hours of studying, stressing, working together, and supporting each other. To everyone at the Miami University Student Counseling Center, especially Kip, Maria, and Emily, thanks for a wonderful year and for supporting me through the completion of this project.

Finally, this dissertation is dedicated to the women who participated in my research. Many thanks for your time, effort, and trust. This could never have happened without you.

ABSTRACT

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DIVERSE WOMEN AGING IN AMERICA: ATTITUDES TOWARD MENOPAUSE AND SELF-OBJECTIFICATION IN MIDLIFE AND BEYOND

AUGUST 2011

Negative messages about aging are prevalent in the U.S., and especially common with regard to women's aging and women's physical appearance. These messages are harmful for women, who often internalize an observer's view of their bodies (Fredrickson & Roberts, 1997) and view menopause as a negative sign of aging (Bloch, 2002; Wilk & Kirk, 1995) and losing beauty, youth, and value (Kaufert, 1982). Some studies suggest that there are cultural differences in views of menopause (Avis et al., 2001; Holmes-Rovner et al., 1996; Marvan, Islas, Vela, Chrisler, & Warren, 2008; Sampselle, Harris, Harlow, & Sowers, 2002) and attitudes about menopause, symptoms of menopause, and body image may be related (Bloch; McKinley & Lyon, 2008), but more research is needed to further understanding in this area. The current investigation assessed group differences in experiences of menopause and body image at midlife. Women from a community sample (n = 397) completed a demographic survey, the Menopause Attitude Scale (Bowles, 1986), the Menopause Symptom List (Perz, 1997), the Figure Rating Scale (Stunkard, Sorenson, & Schlusinger, 1983), the Self-Objectification Questionnaire (Noll & Fredrickson, 1998), and the Objectified Body Consciousness Scale (McKinley &

Hyde, 1996). Results indicated that younger participants experienced more body shame and body surveillance compared to older women, but older women reported higher levels of self-objectification. White women reported higher levels of body shame and body dissatisfaction-think than African American women. Younger women, White women, women who experienced more body shame and body dissatisfaction-feel reported more negative views of menopause. Body shame and body dissatisfaction-feel were associated with more frequent and severe psychological symptoms of menopause. A path analysis showed that White women, premenopausal women, and women who reported more body dissatisfaction-feel also reported more negative views about menopause. Holding more negative attitudes about menopause predicted experiencing more problematic symptoms of menopause. These findings have important implications for research, theory, and practice in the field of psychology and shed much needed light onto the midlife menopausal and body image experiences of African American and White women in the United States.

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CHAPTER I

INTRODUCTION

Rationale

There are many negative and harmful messages about women and specifically women's bodies in mainstream U.S. culture that impact the lives of most women (Gosselink, Cox, McClure, & DeJong, 2008; Kilbourne, 2000). Fredrickson and Roberts (1997) described this cultural context as being sexually objectifying and stated that women living in such an objectifying culture experience many deleterious effects. In particular, women have the unique "experience of being treated *as a body*" (p. 174) instead of as a person and internalize the perspective that their bodies and appearance are what matter most about who they are in the world. Fredrickson and Roberts called this experience self-objectification, which occurs when a woman internalizes an observer's perspective on her own body.

Although this is a relatively recent theory, developed in the late 1990s, a good deal of research has supported the theory and its predictions for women's well-being. Studies have shown that self-objectification is linked with body dissatisfaction, body shame, and habitual body monitoring (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998). Research has also shown a relationship between self-objectification and low self-esteem, anxiety, depression, eating disorders, and sexual dysfunction (Noll & Fredrickson, 1998; Peat, Peyerl, & Muehlenkamp, 2008). Additionally, self-

objectification interferes with cognitive performance and interrupts flow or creativity (Szymanski & Henning, 2007). Body dissatisfaction and self-objectification are problematic in many ways.

However, much of the research on these topics has been limited in significant ways that hamper the generalizability of the results. Most of the studies on body image and on objectification theory have utilized samples of predominantly young, White, heterosexual women (Peat et al., 2008; Winterich, 2007). These limitations are important for future researchers to address given research that suggests that culture and demographic factors, like age and ethnicity, may contribute to different findings.

Attending to the body image experiences of middle-aged and older women in research is vital given the intersections of ageism and sexism in U.S. culture. Ageism, which refers to stereotyping, prejudice, and discrimination that people experience because of their age (Iversen, Larsen, & Solem, 2009), combines with sexism to create different standards for men and women as they move through the lifespan. Aging women face more difficulty than do men as a result of the double standard of aging and living in a youth-worshipping culture (Lauzen & Dozier, 2005). While aging men retain societal value, "older women are seen, at best, as relatively invisible, lacking clear role definition, and at worst, as unfeminine, unattractive, unwanted" (Wilk & Kirk, 1995, p. 238). Given the threat of facing these negative experiences, many women strive to maintain their youth and physical attractiveness, especially in a culture that devalues aging and devalues women for being anything but thin, young, and beautiful. The presence of body

dissatisfaction across the lifespan appears to be widespread, with 80% of middle-aged women reporting dissatisfaction in one study (McLaren & Kuh, 2004).

Although additional work is warranted to elucidate the experiences of older women related to body image, some research has revealed interesting and conflicting findings. One commonly held view is that older women feel more negative about their appearances compared to younger women because they are moving further from society's standards of beauty (Peat et al., 2008). This view suggests that as women age, they experience more body dissatisfaction, more self-objectification, and other aspects of negative body image. By contrast, many studies show that women actually tend to become more satisfied with their weight as they age (Franzoi & Koehler, 1998) and experience less self-objectification, less habitual body monitoring, less body shame, and less eating pathology as they get older (Tiggemann & Lynch, 2001). In general, levels of body dissatisfaction remain constant with age, but researchers have concluded that appearance becomes less important as women move through the middle stages of life (Clarke, 2001; Tiggemann & Lynch).

Recent findings conflict with the trends established in the literature. Previous studies have suggested that body dissatisfaction stays constant with age, but self-objectification and the importance placed on appearance decrease (e.g. Tiggemann & Lynch, 2001). Grippo and Hill (2008) found no differences between different age groups of women on measures of self-objectification and habitual body monitoring. These traits had previously been shown to decline with age, which supports objectification theory's predictions. However, given Grippo and Hill's findings, previous findings in the literature

may be in question. Appearance may continue to be an important determinant of self-worth, identity, and value for women as they move into mid-life. Risk of body dissatisfaction, self-objectification, and other body image problems may continue for women across the lifespan. More work is needed to flesh out these conflicting research findings.

In addition to conflicting research findings with regard to body satisfaction and self-objectification across the lifespan, another flaw in the literature concerning body image in mid-life is that little research has attended to the relationships among age, body image, menopausal symptoms, and women's attitudes towards menopause (McKinley & Lyon, 2008). Menopause refers to the developmental stage that women go through during midlife, where estrogen levels and fertility decline and menstruation becomes irregular and then stops (Elavsky & McAuley, 2009). Not only is the menopausal transition a physiological stage in a woman's life, but menopause takes on many different psychological, social, and cultural meanings (Kaufert, 1982). For many women, menopause signifies loss of youth, loss of attractiveness, and loss of meaning or value, especially in a culture that devalues aging people, and especially aging women (Wilk & Kirk, 1995).

When a culture objectifies women throughout their lives, this context necessarily plays some type of role in determining reactions to menopause. This idea is supported by research that demonstrates that there are cross-cultural differences in experiences of menopause (e.g. Avis et al., 2001; Dillaway, Byrnes, Miller, & Rehan, 2008; Holmes-Rovner et al., 1996; Im, Liu, Dormire, & Chee, 2008; Marvan et al., 2008; Sampselle et

al., 2002). In some cultures, menopause involves many painful symptoms and is seen as a very terrible event for women (Bloch, 2002). In these cultures, including mainstream White U.S. culture, menopausal women are often treated for their "hormone deficiency disease" (Wilk & Kirk, 1995, p. 233), and given hormone replacement therapy, despite possible risks associated with this treatment (Thobaben, 2003). In other cultures, menopause is viewed as a natural part of life (Donati et al., 2009) and a positive experience (Dillaway et al.; Sampselle et al.).

Interestingly, some studies suggest that the symptoms that women experience, which may range from no symptoms at all to a long list of distressing symptoms, are impacted by the cultural expectations and meanings ascribed to menopause and to aging (Bloch, 2002). Thus, in the U.S., where women are objectified and taught that their physical appearance is what matters most about them, menopause is likely to be seen as an indication of old age and valuelessness. Some research (e.g. Bloch; McKinley & Lyon, 2008) has supported the idea that menopausal attitudes are linked with body image and self-objectification. In mainstream U.S. culture, being old is viewed as ugly, menopause indicates being old, and thus menopause also indicates being ugly, which is a cultural message that may be very deleterious for women to internalize, especially as they are undergoing the midlife transition of menopause.

In spite of promising initial findings with regards to the relationships between body satisfaction, self-objectification, menopausal attitudes, and menopausal symptoms, these studies remain limited in number, homogenous in sample, and in need of replication with a more diverse and representative sample of middle-aged and older women. More

research is needed to address these issues and to expand the knowledge regarding older women's experiences of menopause, of their bodies, and how the two interact. The current study attempted to address these issues by assessing middle-aged and older women's body dissatisfaction, level of self-objectification, and degree of body shame and body surveillance, and their attitudes toward and symptoms of menopause. In addition, the current study assessed the relationships between these variables and how they were similar or different across different ages, menopausal status, and racial/ethnic groups.

Purpose and Significance

The current study sought to gather more information regarding the relationships between cultural factors, menopausal experiences, and body image. It was predicted that women who experience more negative views of menopause would experience more severe symptoms. It was hypothesized that negative body image and high levels of internalized objectification would be related to both negative views of menopause and experiencing more negative symptoms. Furthermore, it was predicted that negative views of menopause, experiencing more symptoms, and having higher levels of body dissatisfaction and self-objectification would be more common among younger White women compared to other diverse groups of women.

CHAPTER II

LITERATURE REVIEW

Body Image

Beauty, Cultural Norms, and Body Image

Striving to attain beauty is nearly universal for human beings. There is ample evidence of the value placed on beauty, especially the beauty of women, throughout human history, art, and literature. Ancient Greeks talked of the beauty of Aphrodite and war was waged over the beautiful Helen of Troy in the great literary classic, *The Iliad* (Homer, 1870). Historic artworks depict images of women deemed to be beautiful and paparazzi follow actresses and models in the hopes of capturing their beauty on film.

Although the emphasis on beauty is ubiquitous, it is also subjective and varies across culture and historical period. For example, among the Karen-Padaung people of Thailand and Myanmar, having the appearance of a long neck shaped by years of wearing neck rings is thought to make a woman beautiful (Waddington, 2002). Until recent centuries, foot binding was a common practice in China. Although this practice deformed women's feet and was extremely painful, young girls were expected to have bound feet in order to be physically acceptable and therefore, appropriate marital partners (Dworkin, 1974). In past centuries, pale skin was considered a mark of beauty in Western cultures. Women wore protective clothing and hats to ensure that they would maintain a milky skin tone. Today, tanned skin is seen as a sign of beauty and many

people tan their skin in spite of well-documented health risks of sun exposure including skin cancer (Cox et al., 2009). The rules of beauty may be different for African American women, as racism dictates that light skin is more attractive than darker skin tones. Many Black women attempt to emulate a White standard of feminine beauty by using skin-lightening and hair-straightening products (Hill, 2002). Literary genius bell hooks (1996) talked about good hair in her memoir *Bone Black: Memories of Girlhood.* She stated that "real good hair is straight hair, hair like white folk's hair" (p. 91) and she pointed out that the beauty standards for Black women are based on White culture, even though this idea is seldom spoken aloud. hooks' point shows that beauty is more than subjective taste or opinion. Rather, beauty is a complex social phenomenon, linked with and influenced by class, gender, race, and other sociopolitical factors.

Rodin, Silberstein, and Striegel-Moore (1984) drew a comparison between these historical beautifying practices and more modern trends in dieting. While wearing corsets was a common practice throughout the 19th century, many girls and women diet as a way of life in today's society. One study showed that 40% of women in the U.S. reported being on a diet to lose weight, compared with 20% of men (Berg, 1999). While tight corsets can contribute to a range of health problems from shortness of breath and constipation to fractured ribs and liver displacement, dieting has also been linked to negative health outcomes including disregulation of the metabolic system (Rodin el at.). In the pursuit of weight loss, many women use diet aids such as pills, laxatives, and other supplements that are considered risky (Celio et al., 2006). Products that contain ephedrine have been shown to be particularly dangerous. According to Chan (2009),

incorrect use or abuse of ephedrine may result in "severe hypertension, palpitations, tachycardia, myocardial infarction, stroke, seizure, psychiatric disorders and death" (p. 454). Because of these issues, the U.S. Food and Drug Administration banned supplements that contain ephedrine in 2004 (Van Thuyne, Van Eenoo, & Delbeke, 2006). Only one year later, the ban was lifted by a federal judge who ruled in favor of a company that produces dietary supplements (Van Thuyne et al.). Today, in spite of clear health risks, many women continue to use these products in an effort to lose weight. Rodin and her colleagues pointed out that women have a "long history of...mutilating their bodies for the sake of beauty" which exhibits the "belief that the female body is deficient and in need of reshaping" (p. 276). Although the specific behaviors in which women engage for the sake of beauty have shifted and changed over time, women often pursue extreme measures in the quest for beauty.

Evolutionary psychology's good gene hypothesis states that humans are programmed to be attracted to certain beautiful characteristics, as these traits signify youth, vitality, health, and most importantly, reproductive capacity (Green, 2008). Social psychologists attribute the fascination with beauty to a halo effect, whereby people assume that thin and beautiful people are good and fat or unattractive people are "stereotyped as lazy, greedy, and selfish" (Wade & DiMaria, 2003, p. 461). Beautiful people are assumed to be friendly, smart, kind, interesting, and outgoing, while people who are seen as less attractive are not assumed to have these characteristics or they are assumed to have the opposite of these traits (Rodin et al., 1984). Callan, Powell, and Ellard (2007) conducted a study on reactions to crime and victimization and found that

participants saw a victim's death as more unjust and tragic if she was beautiful. Other studies have shown differences in perception and treatment based on physical appearance in a wide range of areas. For example, attractive people are seen as more desirable to date (Rowatt, Cunningham, & Druet, 1999), are assigned lighter sentences as defendants (Erian, Lin, Patel, Neal, & Geiselman, 1998), and are given better health care (Badr & Abdallah, 2001) compared to less attractive people (Callan et al.).

Regardless of the reasons for the preoccupation with beauty, it is clear that the human species has a strong preference for pleasing, attractive bodies (Gosselink et al., 2008). This preference leads to a strong emphasis on attaining an appealing, attractive appearance, because the social desirability of being beautiful is an extremely strong force (Gosselink et al.). People spend billions of dollars each year in an effort to reach the goal of a perfect appearance, buying products, gym memberships, and even undergoing cosmetic surgery. Furthermore, the advertising industry floods the media with images of beauty that are impossible for real people to attain while encouraging people to purchase products in the illusive pursuit of beauty (Kilbourne, 2000).

Nearly all humans are subject to the pressures of attaining physical attractiveness. Even during childhood, how individuals feel about their physical appearance is a more important contributor to overall self-worth than any other factor (Hymel, LeMare, Ditner, & Woody, 1999; Klomsten, Skaalvik, & Espnes, 2004). In other words, physical appearance is more important than academic skills, social skills, or physical competence in predicting overall self-esteem for both boys and girls. As children get older, boys become valued for traditionally male characteristics and roles. Appearance starts to play a

smaller role in predicting global self-esteem for boys compared to girls (Gentile et al., 2009). With regard to heterosexual mate selection, men are typically desired and valued for their financial success, earning potential, and social status (Toro-Morn & Sprecher, 2003).

While men have other qualities from which to derive self-esteem, most women learn that one of the most important things about them is the way they look. Research suggests that physical attractiveness, youth, and sexiness rank high on the list of what heterosexual men desire in a mate (Toro-Morn & Sprecher, 2003). Appearance remains the primary criterion on which women are judged. While men are often valued for their financial success, women are valued for their physical attractiveness (Sanchez & Broccoli, 2008). In U.S. culture, women are taught that they should appear young, thin, and large-breasted in order to be considered beautiful, and thus valuable. According to Gosselink et al. (2008), women are the primary targets, consumers, and victims of this beauty-enforcing socialization. An unattractive man can be valued for his wit, intelligence, sense of humor, or social status. An unattractive woman, on the other hand, is much less socially acceptable. In general, cultural norms for appearance are much stricter and more oppressive for women compared to men (Anleu, 2006).

Gosselink et al. (2008) used the term *beauty culture* to describe the "normative standards for females' attractiveness (i.e., thin and youthful idealizations) as well as women's personal and interpersonal awareness of, interaction with, and responses to these norms" (p. 308). The authors stated that women are socialized in this beauty culture to strive to attain the unrealistic and impossible in terms of appearance, thinking

that if they can become beautiful, they will be valued more by others and by society. Even though many women try their hardest, none are truly able to attain perfection, which was well-illustrated by Dove's campaign for real beauty. In one ad, titled *Evolution*, an average-looking woman goes through a dramatic makeover and photo-shoot. Then, each step of the computer touchup is shown, so that the final photograph used on a billboard looks drastically different and far more perfect than the actual woman behind all of the makeup and technology (http://www.dove.us/#/features/videos/default.aspx[cp-documentid=7049579]/). Jean Kilbourne (2000; 2010) talked about the rarity of the only body type that is shown as valuable in the media in her classic film *Killing Us Softly 3* and the recently updated version *Killing Us Softly 4*. Kilbourne noted that women with this ultra-thin, very tall body type also usually have very small breasts. The women shown in the media often have this rare, thin body type and large breasts, which, she surmised, means that these women have most likely had cosmetic surgery. According to Kilbourne, this perfect body type does not really exist in nature.

In sum, society dictates and enforces norms of beauty that are impossible to attain (Anleu, 2006). As women are socialized in this beauty-obsessed culture, they internalize messages about what they should look like, who they should be, and what they are worth. Because of this internalization process, the cultural norms of beauty influence women's identities to a great extent. One aspect of a woman's identity that is especially pertinent to the discussion about beauty involves body image, which refers to "a multidimensional attitude toward one's body that includes perceptual, affective, and

cognitive components" (Peat et al., 2008, p. 343). Body image is comprised of how a woman thinks and feels about her body. Most research on body image focuses on women's satisfaction with their physical appearance and shows that many women struggle significantly with this issue and feel strongly dissatisfied with their appearance (Peat et al.). In fact, body image distress and dissatisfaction with appearance are so endemic that Rodin et al. called it "a normative discontent" (1985, p. 267). In general, body dissatisfaction is pervasive (Peat et al.).

Objectification Theory

Fredrickson and Roberts (1997) asserted that self-objectification is another important factor that impacts body image and contributes to body dissatisfaction, especially for women. Objectification is "the experience of being treated *as a body* (or collection of body parts) valued predominantly for its use to (or consumption by) others" (Fredrickson & Roberts, 1997, p. 174, italics in original). Although men are increasingly exposed to objectifying media images, the experience of being treated as a sexual object remains primarily the experience of women (Kilbourne, 2000; 2010). As women endure objectifying media images and sexually objectifying attention from heterosexual men, many women begin to internalize this observer's perspective; they start to see themselves as objects instead of agents. Women who are agents are active, independent, and in charge of authoring their lives, while objects are passive beings that are acted upon and used by others. According to objectification theory, this objectified, observer's view of the self leads to an increase in habitual body monitoring, which is "the experience of near continual monitoring of one's body as others in society may be seeing it" (Szymanski &

Henning, 2007, p. 46). Habitual body monitoring in turn leads to body dissatisfaction and an increased risk for eating dysfunction (Grippo & Hill, 2008). The theory has been widely researched over the past decade and adds substantially to the psychological understanding of women's experiences within a sexually objectifying social context.

Similar to other psychological constructs, self-objectification is thought to be both a state and a trait phenomenon (Harper & Tiggemann, 2008). Trait self-objectification remains stable over time and refers to the extent to which a person internalizes the observer perspective (Harper & Tiggemann). State self-objectification, on the other hand, changes over time and across situations, increasing at times when the importance of the body and physical appearance are emphasized (Harper & Tiggemann). In other words, each person will have some level of internalized objectification that remains relatively consistent across time and place, much like each person has a base level of openness or anxiety. These factors are traits of the individual. Some people will be more anxious than others in the same situation, which means that they have different levels of trait anxiety. In addition to having traits that remain stable and are specific to each person, situational factors can induce state self-objectification. In the same way that being exposed to a poisonous snake would elicit state anxiety for many people regardless of their levels of trait anxiety, being exposed to situations that accentuate the body's physical appearance can induce state self-objectification.

In the original test of objectification theory, men and women were asked to wear a swimsuit or a sweater while alone and then complete various tasks, including a measure of math skills. The results showed that when women were in a situation that primed

objectification (wearing a swimsuit), they performed worse on a set of math problems (Fredrickson et al., 1998). Fredrickson et al.'s results showed that women experience self-objectification more than men, and further, some situations induce self-objectification more than others. Wearing a swimsuit brought up feelings of shame and disgust for women where men simply reported they felt silly. Only the women in the study exhibited impaired math performance and eating restraint in the induced state self-objectification condition. These results supported objectification theory's tenet that self-objectification leads to body shame, eating restriction, decreased attention, and decreased cognitive ability (Fredrickson et al.). Many variations on the original study have since been conducted, with researchers finding similar results (e.g. Gapinski, Brownell & LaFrance, 2003; Gay & Castano, 2010; Hebl, King & Lin, 2004; Quinn, Kallen, & Cathey, 2006).

Huebner and Fredrickson (1999) published an article discussing gender differences in types of memories in an effort to provide support for objectification theory. The authors described two types of memories: field memories and observer memories. In field memories, people remember events in the first person, as though they were reliving the memory. Observer memories, on the other hand, involve remembering events literally as an observer, viewing the event as an outside spectator. Huebner and Fredrickson suggested that this second type of memory, observer memory, might be the result of self-objectification. They recruited 242, predominantly White, undergraduate students who were randomly assigned to four different groups. Each group was asked to remember one event, either studying by oneself at home, giving a presentation in class,

eating with both men and women in a dining hall, or attending a college party where there would be people one did not know well, with the college party conceptualized as the most objectifying (Huebner & Fredrickson). Participants were given information on field and observer memories and asked to indicate the percentage of the memory that was from the field perspective and the percentage from the observer perspective. Results indicated that women experienced more observer memories than men, more negative affect, more shame, more anxiety, and less positive affect but only in the condition in which participants were asked to recall a university party. The authors concluded that this gender difference supports the idea that women, but not men, must divide their attention between their lived experience and their awareness of how they appear to others as they experience social events like parties.

Another situation that seems to trigger state self-objectification, at least among single heterosexual women, includes being exposed to relationship cues. Sanchez and Broccoli (2008) discussed the connection between romantic relationships and self-objectification, stating that women are socialized to value and pursue relationships with men and this pursuit is linked with objectification and the idealized, unrealistic expectations for women's appearances. Undergraduate women who were either single or in a heterosexual relationship completed a lexical decision-making task in which they were exposed to neutral words or relationship priming words, along with a measure of self-objectification. Results indicated that when single women were exposed to relationship-related words, their levels of self-objectification increased. The opposite was true for the women in relationships, whose levels of self-objectification decreased in

response to relationship priming. Sanchez and Broccoli proposed that thinking about romantic relationships increases relationship-seeking behavior and viewing oneself from a third-person observer perspective, but only for women who are single. For coupled women, the relationship priming leads to a decrease in self-objectification as the priming reminds them of their success in seeking and securing a male partner.

Calogero, Herbozo, and Thompson (2009) also published a study assessing conditions that induce self-objectification for women. Specifically, they looked at the impact of appearance-related comments and trait self-objectification on levels of body dissatisfaction and habitual body monitoring, also called body surveillance. Past research has shown that negative or critical comments about appearance are tied to body dissatisfaction and eating pathology. Little work had assessed the impact of positive appearance-related comments (Calogero et al.). In an effort to fill this gap, Calogero et al. measured positive and negative affect associated with receiving compliments and criticisms about appearance. Results indicated that women who scored high on trait self-objectification experienced more body dissatisfaction and body surveillance in reaction to appearance criticisms compared to women who scored lower on trait self-objectification. Calogero et al. suggested that women who self-objectify to a greater extent likely view appearance as more important and more central to their self-concept. Appearance criticisms were also associated with higher body dissatisfaction and body surveillance for lower-self-objectifying women, just not to the same extent as the high-self-objectifying group. This finding might mean that critical comments about appearance lead to state

self-objectification for women, regardless of their levels of trait self-objectification (Calogero et al.).

The most interesting and counterintuitive findings involved women's reactions to compliments about their appearance. Calogero et al. (2009) found that when women had a positive emotional reaction to a compliment, they felt more body dissatisfaction and engaged in more body surveillance. Many people assume that compliments about appearance will have a positive effect, but this may not actually be the case. Instead, this study suggested that any comments about appearance may lead to an increase in focus on appearance, evaluation, and seeing the self as an object. The authors put forth the idea of *complimentary weightism* to explain this idea. Compliments about physical appearance "may be intended to make [a woman] feel good or lift her spirits; however, it is precisely when women feel good about these compliments that the negative outcomes are most evident" (Calogero et al., p. 129). When women receive compliments about their appearance, they are reminded of the fact that they live in an objectifying culture that values them for their looks. This reminder may lead women to think about how they fall short of the thin ideal. Calogero et al. stated that this process holds true for all women, even those who do not typically base their self-value on appearance. Calogero et al. concluded that "to say something nice may be worse that saying nothing at all when the content of the comments is about the appearance of women's weight or shape" (p. 130). Comments about appearance, even those that are positive in nature, lead to state self-objectification and other negative body-related outcomes.

In another study, Harper and Tiggemann (2008) tested the impact of media exposure on women's state self-objectification and body dissatisfaction. According to these authors, media exposure plays a substantial role in creating and reinforcing the cultural norms and expectations for female appearance, specifically the idealization of extremely thin, sexually objectified women. In particular, media images of thin women communicate that thinness is desirable, good, expected, and normal (Harper & Tiggemann). To add to literature in this area, Harper and Tiggemann conducted an experimental test of the hypothesis that exposure to media images of thin, idealized women would trigger increased levels of state self-objectification. They also proposed that women would experience greater levels of state self-objectification if they were exposed to media images of a thin, idealized woman with an attractive man. Ninety women, 18 to 35 years of age, participated in the study. All participants were undergraduate students at a university in Australia. Researchers randomly assigned the women to three groups. One group was exposed to advertisements that featured a thin, beautiful woman. A second group was exposed to advertisements with a thin woman and at least one attractive man. The third group was shown advertising images without people, which served as a control. Subsequently, participants completed measures of trait and state self-objectification, appearance anxiety, negative mood, and body dissatisfaction. Results indicated that the participants who viewed advertisements with thin, idealized women, alone or with men, showed increased levels of state self-objectification, higher levels of weight-related concerns, more body dissatisfaction, and more negative affect (Harper & Tiggemann).

These findings expand the literature on self-objectification as much of the previous work has involved situations that directly induce state self-objectification (i.e., trying on a swimsuit and looking in a mirror) (Harper & Tiggemann, 2008). This study showed that even more subtle situations that are actually quite common in everyday life for many women (i.e., looking at fashion magazines) can trigger the same types of self-objectifying problems for women as more directly objectifying situations. The authors suggested that this is especially troublesome given how often women are exposed to these types of media images in the routine of everyday life: passing a billboard on the way to work, reading a magazine at the doctor's office, or watching television at home (Harper & Tiggemann). Given the frequency of this exposure, it seems likely that women experience increases in state self-objectification several times each day (Harper & Tiggemann). This problem is ubiquitous; women live in an objectifying world, bombarded with negative, harmful messages that are so easily internalized and so difficult to resist.

Impact of Negative Body Image and Self-Objectification

Given the widespread nature of self-objectification and body dissatisfaction, the empirical study of how women view their bodies is very important. Many studies show that body image is strongly related to psychological health. Specifically, negative body image, appearance dissatisfaction, and self-objectification have been shown to be risk factors for low self-esteem and psychopathology including depression, anxiety, sexual dysfunction, and disordered eating (Noll & Fredrickson, 1998; Peat et al., 2008). Self-objectification has also been tied to risky health behaviors like cigarette smoking. Fiissel

and LaFreniere (2006) found that women who smoke scored significantly higher on measures of objectified body consciousness. Women who internalize the unrealistic body standards and view themselves from an outside perspective may be more likely to smoke cigarettes as a way to control their weight, despite the clear health risks associated with smoking.

Huebner and Fredrickson (1999) suggested that self-objectification has both benefits and costs. Women may benefit from taking on an observer's viewpoint of their bodies because "other people's evaluations of a woman's physical appearance can determine her social and economic life outcomes" (Huebner & Fredrickson, p. 460). If a woman judges her appearance first, she can expect and work to change the judgments that people make about her (Huebner & Fredrickson). In this way, self-objectification is a potentially adaptive response to a negative environmental condition. By assessing how close they are to what is socially expected with regards to appearance, women can make changes that get them closer to the narrow, practically impossible, standard of beauty. This, in turn, may increase their social standing, acceptance, and value.

While there may be some type of benefit, this internalized observer's perspective comes at a heavy price. Self-objectification has many negative implications for the lives of women, leading to "decreased opportunities to experience peak motivational states and diminished awareness of internal bodily states" (Huebner & Fredrickson, 1999, p. 460). Other negative effects include increased body dissatisfaction, body shame (Fredrickson et al., 1998), appearance anxiety, and habitual body monitoring. Self-objectification and habitual body monitoring are also associated with depression (Szymanski & Henning,

2007), risk of eating pathology (Noll & Fredrickson, 1998; Szymanski & Henning), decreased creativity or flow (Szymanski & Henning), and diminished cognitive ability (Fredrickson et al.).

Steer and Tiggemann (2008) found that self-objectification is also related to sexual functioning for women. Internalized objectification leads to appearance anxiety and body shame, which contributes to decreased sexual functioning and feelings of self-consciousness. If a woman is focused on her appearance during sexual activity, she is less present in the moment and less able to experience physical pleasure because her mind is preoccupied with fears about how she might appear.

Muehlenkamp, Swanson and Brausch (2005) found that self-objectification also plays a role in predicting self-harm. They found that self-objectification leads to negative body regard, which contributes to depression, which then increases risk of self-harm. Although self-objectification does not lead to self-harm directly, it does contribute to risk. If a woman has internalized an observer's perspective of her body, she is more disconnected from her body and might view her body as a "hated object" (Muehlenkamp et al., p. 24), increasing the risk of self-injury.

Clearly, the literature in the area of self-objectification supports Fredrickson and Robert's (1997) initial assertion that internalizing an observer's perspective of oneself is related to many negative outcomes. These negative outcomes are widespread across many areas that impact life satisfaction and adjustment for women including physical health, mental health, relationship satisfaction, and cognitive ability.

Body Image Literature Specific to Middle-aged and Older Women

Peat et al. (2008) published a review of the literature in the area of body image and body dissatisfaction that focused on the experiences of older women. They noted that most research in this area has been conducted with samples of younger, college-aged women and that the limited amount of research using an older adult population has shown mixed results. The literature presents two main, opposing perspectives. Some studies have shown that women become more satisfied with their weight as they age (Franzoi & Koehler, 1998). Other studies have suggested that body satisfaction stays constant as women age (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). Because of unrealistic standards of beauty, women may be likely to view aging in terms of a loss of beauty, which might put them at risk for body dissatisfaction (Peat et al.). On the other hand, studies show that "the extent of the negative impact that body dissatisfaction has on self-concept may lessen with age" (Peat et al., p. 345) and in general, physical appearance may become less important as women get older (Clarke, 2001; Tiggemann & Lynch). Regardless of these conflicting findings, the presence of body dissatisfaction across the lifespan is evident. One study showed that 80% of 54-year-old women experienced body dissatisfaction (McLaren & Kuh, 2004). More research in this area is needed in order to get a clearer picture of women's experiences of body dissatisfaction across the lifespan.

Winterich (2007) conducted a qualitative study of women's experiences of aging with a group of 30 women aged 46-71. The study specifically assessed participants' reactions to appearance-related factors such as weight gain, gray hair, and facial hair using semi-structured interviews that were thematically coded. The results showed that

the women tended to feel conflicted about their bodies as they aged and women who were more traditional tended to have more of a difficult time as they moved into the middle stages of life (Winterich). Traditional women tended to adopt more feminine scripts and a more feminine identity. According to Winterich, these more feminine women are at a greater risk of developing psychological problems as they move into midlife, including depression and identity crisis. Caring more about appearance and ascribing to the cultural norms of beauty co-occur with this set of beliefs. More traditional women are likely to have internalized cultural messages (regarding gender roles as well as appearance standards) to a greater extent, which may place them at a greater risk for body dissatisfaction in midlife.

Many researchers and theorists have discussed the double standard of aging, which is in essence an interaction of ageism and sexism. In Western societies, older women are typically treated more harshly and more negative stereotypes are attributed to them compared to older men. In particular, "aging women deal with greater stigmatization of their appearances than do aging men" (Winterich, 2007, p. 54), and are judged more harshly by others (Tiggemann & Lynch, 2001). In part, this is related to how men and women are valued differently in society. Men are valued based on their achievements, which typically increase across the lifespan. Women, on the other hand, are judged primarily based on their appearance and as they move further away from the beauty ideal set by society, their value decreases (Rodin et al., 1984). In their classic work on women and weight, Rodin et al. noted that as women are casting off gender role stereotypes and breaking into new frontiers in society, they are also "increasingly striving

for thinness and are developing eating disorders with rising prevalence" (p. 268). As women gain more power in society, the pressures to obtain the ideal image of youthfulness and extreme thinness increase. In other words, the double standard of aging and the unrealistic beauty standards imposed upon women are not unrelated concerns; sexism, sizism, racism, and ageism all intersect and are impacted by issues of power.

Because of this double standard of aging, women are at a disadvantage when it comes to aging. In addition, women tend to show age-related changes more quickly than men. For example, wrinkling is caused, in part, by a thinning of the dermis, which is the middle layer of skin (Berk, 2007). Women typically have a thinner dermis compared to men, and so their skin often shows wrinkles earlier (Whitbourne, 2001). Additionally, research suggests that appearance and obtaining the ideal standards of beauty are a lot more important to women's identity than to men's (Tiggeman & Lynch, 2001). Given these ideas, it seems that women are at a greater risk of encountering difficulty in adjusting to new stages of life as they age, especially with regards to appearance and body satisfaction. However, some research shows that the opposite is actually the case: older women place less importance on physical appearance as they age (Clarke, 2001; Tiggemann & Lynch), are less likely to suffer from eating disorders (Tiggemann & Lynch), and consider more body sizes to be acceptable compared to younger people (Rand & Wright, 2000).

Furthermore, as women age, they may compare themselves to more appropriate models (i.e., other people their own age) (Tiggemann & Lynch, 2001) as opposed to the ultra-thin images of young women in the media. Peat et al. (2008) suggested that the lack

of media representation given to middle-aged and older women may have a positive effect on women's body image as they get older. Instead of comparing themselves to the unrealistic media images of young women, older women may look to real-life others for social comparison and feel better about their bodies. On the other hand, the lack of media representation could lead older women to compare themselves to the idealized images they see on TV and in magazines. Moving farther from the ideal portrayed by the media could then lead to increased body dissatisfaction (Peat et al.).

Some studies have suggested that women increasingly accept their bodies' age-related changes (Thompson et al., 1998; Webster & Tiggemann, 2003), which may lead to better adjustment. This increased acceptance of age-related changes is largely due to a shift in the types of cognitive control strategies that women use. Primary control refers to behaviors that people engage in to deal with a situation or problem (Webster & Tiggemann). In the case of body satisfaction, women who use primary control strategies might diet, exercise, or engage in other beautifying practices in an effort to attain the idealized standard of attractiveness. Secondary control strategies are "cognitive control mechanisms that can be adopted when behavioral control is difficult" (Webster & Tiggemann, p. 242). Examples of secondary control strategies that may be used to adapt to changes in appearance include changing or lowering expectations or decreasing the amount of importance placed on appearance (Webster & Tiggemann). With regard to body image in midlife and beyond, women are thought to increase their use of secondary control strategies, which in turn decreases the overall importance of physical appearance to their overall sense of self and their self-esteem (Webster & Tiggemann).

Webster and Tiggemann (2003) studied the impact of secondary cognitive control strategies on women's adjustment to their changing bodies. They recruited 106 women aged 20-65 and asked them to complete measures of body dissatisfaction, body importance, self-concept, self-esteem, and cognitive control over the body. Results showed that body dissatisfaction and body importance were the same across age groups, but older women use different cognitive strategies that serve to protect their self-concept and self-esteem from the effects of body dissatisfaction. In other words, for younger women, body dissatisfaction had a large impact on overall self-esteem and self-concept. Cognitive control played a protective role for older women. As their bodies became less attractive compared to cultural ideals, older women used more secondary control strategies that helped them to accept their changing bodies and acted as a buffer to their self-view and self-esteem (Webster & Tiggemann). Thus, it seems that younger women are more prone to use primary control strategies (i.e., dieting), and as women age, their use of secondary control strategies (i.e., acceptance) increases.

These studies suggest that several factors may be working in women's favor, assisting them in adjusting to changes in their bodies and in placing less importance on their physical appearance. In addition to individual women placing less emphasis on appearance, objectification theory suggests that society also places less importance on women's appearance as they age (Tiggemann & Lynch, 2001). Sexual objectification, or being treated as a sexual object, is a phenomenon that happens mostly to younger women who are capable of reproduction. According to Tiggemann and Lynch, "as women age and their bodies become less sexually objectified and relatively invisible, they may also

be able to relinquish the internalized observer's perspective on themselves and the concomitant habitual body monitoring..." (p. 244) that is associated with self-objectification. Thus, objectification theory suggests that aging should have a positive impact on women's psychological health because they will become less objectified as they get older. Along with feeling less objectified, they will also feel less shame and anxiety about their bodies and experience less eating pathology (Tiggemann & Lynch).

Tiggemann and Lynch (2001) conducted a cross-sectional study with 322 women ages 20-84 to test objectification theory as it applies to women of different age groups. Results showed that young women (20s and 30s) had the highest scores of self-objectification, appearance anxiety, body monitoring, and eating disordered symptoms. Middle-aged women (40s and 50s) scored in the middle ranges on each of these measures, potentially reflecting that they are in a transition period. Older women (60s and up) had the lowest scores. Tiggemann and Lynch suggested that women in this age group start to identify themselves as old, are no longer objectified by society, and thus no longer objectify themselves either. Other aspects of body become more important, including physical health and functionality, as opposed to physical appearance (Tiggemann & Lynch).

Consistent with much of the literature in this area, Tiggemann and Lynch's (2001) study showed that body dissatisfaction remained constant across age groups. However, the study also showed that self-objectification, habitual body monitoring, appearance anxiety, and eating disorder symptoms decreased with age. These are perplexing findings in some ways, given that body dissatisfaction and dieting behaviors are common for all

women but eating disorders decline in early adulthood and are mostly diagnosed in young women (Tiggemann & Lynch). Even though body dissatisfaction has been shown to contribute to the development of eating disorders and body dissatisfaction remains consistent across age groups, eating disorders decline with age (Stice et al., 1998), which seems paradoxical.

Even though dissatisfaction with one's body is ubiquitous and stable across the lifespan, the importance of appearance may decrease with age. This idea was supported by Tiggemann and Lynch's (2001) findings, which suggested that the desire to be thinner is a common experience for women of all ages, but the emphasis placed on the body declines as people get older. This age effect confirms objectification theory's prediction that as women get older, they are less objectified by society, and thus are better able to let go of that observer's perspective on their bodies (Tiggemann & Lynch). Fortunately, this decrease in self-objectification allows for better adjustment, which is contrary to what many might expect given that women move further from the societal ideal as they age.

Tiggemann and Lynch (2001) concluded that the stability of body dissatisfaction across age categories is misleading. Instead of body dissatisfaction having a truly stable and consistent course over time, the appearance of stability may actually be the result of two counteracting movements that happen with age. With age, women do get further from the ideal. Many body changes, including an increased body mass index (BMI), wrinkles, and gray hair, occur (Tiggemann & Lynch; Winterich, 2007). Research has suggested that BMI is positively correlated with body dissatisfaction and shame. Studies also show that self-objectification and body monitoring decline with age, which is

associated with experiencing less body dissatisfaction. Hence, measures of body dissatisfaction appear to stay the same across age, but this stability is the result of "two simultaneous but opposing changes with age" (Tiggemann & Lynch, p. 521).

Grippo and Hill (2008) conducted a more recent study on this topic, recruiting 138 White heterosexual women, aged 40 to 87. Their study showed that 40% of participants experienced body dissatisfaction, which confirms that "body dissatisfaction is not just a 'normative discontent' (Rodin et al., 1984) found in younger women; it appears women carry this discontent throughout their lifespan" (Grippo & Hill, p. 179). The study confirmed objectification theory's prediction that self-objectification and habitual body monitoring are positively related to body dissatisfaction.

Contrary to some of the literature in this area that suggests that certain facets of negative body image decline as women get older, Grippo and Hill (2008) found no relation between age and self-objectification or habitual body monitoring. In other words, there were no differences between older and younger women in terms of body dissatisfaction, which is consistent with previous research. However, this more recent study also showed no differences in self-objectification or body monitoring, which had previously been shown to decline with age. Although these are somewhat surprising findings given previous work in this area, Grippo and Hill did find that age moderated the relationship between habitual body monitoring and body dissatisfaction. In other words, there is a weaker relationship between monitoring one's body and feeling dissatisfied with it for older women compared to middle-aged women.

Based on these more recent findings, additional research is needed to further clarify the course of body satisfaction, self-objectification, and habitual body monitoring across women's lifespan. These issues are important to look at further because the study by Grippo and Hill (2008) does not support objectification theory's predictions. Older women may not actually be relinquishing the observer's perspective on their bodies to the extent that previous research would suggest. This finding might mean that older women may continue to be at risk for body dissatisfaction, self-objectification, habitual body monitoring, and the negative health outcomes associated with these types of body image problems.

Limitations

The literature clearly indicates that there are many negative aspects of beauty culture that impact the lives of women. Despite this widespread discussion of the problem of self-objectification, less research has focused on women's resiliency and the factors that prevent internalized objectification. Some researchers have designed programs to increase self-worth, resiliency, and positive body image, but these education and outreach efforts are primarily intended for audiences of pre-adolescent (Khattab & Jones, 2007) and adolescent (Choate, 2007) girls. In many respects, the targeting of younger audiences makes sense given that eating disorders like anorexia nervosa typically emerge in mid-to-late adolescence (American Psychiatric Association, 2000). However, because body dissatisfaction is such a normative problem that is pervasive throughout the United States (Peat et al., 2008; Rodin et al., 1985), more research is needed in this area to further elucidate resilience factors, especially with regards to a more diverse group of women.

In fact, the focus on primarily young, White, middle class, heterosexual women constitutes a very important gap in the literature regarding body image and objectification theory. Most of the research in this area has been conducted with convenience samples of college-aged women (Peat et al., 2008) and omits middle-aged and older women, as well as women of other diverse backgrounds (Winterich, 2007). The lack of attention given to the issues of middle-aged and older adults in the field of psychology likely reflects the larger social context of U.S. culture. The social context is characterized by privilege and oppression, in spite of a cultural belief in equality. The cultural climate is one that devalues aging, which is why ageism likely plays a part in the relative lack of attention given to the experiences of older individuals. Ageism refers to "negative or positive stereotypes, prejudice and/or discrimination against (or to the benefit of) aging people because of their chronological age" (Iversen et al.2009, p. 4).

Ageism, just like any other form of oppression, can be reflected in the relative invisibility or relative social unimportance of a group. In this way, ageism is reflected in the history of the field of psychology. For many decades, the experiences of adults were given less attention than the experiences of children and adolescents. Influential theorists, including Freud, focused primarily on the experiences of childhood. Development was conceptualized as mostly stable after adolescence, with personality and other aspects of the self being largely determined before a person reaches adulthood. Erikson was one of the first psychologists to focus on human development across the lifespan (Berk, 2007), acknowledging that people continue to grow and change

throughout the adult years. Nonetheless, attending to issues of older adults remains a lesser studied area even today (Iversen et al., 2009).

These gaps in the literature lead to concerns regarding generalizability. All women live in an objectifying culture, but the vast majority of research on body image only captures the experiences of a small group of women, typically between the age of 18 and 25 (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). This is problematic because exposure to the beauty culture and self-objectification persist after adolescence and early adulthood and impact the lives of women regardless of their various cultural identities. As women progress through different developmental milestones, the types of challenges they face in life may change. However, these periods of adjustment and challenge all occur within an objectifying social context. Just because a woman moves into mid-life does not mean that she suddenly finds herself exempt from body image struggles or the negative effects of internalized objectification.

Body image at midlife is important to look at given the many cultural pressures to stay young and thin that women experience across the lifespan. In many ways, the cultural norms and expectations for women's appearances contrast with the reality of the aging body. The cultural expectation is for aging women to maintain a youthful appearance. This view is prevalent and reinforced by media that typically only shows young, thin, beautiful women (Kilbourne, 2000). However, women in the United States are getting heavier on average (Webster & Tiggemann, 2003; Winterich, 2007), which suggests that the cultural expectations do not reflect the reality of women's lives. This incongruity influences women as they age with regards to their self-views and self-

esteem about their physical appearance, as well as their overall satisfaction and adjustment to life as they age. Tiggemann and Lynch (2001) suggested that as women move further away from the culturally imposed beauty ideal, they are at greater risk of experiencing body dissatisfaction and poor body image. Notably, moving further away from that ideal seems to be a part of the aging process. As women age, they put on weight, their hair turns gray and gets thinner, their skin loses elasticity, and their body shape changes (Tiggemann & Lynch).

Because of an ageist social context, unrealistic beauty standards, and the natural physical changes that occur with age, attending to body image and self-objectification at mid-life is an important area in need of additional research. Although it is not surprising that the experiences of marginalized individuals have been paid relatively less attention in society as well as in the psychology literature, the time has come to correct this problem and attend to the experiences of women throughout their lives to a greater extent.

Fortunately, some researchers have answered this call. More studies in the past decade have focused on developmental issues relevant to the lives of women during midlife (e.g. Clarke, 2001; Franzoi & Koehler, 1998; Grippo & Hill, 2008; McLaren & Kuh, 2004; Rand & Wright, 2000; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003; Winterich, 2007). Despite a growing effort in this area, more research is needed to further elucidate contradictory, recent findings (i.e., Grippo & Hill) regarding the application of objectification theory to the experiences of midlife women. Additionally, the relatively limited amount of research that has focused on issues relevant to the lives of women in midlife (including body image) has primarily utilized a very homogeneous

group of primarily White, heterosexual, wealthy, educated, middle-aged women (Peat et al., 2008; Winterich, 2007). Although there has been progress in expanding body image research into older populations, much work is left to be done in designing research that captures information about other, more diverse groups of women.

Menopause

Like the developmental milestone of puberty, menopause is an important phase in a woman's life that influences her development in both a physical and a psychological manner (Wilk & Kirk, 1995). Understanding the impact that menopause has on a woman's identity and sense of self provides the context in which body satisfaction or dissatisfaction occurs for women in mid-life. Thus, it is important to take this developmental experience into consideration in attempting to understand the literature on body image during mid-life.

In the most basic sense, menopause refers to the cessation of menstruation, which follows a longer period in which ovarian functioning and fertility decline (Elavsky & McAuley, 2009). During this period of decline, called the climacteric, menstrual periods become irregular and many women start to experience various physical and psychological symptoms. The climacteric culminates with menopause, which is defined by a woman not having had a period for 12 consecutive months (Roberts, 2007; Winterich, 2003). Most women go through menopause during midlife, between the ages of 40 and 58 (Roberts). In the general population as well as in many academic circles, the terms climacteric and menopause are used interchangeably (Kaufert, 1982; Neugarten & Kraines, 1965) to denote the overall period of change that women experience in midlife.

Similar to other work that studies women's experiences of midlife, this paper will use the term menopause to refer to the entire developmental, climacteric stage that takes place during midlife.

Menopause is a physical aspect of development that happens to all women with functioning ovaries when they reach midlife. Declining ovarian functioning, diminishing release of estrogen, and the end of menstruation are physiological changes that take place in a woman's body during the climacteric or menopausal transition (Elavsky & McAuley, 2009; Neugarten & Kraines, 1965). However, this process is not only a physical event in a woman's life. There are important socio-cultural aspects of menopause that influence women's personal experiences as well as the greater cultural meanings ascribed to menopause (Kaufert, 1982). In fact, Im et al. described menopause as culture-bound, stating that "menopausal changes are perceived, evaluated and acted upon within a system of culturally determined beliefs" (2008, p. 542). Menopause is much more than a physical event in a woman's life.

According to Kaufert (1982), the physical changes associated with menopause are especially vulnerable to cultural interpretation, primarily because these changes are so ambiguous and historically not discussed (Bannister, 1999). On one level, menopause has a simple, clear-cut definition as being "the last menses" (Kaufert, p. 148). Yet, much confusion, conflict, and ambiguity shroud the symptoms and signs that a woman is experiencing menopause. Kaufert claims that even the cessation of periods, which seems straightforward, is actually quite ambiguous for women at midlife. Amenorrhea could be caused by a number of factors including menopause, pregnancy, or some sort of illness or

other physical condition that causes a lack of period (Kaufert). A lack of menstruation can be the result of stress, poor nutrition, significant weight loss, excessive exercising, and many other factors (Sheinfeld, Gal, Bunzel, & Vishne, 2007). Because of this lack of clarity, understanding which signs of menopause are actually due to the physical changes that take place is important.

Symptoms Associated with Menopause

There are many individual differences when it comes to the experience of menopausal symptoms, and "the symptoms that accompany it vary greatly from one woman to another" (Bloch, 2002, p. 61). Symptoms are typically mild and diminish slowly with time (Bloch) and they can occur at different times for different women. According to Neugarten and Kraines (1965), some women experience symptoms early on during the climacteric, some experience symptoms at the same time as menopause, and some experience symptoms much later after their last menstrual cycle. Surprisingly, given stereotypes that suggest that menopause is a terrible time "coupled with almost unbearable difficulties" (Bloch, p. 61), some women do not experience any menopausal symptoms at all. Similarly, Roberts (2007) claimed that there are no universal symptoms of menopause, which also contrasts with common stereotypes.

Many researchers associate a plethora of symptoms with menopause, while other researchers disagree. There has been a lot of dispute about which physical symptoms experienced by women during midlife are actually due to menopause and which are unrelated but simply occur simultaneously (Neugarten & Kraines, 1965). Despite this controversy, most researchers agree that vasomotor symptoms, including hot flashes and

night sweats, are common symptoms that many menopausal women experience (Elavsky & McAuley, 2009). Vaginal dryness is also associated with the physical changes that occur during menopause (Im et al., 2008). Fortunately, vaginal dryness can easily be accommodated by use of lubricating products. Also, about one in ten women experience severe hot flashes, which runs contrary to the stereotype (Wilk & Kirk, 1995). Hot flashes may not be nearly as common as most people assume, or at least they may be much more manageable than many people think.

Research shows that many symptoms that are often attributed to menopause, at least by women in mainstream U.S. culture, are in fact not caused by menopause. Kaufert (1982) stated that fatigue, headaches, and feeling dizzy or irritable are not necessarily associated with menopause. These physical symptoms happen at other times in life and have many possible causes besides menopause. Depression is another experience that is often mistakenly attributed to menopause. Many women who experience depressive symptoms during menopause also experienced depressive symptoms earlier in their lives (Becker et al., 2001; Wilk and Kirk, 1995), which suggests that menopause is not the only causal factor at play. One study showed that 95% of women who were diagnosed with menopausal syndrome actually had a history of the same medical problems prior to menopause (Becker et al.; Donovan, 1951) and the existence of a universal menopausal syndrome has been refuted (Avis et al., 2001; Derry, 2004).

While many women report that they feel more forgetful during menopause, research actually shows that this is not the case (Im, 2007). Perceptual speed and working

memory declines are not associated with menopause. Similarly, many women experience insomnia during midlife and associate sleep problems with menopause. Lamberg (2007) pointed out that other health issues, such as sleep apnea, restless legs syndrome, arthritis, and diabetes, might play a substantial role in sleep problems during midlife, as opposed to menopause being the singular culprit. Additionally, midlife women are often responsible for the caretaking of aging family members, which often interrupts getting a restful night's sleep (Lamberg). One study showed that even though menopausal women report the most dissatisfaction with their sleep, they have better sleep, deeper sleep, and more sleep than premenopausal women (Young, Robago, Zgierska, Austin, & Finn, 2003). These findings suggest that menopause may unduly suffer from a bad reputation, wherein people misattribute symptoms to menopause and expect the worst from this midlife transition.

Some researchers have explored two possible explanations of menopausal symptoms: an endocrine-factor theory and an emotional-factor theory (Neugarten & Kraines, 1965). The first theory suggests that any symptoms women experience during menopause are caused by a hormonal imbalance. The second theory looks to each woman's pre-menopausal personality type for an explanation of the kinds of symptoms she experiences and how severe those symptoms may be. According to Neugarten and Kraines, the hormone imbalance theory is supported by studies that show that menopausal symptoms can be relieved by taking estrogen. A recent study by Baksu, Baksu, Goker, and Citak (2009) supports this idea. Baksu et al. assessed the impact of several different forms of delivery of estrogen in 132 women who had undergone

hysterectomy. In comparing oral, intranasal, and percutaneous gel forms of estrogen administration with a no treatment condition, the researchers found that estrogen level was significantly related to menopausal symptoms, anxiety, and depression. The women who received no estrogen replacement treatment experienced more menopausal and psychological symptoms, while women who were given estrogen showed improvements in these areas (Baksu et al.).

Although Baksu et al.'s study (2009) seems to provide strong evidence for the hormone imbalance theory, it is important to consider the possible confounding effect of expectation. The control group in this study did not receive any treatment at all and hence were not expecting any improvement in their symptoms. This idea is important given that other studies have shown that there are no differences in symptom relief when other medications aside from estrogen, including placebos, are given to patients (Neugarten & Kraines, 1965). The expectations that women hold, which are strongly influenced by cultural context, may impact a woman's experience of menopause to a great extent. For example, women who hold more negative views about menopause and about getting older are more likely to experience hot flashes (Derry, 2004). In mainstream U.S. culture, a medicalized perspective on menopause is very common (Derry; Voda & Ashton, 2006). As a result, many women may believe that estrogen therapy is the best or only way to alleviate menopausal symptoms. They may expect to suffer greatly during menopause and then see medical treatment as the only route to relief. Thus, the hormone imbalance perspective on menopause is clearly a powerful social construction that views women in midlife as deficient, possibly leading to a self-fulfilling prophecy.

Furthermore, verbal reassurance from a physician may help to relieve menopausal symptoms by itself (Neugarten & Kraines, 1965). Many middle-aged women talk with medical doctors when they start to experience menopausal symptoms to discuss their experiences and to learn about possible treatment options (Hvas, Reventlow, & Malterud, 2004). In one study, Hvas et al. found that women wanted information from their physicians regarding the positive and negative aspects of menopause. Menopausal women wanted to learn more about how other women deal with menopause, and they wanted reassurance that nothing was physically wrong with them (Hvas et al.). Although some women contacted their doctors mainly to obtain prescriptions for estrogen, many women wanted much more than that from their doctors. Bannister (1999) conducted a qualitative, ethnographic study on women's experiences of menopause and similarly found that women seek more than medical treatment during menopause. Participants in Bannister's study found the medical profession to be lacking in terms of assisting them through this stage of life. Several participants noted that they felt disrespected, ignored, and that their physical complaints were dismissed by their doctors. Many women in the study received the most help and support from other menopausal women. In dialogues with one another, "midlife myths and misconceptions were balanced by personal accounts of their changing bodies ...[and] a wealth of knowledge and information would emerge" (Bannister, p. 529). These findings suggest that support, from doctors as well as from peers, can be very beneficial for menopausal women.

Another problem in getting an accurate understanding about the symptoms that women experience in menopause is that many of the studies recruit primarily women

who seek medical help for their symptoms (Neugarten & Kraines, 1965). Women who do not seek assistance are not included in the research, generally speaking. This means that women who have fewer struggles with menopause or handle their struggles more easily are left out of the literature, which might skew reports of menopausal symptoms to be more negative. According to Roberts (2007), only 10% of women actually seek medical help for their menopausal symptoms, which suggests that the literature may indeed be biased.

In an attempt to get a clearer picture of the different menopausal experiences that women have, Neugarten and Kraines (1965) created a symptom checklist that included 12 somatic symptoms (such as hot flashes or breast pains), 11 psychological symptoms (including irritability, crying, and depression), and five psychosomatic symptoms (such as headache, pounding heart, or feeling dizzy). The researchers administered the checklist to 460 women divided into the following groups: adolescents (ages 13-18), young women (ages 20-29), premenopausal women (ages 30-44), menopausal women (ages 45-54), and postmenopausal women (ages 55-64). Results showed that the menopausal group had the highest scores with regard to somatic and psychosomatic symptoms. The postmenopausal group reported the fewest symptoms, even though they typically had the lowest levels of estrogen (Neugarten & Kraines). Surprisingly, the adolescent group reported the most psychological symptoms, even when compared to the women going through menopause. With regard to vertigo, insomnia, and fatigue, this study showed no differences between the different groups of women, indicating that these symptoms are not likely associated with menopause.

Compared to the other age groups in the study, the adolescent and menopausal groups reported the most symptoms. Neugarten and Kraines (1965) attempted to explain these findings, stating that psychological and social stressors are the greatest for these two groups. Adolescents are going through the big transition of puberty, moving from childhood into adulthood. Similarly, menopausal women are undergoing a physical transition that leads to the end of reproductive capacity. Many women also undergo changes in their social roles during midlife, including the transition associated with launching children (Neugarten & Kraines). On the other hand, the authors also argued that these two developmental periods may not be that much more stressful for women. They explained that early and middle adulthood involve many potentially stressful changes as well. Women who choose to marry, enter long-term relationships, have children, and who pursue education or careers often encounter life stress.

Another explanation that Neugarten and Kraines (1965) suggested is that adolescence and menopause both involve hormonal or endocrine changes. However, among those women aged 45-54, the women who reported they were in menopause also reported more symptoms. The women in this same age range who did not acknowledge being menopausal did not report the same degree of symptoms. This group of non-menopausal middle-aged women likely experienced the same developmental stressors, psychosocially speaking, that their menopausal age mates experienced. This idea supports the hypothesis that menopausal symptoms are related to endocrine system changes. Neugarten and Kraines suggested that adolescents experienced more symptoms

because of an increase in the production of sex hormones. Menopausal women experienced more symptoms due to a decrease in these hormones.

Based on these findings, it seems logical to conclude that some of the symptoms women experience in midlife are related to the hormonal changes that take place during menopause. However, this does not explain why adolescent women, who are similarly experiencing drastic hormonal shifts, experience the most emotional or psychological symptoms, even more than menopausal women. Neugarten and Kraines (1965) stated that there are age differences with regards to attitudes towards menopause that may provide an explanation. One study found that middle-aged and older women have fewer negative attitudes about menopause compared to younger women (Neugarten, Wood, Kraines, & Loomis, 1963). Furthermore, middle-aged women may feel like they will be able to control their symptoms to a degree and they view these symptoms as temporary (Neugarten & Kraines). They are also better able to regulate their emotions. For menopausal women, "their ability to cope with stress is an important mediating variable in determining their reactions to biologic developments" (Neugarten & Kraines, p. 272).

Although middle-aged women do undergo physiological changes that lead to somatic symptoms, it seems that fewer women deal with the psychological symptoms stereotypically associated with menopause. If menopausal women do experience psychological issues, they may be able to deal with them more effectively than many people assume. In support of this idea, Im et al. (2008) found that menopausal women are often optimistic regarding their symptoms. They use humor to cope with any negative or difficult aspects of menopause and often see menopause as a time to redefine

themselves and reflect on their experiences. While menopause may be a time of immense psychosocial change for women, this developmental period also involves an "opportunity for personal growth and restructuring" (Collins, 1997, p. 94). Menopause may be a much more positive event in women's lives than is often assumed.

Social Construction of Menopause

Based on these research findings that suggest that menopause is not necessarily to blame for many stereotypical menopausal symptoms, why is this developmental transition thought to be such a negative experience, rife with so many problematic symptoms? Kaufert (1982) suggested that that the social constructions or myths that people hold about menopause provide an explanation. Social constructions are views that people hold that may seem like certainty or fact, but are actually subjective creations that rely on culture and language. They are "ideas of what is true [created] … in conversations with other people" (Guterman & Rudes, 2008, p. 136). Much of the research on menopause aligns with one of two main social constructions that influence the cultural understanding of this experience: a medical and a feminist construction (Im, 2007; Harris, 2008; Kaufert, 1982; Voda & Ashton, 2006). According to Kaufert, these views communicate how people see women in U.S. culture as well as how they value women as they age. She pointed out that "menopause marks the end of fertility, and attitudes towards the menopause will be the product of the status of women in society, to the extent that the latter reflect the value attached to their reproductive capacity" (Kaufert, p. 145). By looking at how menopause is viewed, one can gain an understanding of how women are viewed by a particular culture.

There seems to be a relationship between a cultural view of menopause as being positive or negative and the societal value given to women as they move into middle age (Kaufert, 1982). If older women are given value in society, entering menopause may not be seen as a negative event. However, in an ageist, sexist culture where older women are devalued and attributed with negative stereotypes, entering menopause may instigate a much more negative reaction (Wilk & Kirk, 1995). This cultural difference relates back to the ambiguity and controversy that surrounds symptoms that are potentially related – or unrelated – to menopause. During mid-life, a woman might simultaneously experience menopause, hot flashes, and symptoms of depression. Kaufert (1982) explained that the woman's cultural context will determine how she understands these experiences. In a culture where menopause is viewed negatively and assumed to have many terrible symptoms, she is likely to attribute all of her negative experiences to menopause. If she lives in a culture that views menopause as a natural part of life, she is less likely to blame her depression on menopause. Experiencing symptoms is separate from whether a person defines the symptoms as part of menopause (Kaufert), which is an important point. Fitting with this idea, Collins (1997) stated that the attitudes women hold about menopause and aging have a great impact on the symptoms that they actually experience, while changes in hormone levels play a much smaller role. These attitudes, which play such an important part in how people attribute and understand their experiences, are largely due to culture and the way that people socially construct their realities.

The medical and feminist perspectives are two prevailing views of menopause that act as frameworks for attributing symptoms and understanding the experience,

especially within U.S. culture (Harris, 2008; Im, 2007; Kaufert, 1982). The medical model has been conceptualized by some as a perspective of controlling women's lives and women's bodies, where doctors are considered experts and women are passive, expected to describe their symptoms and trust the doctor's determinations about those symptoms (Kaufert). Medical attention to women's physiological processes has had a long history (Kaufert) and "women's bodily processes have long been viewed as somewhat shameful, unknown, and mysterious, possibly evil" (Wilk & Kirk, 1995, p. 237). Kaufert described a prevailing cultural view in the 19th century that assumed that studying would interfere with the menstrual cycle and cause problems with having children. This view, derived from the medical knowledge and understanding of female physiology of the day, greatly influenced cultural values, including the idea that women should not have access to higher education (Kaufert). According to Kaufert, medical professionals also keep control over women's bodies through controlling access to birth control and abortion.

For the most part, menopause is understood from this medical perspective that pays little attention to the psychological and social aspects of this developmental stage (Wilk & Kirk, 1995). Menopause is considered to be a "hormone deficiency disease" that is viewed very negatively (Wilk & Kirk, p. 233), pathologically (Harris, 2008), and even as a "catastrophic event" in a woman's life (Voda & Ashton, 2006, p. 403). This perspective focuses primarily on the physical aspects of the menopausal transition, to the exclusion of the social and psychological aspects and largely frames menopause in a negative way.

Despite efforts towards a more broad view of human development, applied psychology is not immune to the influence of the pervasive negative medical view on menopause. Wilk and Kirk (1995) stated that menopause is often ignored by therapists, even though this developmental stage could have a substantial influence on a client's presenting concerns and goals for therapy. Although 85% of therapists understood menopause as a stage of development, only 16% actually discussed it with menopausal clients. Wilk and Kirk explained these findings, stating that therapists have potentially bought into the medical understanding of menopause, leaving discussion about menopausal experiences, meanings, and struggles up to OB/GYNs. In addition, the lack of attention that therapists give to issues regarding menopause could be related to therapists' own ambivalence and internalization of societal views that menopause is bad, taboo, and wrong to discuss (Wilk & Kirk). This idea is supported by the finding that therapists who were young women or men were more comfortable talking about menopause compared to their middle-aged, female counterparts. Middle-aged female therapists reported more discomfort in talking about menopause with clients. They may avoid discussions about midlife and menopause out of their own discomfort and negative internalized ideas about this stage of life as it applies to themselves.

In contrast to the medical model that views menopause as a disease in need of treatment, the feminist model offers a more positive, woman-centered perspective. The feminist perspective was developed as a critique of the medical perspective, and according to Kaufert (1982), it is really a reaction against the medical model. In this way, the feminist model does not offer a wholly different view than the medical model

and it does not stand alone. It is a reactionary conceptualization that still relies on the social construction of the medical model. In spite of this, the feminist model remains a vital breath of fresh air in the discourse on menopause because it "acknowledges women and their issues as important and valuable" (Harris, 2008, p. 964). Instead of viewing menopause as a disease (Wilk & Kirk, 1995), the feminist model focuses on the natural and empowering aspects of this transition. The focus is on trusting women and empowering them to trust themselves and their bodies. Women's actual experiences are given a lot of value, as opposed to just relying on a medical understanding of those experiences (Kaufert). In line with this viewpoint, the feminist movement has involved creating centers for women to receive alternate medical care, educating women about bodies, and providing spaces for women to gather and support one another (Kaufert). In these ways, the feminist view stands in stark contrast to the deficiency-focused medical view of menopause. Voda and Ashton (2006) described these contrasting perspectives, stating that "a line was drawn that can be likened to a menopausal fault line" (p. 404) with the disease perspective of the medical community on one side of the line and the feminist perspective in fervent disagreement on the other side.

Given Voda and Ashton's (2006) description of the medical and feminist models pitted against each other, one might assume the divide to be clear-cut and complete, with biological and physiological explanations of menopause in the medical camp and social or cultural explanations in the feminist camp. However, this is not the case. Derry (2006) presented an alternative biological view of menopause and discussed limitations of the medical, disease conceptualization of menopause. In doing so, she crossed the

menopausal fault line to provide a more complex understanding of the biology of menopause.

According to Derry's (2006) view, the Lifespan Biological Model, menopause should be viewed more positively and through a different lens. Human females are unique in that they are the only mammals to have a developmental stage where they are post-menopausal and no longer reproductive, but still healthy and capable (Derry). The medical perspective seems to assume that because menopause is unique to humans, that it must also be wrong and pathological. Derry, on the other hand, stated that "it is unusual for a mammal to have such a life stage [as menopause], but there is nothing unusual about humans having unusual life stages" (p. 393). She argued that menopause is not pathological and stated that research often overemphasizes the importance of reproductive hormones, especially estrogen, without a full understanding of the larger system in which hormones play a part.

Lower levels of estrogen are assumed to cause terrible illness for post-menopausal women. In contrast to this widely-held view, Derry (2006) pointed out that women's bodies compensate for age-related and menopause-related changes. Lower levels of estrogen may be needed for healthy functioning once reproductive capacity has ceased. As bones become weaker and less dense, they also grow wider. As one type of estrogen drops off, another type that is actually more easily used by the aging body takes over as the dominant estrogen (Derry). These examples show how menopausal changes can be seen in a completely different light when placed in a different and more complete context.

Meanings of Menopause

In addition to these cultural views of menopause, it is important to consider the meaning that women themselves make of this developmental transition. Wilk and Kirk (1995) discussed many of the different meanings that are often attributed to menopause. According to their study, a majority of women who talk about menopause in therapy (70%) saw menopause as a sign of getting old, which likely reflects a widespread viewpoint. Menopause is often seen within a context of loss: loss of childbearing ability, loss of a spouse, loss of the self as sexually attractive, loss of feminine gender role, and loss of the self as able-bodied and independent (Wilk & Kirk). In an ageist culture, menopause may also mean a loss of value in society. According to Wilk and Kirk, "older women are seen, at best, as relatively invisible, lacking clear role definition, and at worst, as unfeminine, unattractive, unwanted" (p. 238). Aging women are thought of in a very negative way, which reflects a double standard of aging because older men are not necessarily viewed in this same way (Lauzen & Dozier, 2005). Anti-aging views are widespread in U.S. culture, which lead some women to go to extraordinary measures to maintain youth. Wilk and Kirk made a cogent point in saying that:

> If the individual woman herself believes that her youth, beauty, and body are the most important things in her life… then little wonder she does everything she can to preserve them… and little wonder that the body changes of menopause feel like a threat. (p. 238).

Furthermore, menopause may trigger women to experience greater levels of existential anxiety, as it may make women more aware of their mortality. Existential

anxiety arises when people are faced with the difficult truths of human existence: death, freedom, isolation, and meaninglessness (Yalom, 1980). Wilk and Kirk (1995) stated that menopause involves the "loss of the invulnerable self protected from death by an older generation" (p. 238). In other words, as women move through mid-life, they start to realize they are becoming the older generation. In this way, menopause highlights existential truths, including the inevitability of death, which many women may have simply avoided earlier in life. Logically, this existential awakening could contribute to the discomfort and negativity associated with menopause because many people try to avoid facing the uncomfortable realties of existence. However, according to Hvas and Gannik (2008), the existential perspective on menopause also includes possibilities, freedom, growth, and self-discovery, which contrast greatly from the negative stereotypes that are so common in mainstream U.S. culture.

In spite of the presence of positive aspects of menopause, negative meanings are overwhelming and pervasive and in fact, some women struggle to acknowledge menopause when they experience it. Pramataroff, Leppert, and Strauss (2007) studied the denial of menopause, stating that some middle-aged women confuse the cessation of their periods with pregnancy. Even when doctors confirm that they are not pregnant, but are going through the climacteric, they are confused and convinced they are still fertile. Pramataroff et al. compared women who accepted menopause to women who denied their climacteric. Results showed that deniers were more neurotic, more depressed, felt more negatively about their bodies, and held more traditional views about sex. The authors claimed that deniers may be mourning loss of fertility and the things associated

with fertility (i.e., youth, attractiveness, and health) to a greater extent. These results are possibly a result of more traditional gender role socialization and internalizing the negative cultural values about menopause to a greater extent.

These results also support the idea that views about menopause are socially maintained, instead of being primarily the result of biology or physiology. Many studies have confirmed this idea, showing that women who hold negative attitudes about menopause also report the most negative symptoms (Bauld & Brown, 2009; DeAngelis, 2010). Cultural stereotypes and expectations play a large role in attitudes towards and experience of the climacteric. Women have more negative reactions to menopause in cultures that devalue older women, but this is not the case where older women are valued and revered (Wilk & Kirk, 1995). It is possible for menopause to be an opportunity for women to redefine themselves, to change the losses associated with menopause into a positive identity that "is not defined by relationship to childbearing, to a sexualized femininity, by youth, by omnipotence, or by denial" (Wilk & Kirk, p. 238). In spite of the many negative cultural understandings of menopause, there are also positive meanings that women can attribute to this transition.

Cross-Cultural Experiences of Menopause

There are some noteworthy cross-cultural differences that exist with regard to women's experiences of menopause. The Study of Women's Health Across the Nation (SWAN), conducted by Avis et al. (2001), addressed between-group differences in experiences of menopausal symptoms. Results of this study support the idea that culture has a large impact on the experience of menopause. SWAN participants included 14,906

White, African American, Chinese, Japanese, and Hispanic women between the ages of 40 and 55. The researchers controlled for education, health, and socioeconomic status and found hot flashes and night sweats to be common menopausal symptoms. The following group differences were found. White women experienced more psychosomatic symptoms, like depression or irritability, compared to other groups. African American women and women who were in perimenopause, which is the menopausal transition period, women who took hormones, or women who were surgically menopausal reported more vasomotor symptoms such as hot flashes. Asian American women reported fewest symptoms.

Menopausal symptoms are influenced by culture and vary from one culture to another (Marvan et al., 2008). One study showed that change in the menstrual cycle was the only menopausal symptom reported by many Indian women (Flint, 1975). Lock (1986) found that few Japanese women experienced depression or irritability and reports of hot flashes were less common compared to reports from women in Western cultures. In fact, it seems that the menopausal transition is not considered to be a matter of great importance in Japanese culture (Lock). In one study, 92% of Italian women aged 40-60 years of age reported that menopause is a normal part of life for women and 42% reported described menopause as a positive experience (Donati et al., 2009).

Within the U.S., negative reactions towards menopause may be more prevalent among White women compared to women of other ethnic backgrounds (Holmes-Rovner et al., 1996). This idea was supported by the results of a recent qualitative study by Dillaway et al. (2008). Based on interviews with 61 women from various racial and

socioeconomic backgrounds, the researchers found noteworthy group differences. African American and Latina working-class women saw menopause as a positive event. Middle-class White women, on the other hand, experienced more negative feelings.

In a study on group differences in attitudes towards menopause, Sampselle et al. (2002) explored the different meanings that women give to menopause. By comparing African American and White women's perspectives, they found that the White women in their study were "primarily concerned about menopause as a harbinger of physical aging and the ensuing disadvantage of divergence from society's ideal of a youthful appearance" (p. 351). African American women viewed menopause as "a normal, even welcome, part of life" (p. 351). Holmes-Rovner et al. (1996) found similar results and noted that African American women see menopausal symptoms as "not terribly bothersome" (p. 422). The Sampselle et al. study showed that pre- and peri-menopausal women often feared menopause and assumed that they would experience emotional problems. However, most women actually found menopause to be a time of strength, re-definition, goal setting, and positive self-esteem (Sampselle et al.). Both African American and White women cared less about following social standards, experienced an increase in self-worth, and felt more mature compared to previous stages in their lives. However, changes in appearance impacted White women's self-esteem more than African American women's. The authors suggested that African American women were less negatively impacted by menopause, possibly as a sign of resilience tied to the fact that the norms of mainstream beauty are White norms (Sampselle et al.).

Im, Lee, and Chee (2010) reported similar findings in their qualitative study that aimed to describe the menopausal experiences of Black women at midlife. The researchers recruited 20 midlife Black women to participate in an online forum about menopause over a six month period. Results showed that the participants were "raised to be strong and to accept hardship" and to see menopause as "just another part of life to 'endure'" (p. 439). In addition, the women in the study had positive views about menopause. They indicated that menopause is part of a natural aging process, where "getting older doesn't necessarily equal a loss of power" (p. 439). Im et al. discussed African American culture and noted that older women are revered for their wisdom and maturity and seen as matriarchs.

Where some studies have suggested that African American, Latina, and Asian women have more positive experiences of menopause (e.g. Dillaway et al., 2008; Holmes-Rovner et al., 1996; Im, Lee, & Chee, 2010; Sampselle et al., 2002), Sommer et al. (1999) published a study of ethnic differences in attitudes towards menopause with a sample of 16,065 U.S. women that suggests a different cross-group trend. Results of this large-scale cross-sectional study showed that African American and White women reported the most positive views about menopause, followed by Latina women. Asian American women reported the least positive views about menopause. The researchers explained their findings by suggesting that African American and White women associate menopause with an increase in freedom and independence. For Latina and Asian women, an increase in independence may be viewed less positively as a result of interdependent, collectivist cultural values that emphasize the role of motherhood and family

interconnectedness. Sommer et al. pointed out that their findings run "counter to the traditional concept of respect for the elderly in the Asian culture, which might be expected to translate into a more positive attitude toward menopause as a manifestation of aging" (p. 873). These mixed findings and contrasting explanations highlight the need for future research to explore this area further.

Limitations

Although there are a number of studies on women's experiences at midlife, research on other developmental stages (childhood, adolescence, young adulthood) remains much more prevalent and available. Wilk and Kirk (1995) claimed that there is a "serious lack of psychological research into the developmental issues which arise prior, during, and following menopause" (p. 233). It seems that there is an imbalance in the literature, with much more attention being paid to the experiences of younger women in particular.

This is not to say that research has not attended to the issue of menopause. Many studies have explored women's menopausal experiences, especially related to symptoms of menopause. However, much of that work is from a medical perspective that focuses on menopause as a physiological process, to the exclusion of attending to the psychological and sociocultural aspects of this stage of life. Furthermore, the U.S. Department of Health and Human Services published reports on menopause and the use of hormone therapy through the Women's Health Initiative in 2007 (Im et al., 2008). According to Im et al., these reports may have had an impact on women's experiences of menopause that has not been captured in the literature at this point.

Most importantly, the existing work on menopausal experiences typically utilizes a narrow, homogeneous sample. Im et al. (2008) stated that most studies of menopausal symptoms include primarily White women as participants. In this way, the prevailing views on menopause may reflect only the experiences of privileged, White women. According to Kaufert (1982), the menopausal woman is assumed to be heterosexual, married, and wealthy. A White, upper-middle class view of menopause is often presented as universal and applicable for all women, when research indicates that this is very unlikely to be the case (e.g. Holmes-Rovner et al., 1996; Im et al.; Marvan et al., 2008; Sampselle et al., 2002). The overwhelmingly negative views on menopause may be quite culturally specific and not universal to all women. Because there are few cross-cultural studies of menopause in the U.S. (Avis et al., 2001) and because of mixed results in the literature, this is yet to be determined. However, the results of the few studies that have assessed for group similarities and differences show promising results and point to the need for future multiculturally-informed work in this area.

Menopause and Body Image: Experiences at Mid-Life and Beyond

Because of the emphasis on appearance and changes that occur with aging and menopause, it seems likely that attitudes about menopause would influence body-image during mid-life. However, research examining this relationship is sparse. McKinley and Lyon (2008) commented on this surprising lack of research, stating:

> Given the importance of appearance in the cultural constructions of ideal femininity in the U.S. and the connections between constructions of ideal femininity and menopause as well as the physical changes associated with

menopause, it is surprising that there is so little research examining this relationship. (p. 379)

Only a handful of studies have looked at the relationships among body image and menopausal status, symptoms of menopause, and attitudes towards menopause.

Deeks and McCabe (2001) conducted a study on the effects of menopausal stage on body image. They found no significant effects for menopause on body image after controlling for age. The effects of age and the effects of menopause seem to be confounded because women get older as they move through the stages of menopause. It is difficult to tease apart effects due to general aging and effects specifically caused by menopause. Deeks and McCabe suggested that future research should address this issue. Their study showed that age influenced ratings on the Figure Rating Scale, which is a widely-used measure of body dissatisfaction. In this measure, participants are exposed to drawings of figures that range from very skinny to very large and then rate the figures on various dimensions (e.g. which picture most looks like them, which is their ideal, or which is society's ideal) (Thompson & Altabe, 1991). In Deeks and McCabe's study, premenopausal, younger participants felt more positively about their appearance compared to women in menopause. Menopausal, older women reported lower ratings of how they felt about their looks, but the authors were unsure if this decrease in satisfaction was the result of weight changes, changes in fat distribution, wrinkling of skin, or other age-related changes in appearance. Premenopausal women felt more fit than menopausal women, but there were no differences with regard to satisfaction with body parts (Deeks & McCabe). Women were equally dissatisfied with their bodies, particularly their lower

and mid-torsos. Participants chose bigger figures as ideal as they got older, but choices of ideal figures remained relatively small. The authors concluded that postmenopausal women accept that they are going to be somewhat bigger and believe that society will accept this weight gain to some extent. However, they also suggested that research still needs to assess how women feel about having a larger body, beyond just accepting it as fact (Deeks & McCabe).

McLaren, Hardy, and Kuh (2003) conducted a longitudinal study that assessed Body Mass Index (BMI) and body satisfaction over the lifespan. The study began when participants were seven years old and the most recent data were collected when the women were 54. Results of this study showed that women who were heavier when they were younger in life were more dissatisfied with their bodies at midlife. Furthermore, both puberty and menopause were shown to be particularly relevant developmental periods where body dissatisfaction increased. McLaren et al. speculated that puberty led to more dissatisfaction because of changes in body type from a thin, androgynous shape to more feminine, curvy proportions. At the end of data collection, though all participants were the same age, they differed in menopausal status, with some women pre-menopausal, some peri-menopausal, and some post-menopausal. The study showed that the postmenopausal women were more satisfied with weight compared to same-aged women of other menopausal statuses (McLaren et al.). The authors explained these findings by saying that pre-menopausal women are aware that menopause is about to happen for them and may be feeling worried about and aware of their bodies as a result. Women who have already gone through menopause are thought to have fewer symptoms,

and hence less of a focus on their bodies, which is thought to lead to less appearance-related worry. McLaren et al. also pointed out that menopause could mark a transition in which physical appearance becomes less important and less central to women's self-concept.

In the only study located on the relationship between menopausal attitudes, body image, and objectified body consciousness, McKinley and Lyon (2008) tested general menopausal attitudes, appearance-related menopausal attitudes, body esteem, and self-objectification in a sample of 74 European American women aged 50-68. The researchers controlled for age, menopausal status, and Hormone Replacement Therapy (HRT) use, stating that these factors have been shown to influence body experience. Results showed that body esteem was related to having more positive attitudes about menopause, but only for appearance-related menopausal attitudes. General menopausal attitudes, appearance-related attitudes, and appearance-related aging anxiety were related to body surveillance, which was in turn related to body shame (McKinley & Lyon). The authors suggested that having negative views of menopause may be related to an increase in self-objectification.

McKinley and Lyon (2008) concluded that if women believe that menopause brings about weight gain and loss of attractiveness, they are more likely to experience body-related problems. Alternatively, they suggested that high self-objectifiers may have more negative views of menopause and more anxiety related to aging. Based on the research that has been done up to this point, it is unclear if resisting self-objectification leads to more positive appearance-menopause attitudes or if more positive menopausal

attitudes leads to less body shame and self-objectification (McKinley & Lyon). Additionally, a third factor may predict both body shame and menopausal attitudes.

In a similar study, Bloch (2002) assessed the relationships among body image, self-esteem, and estrogen level to see if these factors predicted the severity of symptoms of menopause. Participants included 51 Austrian women aged 43-63 who were in various stages of menopause or had undergone a hysterectomy. Results of the study showed that attitude towards menopause was related to women's experiences of menopausal symptoms. Specifically, having a negative attitude about menopause was related to experiencing more severe symptoms (Bloch). Furthermore, women who were satisfied with their appearance reported fewer symptoms. Bloch also found a relationship between self-esteem and menopausal symptom experience, whereby women with high self-esteem experienced the lowest symptoms. Finally, Bloch showed that estrogen level was not related to experiences of menopausal symptoms, which counters a commonly held belief. Women who were postmenopausal and had lower estrogen levels did not necessarily have more symptoms (Bloch), which suggests that attitudes and expectations play a substantial role in the symptoms of menopause that women experience.

In 2003(a) DeSoto published an article criticizing Bloch's (2002) findings, ultimately accusing Bloch of drawing conclusions about causation from correlational research. In her 2002 article, Bloch argued that women experience a self-fulfilling prophecy where negative views of menopause lead to more negative experiences and more problematic symptoms (DeSoto, 2003a). In reaction to this, Desoto argued that some women have lower estrogen levels, leading to more menopausal symptoms, which

then leads to a more negative view of menopause. Because Bloch's research was not experimental, conclusions about causality cannot be made. However, in support of her argument, Desoto pointed out the importance of parsimony in research. Parsimony, often referred to as the principle Occam's razor, is the idea that the simpler explanation should be assumed given a choice between several alternative possibilities (Palmer, 1987).

DeSoto (2003a) stated that her explanation is more parsimonious and logical as well as more beneficial for the well-being of middle-aged women for several reasons. First, she explained that helping women to change their attitudes about menopause in order to improve their symptoms would be "at best, less than ideal" (p. 299), especially given the large amount of research that supports the medical, hormone-imbalance perspective on menopause. Furthermore, if doctors were to adopt Bloch's view that attitudes impact symptoms of menopause, they may not take women seriously when they experience symptoms and seek help (DeSoto). DeSoto discussed the impact of estrogen on neural functioning and noted that decreasing estrogen levels in menopausal women play a large part in the symptoms that women experience. She compared Bloch's view of menopause to views of pregnancy that were prevalent in the 1940s and 1950s that assumed women with morning sickness were experiencing symptoms as a result of holding negative views of pregnancy, arguing that real, physiologically based symptoms might be misattributed to what is in a woman's head.

In the same 2003 publication, Bloch published a counterargument to DeSoto's (2003a) criticisms. Bloch stated that she was attempting to move beyond a medicalized view of menopause in her work, "to provide a psychological perspective and to motivate

alternative studies… [that look at] what factors, besides hormonal loss affect menopausal complaints" (p. 303). Bloch pointed out the problems with pathologizing menopause and viewing it as a disease in need of medical treatment. She talked about how other aspects of menopause, including the emotional or psychological aspects, are typically ignored in the research. According to Bloch, the medical model has "created the 'myth' of the estrogen deficient women,' and the 'solution' of HRT" (p. 303). Ironically, hormone replacement therapy (HRT) has been shown to be problematic and controversial with some research linking its use with strokes, heart disease, and breast cancer (Bloch; Thobaben, 2003; Voda & Ashton, 2006) as well as gallbladder disease, dementia, and deep vein thrombosis (Roberts, 2007).

Bloch (2003) noted that not all women with lower estrogen levels suffer from symptoms and complaints and women who were post-menopausal, and hence had lower estrogen levels, did not report more symptoms than women with average levels of estrogen. The fact that not all women with low estrogen levels experience symptoms and difficulties with menopause suggests that more than estrogen is playing a role in women's experiences. Menopausal experiences are not as straightforward as the medical model implies. In her response to DeSoto's criticisms (2003a), Bloch claimed that there are other valid and important factors that impact women's experiences of menopause. In her reaction, DeSoto stated, "It is my hope that those involved in addressing women's health will become familiar with the facts of estrogen's effects – even if they are 'medical'" (2003b, p. 305). Based on the arguments from both perspectives, which add significant insight into the experiences of menopause, it seems important to keep the

effects of estrogen in mind, but to also forge ahead to expand knowledge of other factors that impact menopausal experiences, including a woman's view of and relationship with her body.

Limitations

The argument between Bloch (2002; 2003) and Desoto (2003a; 2003b) reflects the larger conflict between the medical and feminist perspectives on women's health, and specifically, women's experiences of menopause. Much like the field of psychology has moved from supporting nature, to supporting nurture, to finally recognizing that both nature and nurture influence development, the discourse on menopause should move towards a more encompassing viewpoint that takes multiple factors into account. However, much work towards this goal remains for researchers to accomplish. Biological, medical, and physiological aspects of menopause cannot be ignored. Similarly, attention must be paid to the psychological, social, and cultural aspects. Unfortunately, these latter aspects have received significantly less attention in the literature (Bloch). Further study is necessary in order to garner a more complete understanding of factors that contribute to difficulty and resilience for women at midlife.

The biological aspects that contribute to menopausal symptoms and attitudes are very important (DeSoto, 2003a). However, because much of the research on women's experiences of menopause has addressed the physical aspects, including the impact of estrogen (Bloch, 2003), it is important for future research to add a new layer to the collective understanding of this issue. Looking at psychological aspects of menopause,

including the impact of body image, does not detract from the importance of biological aspects.

There is some degree of support for the idea that body image (Bloch, 2002; Deeks & McCabe, 2001; McLaren et al., 2003), and self-objectification (McKinley & Lyon, 2008) impact women's experiences of menopause. However, there are limited studies that specifically look at the relationships between body image, menopausal symptoms, and menopausal attitudes (McKinley & Lyon). Furthermore, the few studies that have been published in this area utilized samples of women from England, Scotland, and Wales (McLaren et al.), Austria (Bloch), and Australia (Deeks & McCabe). The one study conducted in the U.S. that was located on this topic included only European American women as participants (McKinley & Lyon). Not only is research in this specific area somewhat sparse, but also the results of the work that has been published are unlikely generalizable to a more ethnically diverse population within the U.S. Both of these limitations are important gaps in the literature that need to be addressed in order to get a clearer understanding of the relationships between body image, menopausal attitudes, and menopausal symptoms experienced by women in the U.S.

Purpose of the Current Study

In the United States, cultural norms emphasize the importance of youth and physical attractiveness, especially for women (Kilbourne, 2000). Internalization of these messages is associated with many negative mental health outcomes, including depression and eating dysfunction (Noll & Fredrickson, 1998). Difficulties with body image are compounded for women as they move into midlife and begin to experience losses

associated with aging, including the loss of stereotypical attractiveness (Kaufert, 1982). Thus, some women may struggle with menopause and with body image during midlife. However, relatively little research has focused on this particular relationship (McKinley & Lyon, 2008). Furthermore, research on body image, aging, and menopause has utilized a narrow sample in terms of diversity, which is problematic given that some studies suggest that culture plays a large role in determining adjustment to midlife, to menopause, and with regard to body image.

The current study sought to address these gaps in the literature by assessing middle-aged and older women's attitudes toward and symptoms of menopause, their body dissatisfaction, level of self-objectification, and degree of body shame and body surveillance. Most importantly, the current study assessed the relationships among these variables and how they are similar or different across different age, menopausal status, and racial/ethnic groups. Based on this review of the literature, the following hypotheses were proposed:

1. Self-objectification will be associated with age, ethnicity and menopausal status, such that higher scores for self-objectification will be related to:
   (a) Younger age
   (b) Caucasian ethnicity (vs. Asian, Latina, and African American)
   (c) Pre-menopausal status (vs. peri- and post- menopause)

2. Body shame will be associated with age, ethnicity and menopausal status, such that higher scores for body shame will be related to:

   (a) Younger age

   (b) Caucasian ethnicity (vs. Asian, Latina, and African American)

   (c) Pre-menopausal status (vs. peri- and post- menopause)

3. Body surveillance will be associated with age, ethnicity and menopausal status, such that higher scores for body surveillance will be related to:

   (a) Younger age

   (b) Caucasian ethnicity (vs. Asian, Latina, and African American)

   (c) Pre-menopausal status (vs. peri- and post- menopause)

4. Body dissatisfaction-think will be associated with ethnicity but not with age or menopausal status, such that higher body dissatisfaction-think will be related to:

   (a) Caucasian ethnicity (vs. Asian, Latina, and African American)

   (b) Age and menopausal status will not be predictive of body dissatisfaction

5. Body dissatisfaction-feel will be associated with ethnicity but not with age or menopausal status, such that higher body dissatisfaction-feel be will related to:

   (a) Caucasian ethnicity (vs. Asian, Latina, and African American)

   (b) Age and menopausal status will not be predictive of body dissatisfaction

6. Attitudes toward menopause will be associated with age, ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel such that more negative attitudes toward menopause will be related to:
   (a) Younger age
   (b) Caucasian ethnicity (vs. Asian, Latina, and African American)
   (c) Pre-menopausal status (vs. peri- and post- menopause)
   (d) Higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel
7. Frequency of psychological menopause symptoms will be associated with ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think and -feel, and attitudes toward menopause, such that more frequent psychological symptoms will be related to:
   (a) Caucasian ethnicity (vs. Asian, Latina, and African American)
   (b) Peri-menopausal status (vs. pre- and post- menopause)
   (c) Higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel
   (d) Negative attitudes toward menopause

8. Severity of psychological menopause symptoms will be associated with ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think and -feel, and attitudes toward menopause, such that more severe psychological symptoms will be related to:
   (a) Caucasian ethnicity (vs. Asian, Latina, and African American)
   (b) Peri-menopausal status (vs. pre- and post-menopause)
   (c) Higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel
   (d) Negative attitudes toward menopause
9. Frequency of vaso-somatic symptoms of menopause will be associated with menopausal status, such that more frequent vaso-somatic symptoms will be related to:
   (a) Peri-menopausal status (vs. pre- and post-menopause)
10. Severity of vaso-somatic symptoms of menopause will be associated with menopausal status, such that more severe vaso-somatic symptoms will be related to:
   (a) Peri-menopausal status (vs. pre- and post-menopause)

11. Frequency of general symptoms of menopause will be associated with menopausal status, such that more frequent general symptoms will be related to:

    (a) Peri-menopausal status (vs. pre- and post-menopause)

12. Severity of general symptoms of menopause will be associated with menopausal status, such that more severe general symptoms will be related to:

    (a) Peri-menopausal status (vs. pre- and post-menopause)

13. A path diagram will significantly predict psychological, vaso-somatic, and general menopause symptoms from demographic characteristics (age, BMI, menopausal status, and ethnicity), body image (self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel) and attitudes toward menopause. The model will be tested predicting both:

    (a) Frequency of psychological, vaso-somatic, and general menopause symptoms

    (b) Severity of psychological, vaso-somatic, and general menopause symptoms

CHAPTER III

METHOD

Participants

Originally, the plan for data collection included recruiting 800 participants who lived in the United States and were at least 40 years of age. The purpose of recruiting this number of participants was so that multiple analyses could be run. Due to limitations in the data collection process, several hypotheses were altered to eliminate analyses involving Asian American and Latina women, as these groups were particularly difficult to access.

In total, 508 individuals participated in the study. Participation was restricted to women who were 40 or older, able to read English, and had access to the Internet. Data for 11 participants were not included due to failure to meet the qualifications for the study. One man and ten women under the age of 40 participated and their results were not included in the data analysis. Additionally, 100 participants dropped out of the study prior to completing the full set of surveys. Individuals who did not complete an entire measure or more were not included in the data analysis, leaving 397 participants in the final sample. T-tests and chi-squares were conducted to investigate the potential differences between the participants who completed the surveys and the participants who did not complete all of the study's instruments. Results indicated that the groups were significantly different in age (t (495) = 3.23, p =0.001) and menopausal status (χ^2 (3) =

11.775, p =0.001). Participants who completed the study were 2.87 years older on average and more of the participants who dropped out of the study were pre-menopausal than were peri-menopausal or post-menopausal. The groups were not significantly different with regards to ethnicity (χ^2 (6) = 5.177, p =0.52).

Procedure

Participants were recruited from the community via snowball sampling. Community members, as well as those women who chose to participate in the study, were encouraged to refer potentially interested participants to the investigator. The investigator placed flyers (See Appendix A) in public areas, including local gathering places for middle-aged and older women and sent a flyer out via email (See Appendix B) to various listservs that reach potentially interested individuals. The investigator also posted an advertisement (See Appendix C) on social networking sites (i.e., Facebook) that potential participants were likely to access, explaining the study and providing an Internet link for potentially interested people. Recruitment also involved targeting audiences of the specific ethnic groups that were of interest in this study. For example, the investigator recruited participants through listservs, online chatrooms, and community centers that women of varying ethnic groups utilize.

The flyer/advertisement briefly described the study and explained the benefits of participation. Physical copies of the flyer contained rip-off portions with the website of the study for interested people. Email copies and Internet advertisement versions contained a link for participants to click to access the study. Interested individuals either clicked on a link provided in an email or advertisement or typed in the website address

associated with the study. The investigator used PsychData, which is a secure online research-collection website that has been frequently used in data collection for research in the social sciences. Once participants entered the PsychData website, they were instructed to enter the study's unique ID number.

Precautions were taken to protect confidentiality and participation was entirely voluntary. All participants were informed of the sensitive nature of the study and possible risks. After reading the informed consent letter (See Appendix D) that explained the study, participants completed a demographic survey (See Appendix E), the Menopause Attitude Scale (Bowles, 1986; See Appendix F), the Menopause Symptom List (Perz, 1997; See Appendix G), the Figure Rating Scale (Stunkard et al., 1983; See Appendix H), the Self-Objectification Questionnaire (Noll & Fredrickson, 1998; See Appendix I), and the Objectified Body Consciousness Scale (McKinley & Hyde, 1996; See Appendix J). Participants were able to complete these surveys on a computer that has Internet access at a place and time of their choosing. The order of survey administration was counterbalanced to account for potential order effects and fatigue. Participation took between 15 and 30 minutes. Upon completion of the study, participants were given the opportunity to enter into a drawing for a chance to win one of four $25 Visa gift cards. In addition, they were given the option of receiving a summary of the results of the study via email. Participants were directed to a separate survey to enter their contact information if they chose to enter the drawing and/or receive a summary of the study. Contact information was not connected with participants' survey responses.

Instrumentation

Demographic Survey

A demographic questionnaire created by the researcher assessed various characteristics of the participants including race/ethnicity, age, menopausal status, use of hormone replacement therapy, weight, height, sexual orientation, income, education level, relationship status, number of children, and how participants learned about the study. Menopausal status was assessed following the procedures used by Becker et al. (2001). Women who had no noticeable changes in the frequency of their periods were classified as pre-menopausal, women who have noticed changes in the frequency of their periods compared to the previous year were classified as peri-menopausal, and women who have not had a period for 12 consecutive months were classified as post-menopausal. Women who reported being surgically menopausal were not included in calculations regarding menopausal status.

Menopause Attitudes Scale

The Menopause Attitudes Scale (MAS) is a semantic differential assessment instrument designed to measure women's attitudes towards menopause (Bowles, 1986). The scale consists of 20 bipolar word pairs, including good/bad, clean/dirty, unattractive/attractive, useful/useless, and ugly/beautiful. Participants are provided the sentence stem "during menopause a woman feels…" and asked to rate the set of adjectives on a 7-point Likert scale based on the degree to which the adjectives fit with experiences of women in menopause. Scores range from 20 to 140, with higher scores indicating more positive views toward menopasue. A Chronbach's alpha of .96 indicates

that the scale has good reliability (Bowles). The measure showed good test-retest reliability at six weeks, with a correlation of $r = .87$. Tests of construct validity indicate that the measure appropriately assesses attitudes towards menopause (Bowles). Expected relationships were found between attitudes about menopause and general attitudes of aging. Scores on the MAS were unrelated to views of social roles for women, which indicate good discriminant validity (Bowles).

Menopause Symptom List

The Menopause Symptom List (MSL) measures psychological, vaso-somatic, and general somatic symptoms that are associated with menopause (Perz, 1997). Frequency of each of the three types of symptoms is rated on a 6-point Likert scale, ranging from 0 (never) to 5 (almost always). Severity is also rated on a 6-point scale, ranging from 0 (not applicable – symptom not experienced) to 5 (extreme). Psychological symptoms are measured with eight items that include depressed feelings, moodiness, irritability, and crying spells. Vaso-somatic symptoms include nine items such as palpitations, dry eyes, headaches, hot flushes, and involuntary sweating. General somatic symptoms include eight items such as poor appetite, sleeplessness, weight gain, and poor concentration. Index scores, which combine the three subscales into one average score for frequency and one average score for severity of menopausal symptoms, can be calculated. Test–retest reliabilities for each of the six subscales were all good, ranging from .72 to .92, and Perz found the measure to have adequate validity.

Figure Rating Scale

The Figure Rating Scale (FRS) is a widely used measure of body dissatisfaction that was originally designed by Stunkard et al. (1983). The measure consists of nine male and nine female silhouettes that range from thin to large. Each silhouette is given a number, ranging from 10 to 90, that corresponds with its size. Researchers who have utilized the measure often create their own questions, often asking participants to indicate their current figure and their ideal figure. The current study utilized the instructions used by Thompson and Altabe (1991) in their study of the psychometric properties of the FRS. Participants were asked to choose a silhouette based on these directions:

> (1) choose your *ideal* figure; (2) choose the figure that reflects how you *think* you look; (3) choose the figure that reflects how you *feel* most of the time; (4) choose the figure that you think is most *preferred* by *men*; [and] (5) choose the figure that you think is most *preferred* by *women*... (p. 616).

Thompson and Altabe also asked participants to "pick the opposite sex figure that you find most attractive" (p. 616), but this question was omitted from the current study as it lacks relevance to the purpose of the study. Consistent with this idea, only the nine female figures were presented to participants for their rating choices. The FRS was scored by calculating the differences between the various silhouette selections (Thompson & Altabe). For the current study, body dissatisfaction was calculated by subtracting the ideal figure rating from the rating of how participants *think* they look to yield one measure of body dissatisfaction (called body dissatisfaction-think). A second measure of body dissatisfaction was calculated by subtracting the ideal figure rating from

the rating of how participants *feel* they look, which was called body dissatisfaction-feel. Scores ranged from 0 to 80, with higher scores indicating more body dissatisfaction. According to Thompson and Altabe, the FRS has good test-retest reliability. At two weeks, the reliability coefficient for ideal body rating was .71. For body dissatisfaction-think and -feel, the alphas were .89 and .83, respectively. The FRS is also a valid measure of body dissatisfaction. In their study of the psychometric properties of the FRS, Thompson and Altabe found that the FRS is related to self-esteem, eating pathology, and other body dissatisfaction measures in the expected directions.

Self-Objectification Questionnaire

Noll and Fredrickson (1998) created the Self-Objectification Questionnaire (SOQ) to measure levels of self-objectification. Specifically, the measure "assesses the extent to which individuals view their bodies in observable, appearance-based (objectified) terms versus non-observable, competence-based (non-objectified) terms" (Noll & Fredrickson, p. 628). The authors designed the scale to assess how concerned individuals are about their appearance, as opposed to how satisfied or dissatisfied they are. According to objectification theory, being concerned about appearance is related with many negative outcomes, regardless of whether the concern yields positive or negative self-evaluation. In other words, "women who are satisfied with their bodies as well as those who are dissatisfied with their bodies may each experience the negative consequences of self-objectification simply because they are concerned with their appearance" (Noll & Fredrickson, p. 629).

The scale, in its most recent rendition, consists of 10 attributes, five of which are appearance-related (weight, sex appeal, physical attractiveness, measurements, and firm/sculpted muscles) and five of which are competency-based (strength, energy level, health, physical fitness, and physical coordination). Participants rank these attributes in order of importance to their physical self-concept, with a ranking of one corresponding to most important attribute and ten corresponding to the least important. The scale is scored by adding the rankings for each type of item and subtracting the competency sum from the appearance sum. The range of possible scores is –25 to 25. Higher scores indicate that the participant experiences more self-objectification and gives more importance to their appearance. According to Noll and Fredrickson (1998), the SOQ has satisfactory construct validity. SOQ scores correlated in the expected direction (positively) with a measure of appearance anxiety and a measure of satisfaction with body size.

Objectified Body Consciousness Scale

The Objectified Body Consciousness Scale (OBCS) consists of three subscales including the Surveillance Subscale, Body Shame Subscale, and the Appearance Control Beliefs Subscale (McKinley & Hyde, 1996). Only the Surveillance and Body Shame subscales were used in the current investigation and the eight items of the Appearance Control Belief Subscale were omitted. McKinely and Hyde defined body surveillance as "viewing the body as an outside observer" (p. 181). This subscale measures how much people attend to their bodies and how much they think about how their body looks to others. Body shame refers to "feeling shame when the body does not conform" (p. 181).

This subscale measures the amount of shame participants experience when they feel that their bodies do not fit into the narrow box of culturally acceptable appearance.

The two subscales designed to tap into each of these constructs include eight items apiece that are scored on a six point Likert scale (McKinley & Hyde, 1996). Examples of items on the surveillance subscale include "During the day, I think about how I look many times" and "I often worry about whether the clothes I am wearing make me look good." Examples of items on the body shame subscale include "when I can't control my weight, I feel like something must be wrong with me" and "I feel like I must be a bad person when I don't look as good as I could." Scores on each item are added up and for each subscale, higher scores indicate higher levels of the construct. People who score high on the surveillance subscale attend to their appearance more and think more about how they look as opposed to how their bodies feel. People who score high on the body shame subscale experience more shame, just as the name implies.

McKinley and Hyde (1996) reported a high alpha (.89) for the surveillance scale with a sample of undergraduate women. The body shame subscale had moderate internal consistency with an alpha of .75 in the same study. In a study with middle-aged women, McKinley (1999) found alphas of .76 for the surveillance subscale and .70 for the body shame subscale, indicating that the measure is also reliable and useful with a non-college population. According to McKinley and Hyde, body shame has a strong negative relationship with body esteem, which indicates that the subscale is a valid measure. The surveillance subscale was strongly related with a measure of public self-consciousness, but unrelated to private self-consciousness and social anxiety. McKinley and Hyde

reported that these findings are evidence of convergent and discriminant validity for the surveillance subscale of the OBCS.

Statistical Procedures: Analysis Plan

Preliminary Analyses

Descriptive statistics, namely measures of central tendency such as means, standard deviations, frequencies, and percentages, were calculated and reported in order to provide a description of the sample. T-tests and chi-squares were conducted to investigate the potential differences between the participants who completed the surveys and the participants who dropped out. Weight and height were used to calculate body mass index (BMI) with the following formula: $\text{BMI} = \frac{weight\ (\text{lb})}{height^2\ (\text{in}^2)} \times 703$ (Wollner, Blackburn, Spellman, Khaodhiar, & Blackburn, 2010). BMI was interpreted using the classification system created by World Health Organization (WHO, 2000). A BMI below 18.5 is considered underweight. Healthy weight ranges from 18.5 to 24.9. A BMI between 25 and 29.9 is considered overweight, while a BMI of 30 or higher falls in the obese range. Both BMI and use of hormone replacement therapy were controlled using statistical procedures because these variables may impact women's body image and attitudes towards menopause. According to Sommer et al. (1999), it is important to control for variables that may impact attitudes towards menopause when assessing similarities and differences across ethnic groups.

Primary Analyses

The following statistical procedures were used to test each of the six hypotheses proposed by the investigator.

Hypotheses 1-3. Multiple linear regressions were used to test the relationships among the demographic variables (age, ethnicity, and menopausal status) and the body image variables of self-objectification, body shame, and body surveillance.

Hypotheses 4 and 5. Multiple linear regressions were used to assess the relationships among the demographic variables of age, ethnicity, menopausal status and body dissatisfaction-think and body dissatisfaction-feel.

Hypothesis 6. A multiple linear regression was used to assess the relationships among the demographic variables (age, ethnicity, and menopausal status), the body image variables (self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel), and attitudes towards menopause.

Hypotheses 7 and 8. Multiple linear regressions were used to assess the relationships among the psychological symptoms of menopause (frequency and severity) and the demographic variables (age, ethnicity, and menopausal status), the body image variables (self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel), and attitudes towards menopause.

Hypotheses 9-12. Multiple linear regressions were used to assess the relationships among the vaso-somatic and general somatic symptoms of menopause and the demographic variable of menopausal status.

Hypothesis 13. A path diagram (See Figure 1) was tested using linear regression. The path analysis was conducted using the frequency and the severity of psychological and somatic menopausal symptoms as outcome variables. Because of inconsistency in the literature with regards to the direction of the relationship between attitudes towards menopause and symptoms of menopause (e.g. Bloch, 2002; DeSoto, 2003a), the path diagram was tested two ways, reversing the direction of the relationship between these two variables in order to determine which path diagram better fits the data.

To conduct a path analysis, a minimum of 75 participants were needed for each level of the categorical covariates (i.e., ethnicity). These findings were based on power analyses that were conducted using G*Power software. The ideal sample size should include a minimum of 75 Caucasian, Asian, Latina, and African American women. Similarly, 75 participants were needed for each level of the menopausal status variable (pre-, peri-, and post-menopausal). However, it was expected that within 300 participants, this second requirement would be met. Because the sample size and necessary numbers of women from each ethnic group could not be recruited for participation, hypotheses regarding Asian American and Latina women were eliminated from analysis.

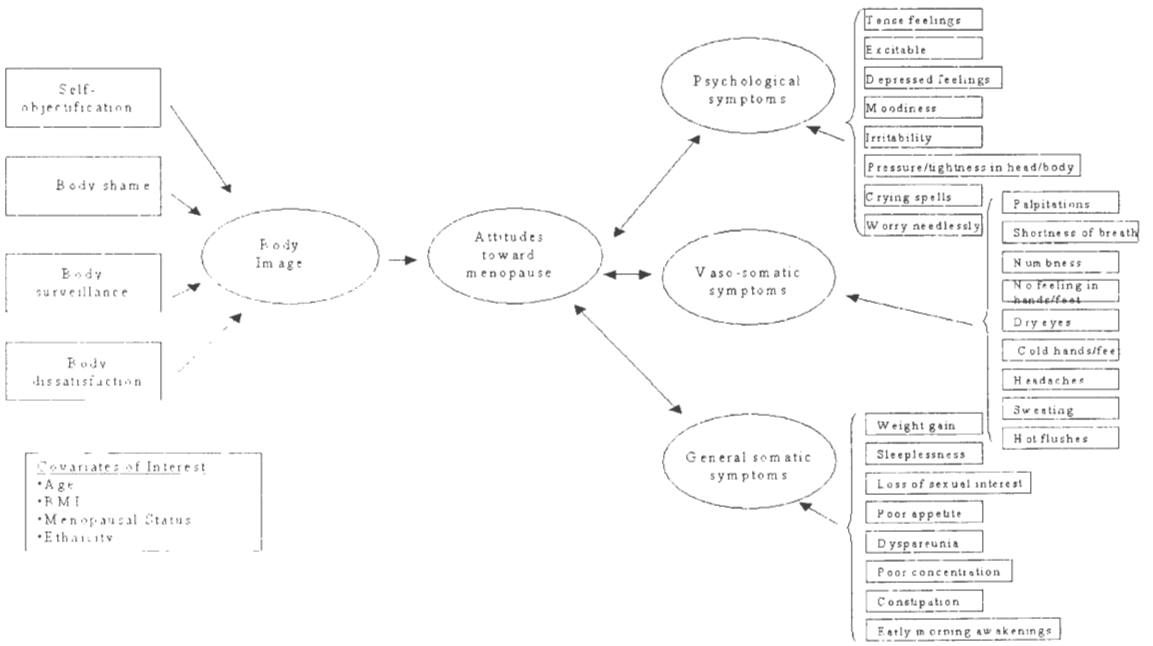

Figure 1. Path diagram to be tested.

CHAPTER IV

RESULTS

Preliminary Analyses

Descriptive statistics including means, standard deviations, frequencies, and percentages were calculated and reported in order to provide a description of the sample (see Tables 1 and 2). Overall, most participants were in their 50s, post-menopausal, and had never taken Hormone Replacement Therapy (HRT) medications. For those who reported experience with HRT, the following medications were most common: Premarin (36 participants), Prempro (12), and Estradiol (11). The majority of the current sample identified as Caucasian, heterosexual, well-educated, and financially advantaged. Although there were fewer African American participants in comparison, the sample size was large enough for statistical comparison of the two groups. Overall, the participants reported being in the overweight range, with an average BMI of 28.69. The majority of the participants identified as heterosexual and were either married or in a domestic partnership. Most participants reported having children, with two children being the most frequently reported number.

Table 1

Descriptive Statistics for Continuous Demographic Variables

Variable	*M*	*SD*	Range
Age (in years)	53.45	7.89	40-90
Years since surgery	15.9	12.53	.25-55
BMI	28.69	7.47	16.1-69.7
Yearly Household Income (in dollars)	98,185.37	101,555.80	10,000-1,200,000

Note. Years since surgery refers to women who reported being surgically menopausal. An outlier of $2,000,000 was excluded from the calculations for Yearly Household Income. BMI = Body Mass Index.

Table 2

Descriptive Statistics for Categorical Demographic Variables

Variable	Frequency	Percent
Menopausal status		
Pre-menopausal	64	16.1
Peri-menopausal	71	17.9
Post-menopausal	164	41.3
Surgically menopausal	98	24.7
HRT Use		
Never used HRT	264	66.5
Used HRT in the past	70	17.6
Currently using HRT	63	15.9
Ethnicity		
Caucasian	300	75.6
African American	77	19.4
Latina	6	1.5
Asian/Pacific Islander	4	1.0
Native American	1	0.3
Biracial/Multiracial	7	1.8
Other	2	0.5

Table 2 Continued

Variable	Frequency	Percent
Sexual Orientation		
Heterosexual	362	91.2
Lesbian	19	4.8
Bisexual	10	2.5
Questioning	2	0.5
Other	3	0.75
No response	1	0.25
Relationship Status		
Married/Domestic Partnership	252	63.5
Single	54	13.6
Divorced	48	12.1
Cohabitating	14	3.5
Widowed	13	3.3
Separated	12	3.0
No response	4	1.0
Number of Children		
Zero	82	20.7
One	58	14.6
Two	144	36.3
Three	63	15.9
Four	37	9.3
Five or more	11	2.8
No response	2	0.5
Education		
Some high school	2	0.5
High school degree/GED	29	7.3
Some college	89	22.4
Associate's degree	33	8.3
Bachelor's degree	87	21.9
Some graduate school	36	9.1
Graduate degree	121	30.5

Table 2 Continued

Variable	Frequency	Percent
How they learned about the study		
Email from friend/acquaintance	278	70.0
Facebook group or fan page	70	17.6
Email from a listserv	20	5.0
Facebook advertisement	19	4.8
Flyer	6	1.5
No response	3	0.8
No response	1	0.3

Note. HRT = Hormone Replacement Therapy.

Body Mass Index (BMI) and use of hormone replacement therapy (HRT) were controlled using statistical procedures. These variables may impact women's attitudes towards menopause and thus they are important to control (Sommer et al., 1999). All hypotheses and a path diagram were tested with multiple regression models. Each dependent variable was regressed on selected predictors, while every analysis included BMI and of HRT serving as control variables. HRT was represented by two binary dummy variables which registered "never had HRT" and "formerly had HRT," respectively. Participants who had never used HRT medications were assigned scores of "never = 1" and "formerly = 0." Those women who had used HRT medications in the past were assigned scores of "never = 0" and "formerly = 1." Finally, women currently taking HRT medications were assigned scores of "never = 0" and "formerly = 0" on the two binary variables.

As control variables, whether and how BMI and HRT might explain variance in the dependent variables was not of central interest per se. That the HRT and BMI variables were placed into the explanatory equation permitted examination of results vis-à-vis each hypothesis-relevant predictor variable with HRT and BMI controlled for. Results indicated that higher scores on self-objectification are related to having used HRT in the past. Current use of HRT was related to more frequent and severe vaso-somatic symptoms of menopause. Low BMI was related to higher levels of body surveillance as well as more frequent and severe psychological symptoms of menopause. Higher BMI was related to more body shame, more body dissatisfaction (think and feel), and more frequent and severe vaso-somatic symptoms of menopause

Descriptive statistics for self-objectification, body shame, body surveillance, body dissatisfaction-think, body dissatisfaction-feel, attitudes toward menopause, and symptoms of menopause were calculated and reported in Table 3.

Table 3

Descriptive Statistics for Major Study Variables

Variable	*M*	*SD*	Possible Range	Actual Range
Self-Objectification	5.48	13.49	-25 to 25	-25 to 25
Body Shame	28.62	10.03	0 to 56	8 to 56
Body Surveillance	34.57	8.83	0 to 56	9 to 56
Body Dissatisfaction-Think	16.35	11.12	0 to 80	0 to 50
Body Dissatisfaction-Feel	19.85	13.83	0 to 80	0 to 60
Attitudes Toward Menopause	84.78	19.84	20 to 140	32 to 131
Psychological Symptom Severity	3.17	1.72	0 to 8.75	0 to 8.75
Psychological Symptom Frequency	3.11	1.71	0 to 8.75	0 to 8.625
Vaso-Somatic Symptom Severity	1.70	1.07	0 to 6.67	0 to 6.67
Vaso-Somatic Symptom Frequency	1.67	1.04	0 to 6.67	0 to 6.57
General Somatic Symptom Severity	2.54	1.19	0 to 6.875	0 to 6.875
General Somatic Symptom Frequency	2.67	1.19	0 to 6.875	0 to 6.375

Note. Higher scores for Self-Objectification indicate greater levels of internalized objectification. Higher scores for Body Shame and Body Surveillance indicate higher levels of the variables. Higher scores for Body Dissatisfaction-Think and -Feel indicate more body dissatisfaction. Higher scores on the Menopause Attitude Scale indicate more positive views of menopause. Higher scores on the symptoms of menopause subscales indicate either more severe or more frequent symptoms.

Primary Analyses

Hypothesis 1

A multiple linear regression was used to test the hypothesis that self-objectification would be associated with age, ethnicity, and menopausal status, such that higher scores for self-objectification were expected to be related to younger age, Caucasian ethnicity (vs. African American), and pre-menopausal status (vs. peri- and post-menopause).

Self-objectification was regressed on the predictor variables of age, ethnicity, and menopausal status. The proposed hypothesis that younger, White, pre-menopausal women would report higher levels of self-objectification was not supported. The *p*-values

for the multiple correlation coefficient and for age were small enough to reject the null hypothesis of no relationship. Age was shown to be the sole statistically significant predictor of self-objectification, with older women reporting higher levels of self-objectification. This finding was contrary to the prediction of the study. The *p*-values for the other predictors (ethnicity and menopausal status) were not sufficiently small to warrant rejection of the null hypothesis of no relationship (see Table 4).

Table 4

The Relationship of Self-Objectification and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	2.684	2.129	0.095	1.260	0.208
HRT Past	4.904	2.387	0.140	2.055	0.020
BMI	-0.016	0.093	-0.009	-0.177	0.859
Age	0.342	0.111	0.201	3.070	0.002
Ethnicity	-0.787	1.776	-0.023	-0.443	0.658
Pre-Menopausal Status	-1.213	2.588	-0.033	-0.469	0.640
Peri-Menopausal Status	2.335	2.468	0.065	0.946	0.345
Post-Menopausal Status	1.194	1.907	0.044	0.626	0.532
Intercept	-14.961	7.139		-2.096	0.037

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Higher scores on Self-Objectification are related to previous use of HRT medication.

$R = .270$, $R^2 = .073$, Adj-$R^2 = .053$, $SE = 13.118$, $F(8, 367) = 3.617$, $P < .001$

Hypothesis 2

A multiple linear regression was used to test the hypothesis that body shame would be associated with age, ethnicity, and menopausal status, such that higher scores

for body shame were expected to be related to younger age, Caucasian ethnicity (vs. African American), and pre-menopausal status (vs. peri- and post-menopause).

Body shame was regressed on the predictor variables of age, ethnicity, and menopausal status. The hypothesis was given moderate support overall, as the multiple correlation coefficient was large enough to reject the null hypothesis of no relationship. Additionally, results for two of the predictors were of sufficient size to reject the hypothesis of no relationship. Age and ethnicity demonstrated the predicted inverse relationship with body shame, where younger Caucasian women tended to report higher levels of body shame compared to older African American women (see Table 5).

Table 5

The Relationship of Body Shame and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	0.199	0.190	0.076	1.046	0.296
HRT Past	0.052	0.213	0.016	0.246	0.806
BMI	0.052	0.008	0.318	6.320	0.001
Age	-0.016	0.010	-0.105	-1.659	0.046
Ethnicity	-0.428	0.158	-0.138	-2.698	0.128
Pre-Menopausal Status	-0.289	0.231	-0.085	-1.250	0.212
Peri-Menopausal Status	-0.036	0.220	-0.011	-0.164	0.870
Post-Menopausal Status	-0.253	0.170	-0.101	-1.490	0.137
Intercept	3.467	0.637		5.443	0.000

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Large values of BMI, especially in the obese range, were related to higher scores on Body Shame.

$R = .364$, $R^2 = .132$, Adj-$R^2 = .113$, $SE = 1.107$, $F(8, 367) = 6.992$, $P < .001$

Hypothesis 3

A multiple linear regression was used to test the hypothesis that body surveillance would be associated with age, ethnicity, and menopausal status, such that higher scores for body surveillance were expected to be related to younger age, Caucasian ethnicity (vs. African American), and pre-menopausal status (vs. peri- and post- menopause).

Body surveillance was regressed on the predictor variables of age, ethnicity, and menopausal status. The hypothesis was not supported overall, as the multiple correlation coefficient was not large enough to reject the hypothesis of no relationship, and results for all but one of the predictors were of insufficient size to reject the hypothesis of no relationship. The *p*-value for age was small enough to warrant rejection of a null hypothesis of no relationship, with age demonstrating the predicted inverse relationship with body surveillance. Younger women tended to have higher scores on body surveillance. No other predictor had a *p*-value that was sufficiently small to warrant rejection of a null hypothesis of no relationship (see Table 6). Very weak support is given to the hypothesis by these findings.

Table 6

The Relationship of Body Surveillance and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	0.002	0.177	0.001	0.011	0.991
HRT Past	-0.017	0.198	-0.006	-0.086	0.931
BMI	-0.013	0.008	-0.090	-1.691	0.046
Age	-0.018	0.009	-0.133	-1.984	0.024
Ethnicity	-0.166	0.148	-0.061	-1.126	0.261
Pre-Menopausal Status	-0.087	0.215	-0.029	-0.404	0.687
Peri-Menopausal Status	-0.089	0.205	-0.031	-0.435	0.664
Post-Menopausal Status	-0.134	0.159	-0.061	-0.845	0.399
Intercept	5.960	0.594		10.042	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI Body Mass Index. Small values of BMI, especially in the emaciated range, were related to higher scores on Body Surveillance.

$R = .176$, $R^2 = .031$, Adj-$R^2 = .010$, $SE = 1.091$, $F(8, 367) = 1.464$, $P < .169$

Hypothesis 4

A multiple linear regression was used to test the hypothesis that body dissatisfaction-think would be associated with ethnicity but not with age or menopausal status, such that higher body dissatisfaction-think would be related to Caucasian ethnicity (vs. African American) and that age and menopausal status would not be predictive of body dissatisfaction-think.

Body dissatisfaction-think was regressed on the predictor variables of age, ethnicity, and menopausal status. The hypothesis was given modest support overall (see Table 7). The null hypothesis of no relationship was rejected for ethnicity, and the

relationship was in the predicted direction whereas African American women reported lower levels of body dissatisfaction. Also as predicted, age and menopausal status were not predictive of body dissatisfaction-think.

Table 7

The Relationship of Body Dissatisfaction-Think and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	0.997	1.446	0.043	0.689	0.491
HRT Past	2.421	1.640	0.084	1.476	0.141
BMI	0.856	0.065	0.572	13.251	0.001
Age	-0.078	0.076	-0.055	-1.023	0.307
Ethnicity	-2.413	1.202	-0.088	-2.009	0.023
Pre-Menopausal Status	-1.525	1.787	-0.049	-0.853	0.394
Peri-Menopausal Status	-0.310	1.691	-0.010	-0.183	0.855
Post-Menopausal Status	0.198	1.298	0.009	0.152	0.879
Intercept	-2.396	4.912		-0.488	0.626

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Large values of BMI, especially in the obese range, were related to higher scores of body dissatisfaction-think.

$R = .578$, $R^2 = .334$, Adj-$R^2 = .320$, $SE = 9.210$, $F(8, 383) = 24.029$, $P < .001$

Hypothesis 5

A multiple linear regression was used to test the hypothesis that body dissatisfaction-feel would be associated with ethnicity but not with age or menopausal status, such that higher body dissatisfaction-feel was expected to be related to Caucasian ethnicity (vs. African American) and that age and menopausal status were not expected to be predictive of body dissatisfaction-feel.

Body dissatisfaction-feel was regressed on the predictor variables of age, ethnicity, and menopausal status. The hypothesis was not supported overall and the predicted relationships did not emerge in the results (see Table 8). With regard to ethnicity, the null hypothesis of no relationship could not be rejected, which was contrary to the proposed hypothesis. Also in contrast with the proposed hypothesis, age and pre-menopausal status were significant predictors of body dissatisfaction-feel. Age was related to body dissatisfaction such that younger women reported higher levels of body dissatisfaction-feel. In contrast, menopausal status was related to body dissatisfaction such that premenopausal women reported lower levels of body dissatisfaction-feel.

Table 8

The Relationship of Body Dissatisfaction-Feel and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*P*
HRT Never	-0.395	1.935	-0.014	-0.204	0.838
HRT Past	2.091	2.195	0.059	0.953	0.341
BMI	0.771	0.086	0.420	8.914	0.001
Age	-0.391	0.102	-0.225	-3.815	0.001
Ethnicity	-1.877	1.608	-0.056	-1.168	0.244
Pre-Menopausal Status	-5.037	2.391	-0.132	-2.107	0.018
Peri-Menopausal Status	-1.511	2.262	-0.041	-0.668	0.505
Post-Menopausal Status	0.498	1.737	-0.018	0.286	0.775
Intercept	21.233	6.573		3.230	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Large values of BMI, especially in the obese range, were related to higher scores on body dissatisfaction-feel.

$R = .457$, $R^2 = .209$, Adj-$R^2 = .192$, $SE = 12.324$, $F(8, 383) = 12.613$, $P < .001$

Hypothesis 6

A multiple linear regression was used to test the hypothesis that attitudes toward menopause would be associated with age, ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel such that more negative attitudes toward menopause were expected to be related to younger age, Caucasian ethnicity (vs. African American), pre-menopausal status (vs. peri- and post-menopause), and higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel.

The variable of attitudes towards menopause was regressed on the predictor variables of age, ethnicity, menopausal status, self-objectification, body shame, body surveillance, and body dissatisfaction (think and feel). The hypothesis was not supported overall because of a pattern in the results that included data that could not reject the null hypothesis of no relationship as well as results that were contrary to the proposed hypothesis (see Table 9). Age, ethnicity, body shame, body dissatisfaction-think and body dissatisfaction-feel were statistically significant predictors of attitudes toward menopause. Younger women, Caucasian women, women who reported more body shame, and women who experienced more body dissatisfaction-feel also tended to experience more negative views of menopause. These findings are consistent with the proposed hypothesis. However, results also indicated that women who reported higher levels of body dissatisfaction-think did not report more negative views of menopause as expected. Instead, high scores on body dissatisfaction-think were associated with more positive views of menopause, which is the opposite of what was predicted.

Table 9

The Relationship of Attitudes toward Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	3.699	2.917	0.089	1.268	0.206
HRT Past	3.933	3.283	0.077	1.198	0.232
BMI	-0.075	0.161	-0.029	-0.465	0.642
Age	0.340	0.156	0.136	2.185	0.015
Ethnicity	4.791	2.455	0.098	1.951	0.025
Pre-Menopausal Status	-4.761	3.551	-0.088	-1.341	0.181
Peri-Menopausal Status	-3.490	3.364	-0.067	-1.037	0.300
Post-Menopausal Status	0.218	2.606	0.005	0.083	0.934
Self-Objectification	0.101	0.079	0.069	1.287	0.199
Body Surveillance	-0.236	1.048	-0.013	-0.225	0.822
Body Shame	-2.862	0.987	-0.180	-2.900	0.004
Body Dissatisfaction-Think	0.254	0.142	0.145	1.794	0.035
Body Dissatisfaction-Feel	-0.416	0.116	-0.291	-3.579	0.001
Intercept	75.617	11.148		6.783	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index.

$R = .459$, $R^2 = .211$, Adj-$R^2 = .182$, $SE = 17.845$, $F(13, 361) = 7.434$, $P < .001$

Hypothesis 7

A multiple linear regression was used to test the hypothesis that frequency of psychological menopause symptoms would be associated with ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think and -feel, and attitudes toward menopause, such that more frequent psychological symptoms

were expected to be related to Caucasian ethnicity (vs. African American), peri-menopausal status (vs. pre- and post- menopause), higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel, and negative attitudes toward menopause.

Frequency of psychological symptoms was regressed on the predictor variables of ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction (think and feel), and attitudes towards menopause. The hypothesis was given modest support. Use of HRT, ethnicity, pre- and post-menopausal status, self-objectification, body surveillance, and body dissatisfaction-think all had p-values above .05, indicating statistically insignificant relationships between each of these variables and the dependent variable, frequency of psychological symptoms. Results for peri-menopausal status, body shame, body dissatisfaction-feel, and menopause attitudes were consistent with predictions (see Table 10). Women who reported more frequent psychological symptoms of menopause also reported higher levels of body shame and body dissatisfaction-feel, they endorsed more negative attitudes toward menopause, and they were more likely to be peri-menopausal.

Table 10

The Relationship of Frequency of Psychological Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-1.335	1.843	-0.046	-0.724	0.469
HRT Past	-2.622	2.058	-0.074	-1.274	0.203
BMI	-0.241	0.103	-0.133	-2.348	0.019
Ethnicity	-0.465	1.567	-0.014	-0.297	0.767
Pre-Menopausal Status	-2.514	2.167	-0.067	-1.160	0.247
Peri-Menopausal Status	4.039	2.100	0.111	1.923	0.025
Post-Menopausal Status	-1.218	1.625	-0.044	-0.750	0.454
Self-Objectification	-0.031	0.050	-0.031	-0.623	0.534
Body Surveillance	-0.309	0.665	-0.025	-0.465	0.642
Body Shame	2.582	0.633	0.235	4.076	0.001
Body Dissatisfaction-Think	-0.146	0.090	-0.120	-1.622	0.106
Body Dissatisfaction-Feel	0.321	0.074	0.324	4.319	0.001
Menopause Attitudes	-0.170	0.033	-0.246	-5.136	0.001
Intercept	36.789	5.487		6.704	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Small values of BMI, especially in the emaciated range, were related to more frequent psychological symptoms of menopause.

$R = .580$, $R^2 = .336$, Adj-$R^2 = .312$, $SE = 11.331$, $F(13, 362) = 14.105$, $P < .001$

Hypothesis 8

A multiple linear regression was used to test the hypothesis that severity of psychological menopause symptoms would be associated with ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction-think and

-feel, and attitudes toward menopause, such that more severe psychological symptoms were expected to be related to Caucasian ethnicity (vs. African American), peri-menopausal status (vs. pre- and post- menopause), higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel, and negative attitudes toward menopause.

Severity of psychological symptoms was regressed on the predictor variables ethnicity, menopausal status, self-objectification, body shame, body surveillance, body dissatisfaction (think and feel), and attitudes towards menopause. The hypothesis was given modest support. Use of HRT, ethnicity, pre- and post-menopausal status, self-objectification, and body surveillance all had *p*-values above .05, indicating a lack of statistical significance. Results for peri-menopausal status, body shame, body dissatisfaction-feel, and menopause attitudes were consistent with this hypothesis (see Table 11). Women in peri-menopause, women who reported more body shame and more emotional body dissatisfaction, and women who reported more negative views of menopause also reported more severe psychological symptoms of menopause. Contradictory to the proposed hypothesis, lower levels of body dissatisfaction-think were associated with more severe psychological symptoms of menopause ($p = .047$).

Table 11

The Relationship of Severity of Psychological Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-1.612	1.863	-0.056	-0.865	0.388
HRT Past	-2.045	2.080	-0.057	-0.983	0.326
BMI	-0.174	0.104	-0.095	-1.675	0.046
Ethnicity	-1.864	1.584	-0.054	-1.176	0.240
Pre-Menopausal Status	-2.525	2.191	-0.067	-1.152	0.250
Peri-Menopausal Status	4.425	2.123	0.121	2.084	0.019
Post-Menopausal Status	-0.858	1.643	-0.031	-0.522	0.602
Self-Objectification	-0.072	0.050	-0.070	-1.424	0.155
Body Surveillance	0.102	0.673	0.008	0.152	0.879
Body Shame	2.295	0.640	0.207	3.583	0.001
Body Dissatisfaction-Think	-0.153	0.091	-0.125	-1.683	0.047
Body Dissatisfaction-Feel	0.312	0.075	0.312	4.148	0.001
Menopause Attitudes	-0.162	0.034	-0.233	-4.843	0.001
Intercept	35.903	5.548		6.472	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Small values for BMI, especially in the emaciated range, were related to more severe psychological symptoms of menopause.

$R = .577$, $R^2 = .333$, Adj-$R^2 = .309$, $SE = 11.456$, $F(13, 362) = 13.888$, $P < .001$

Hypothesis 9

A multiple linear regression was used to test the hypothesis that frequency of vaso-somatic symptoms of menopause would be associated with menopausal status, such that more vaso-somatic and general menopause symptoms were expected to be related to peri-menopausal status (vs. pre- and post- menopause).

Frequency of vaso-somatic symptoms of menopause was regressed on the predictor variable of menopausal status. The hypothesis was not supported overall because results for the predictors were contrary to predictions (see Table 12). Premenopausal status was the sole statistically significant predictor of the frequency of vaso-somatic symptoms of menopause. Premenopausal women reported less frequent vaso-somatic symptoms of menopause.

Table 12

The Relationship of Frequency of Vaso-somatic Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-3.001	1.423	-0.151	-2.108	0.018
HRT Past	-3.572	1.596	-0.147	-2.239	0.013
BMI	0.130	0.063	0.104	2.065	0.020
Pre-Menopausal Status	-4.320	1.692	-0.167	-2.553	0.011
Peri-Menopausal Status	1.592	1.653	0.063	0.963	0.336
Post-Menopausal Status	-1.168	1.248	-0.061	-0.935	0.350
Intercept	14.929	2.196		6.799	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Women currently taking HRT medication reported more frequent vaso-somatic symptoms of menopause. Large values for BMI, especially in the obese range, were also related to more frequent vaso-somatic symptoms.

$R = .243$, $R^2 = .059$, Adj-$R^2 = .045$, $SE = 9.233$, $F(6, 391) = 4.089$, $P < .001$

Hypothesis 10

A multiple linear regression was used to test the hypothesis that severity of vaso-somatic symptoms would be associated with menopausal status, such that more vaso-somatic was expected to be related to peri-menopausal status (vs. pre- and post-menopause).

Severity of vaso-somatic symptoms of menopause was regressed on the predictor variable menopausal status. The hypothesis was not supported overall because results for the predictors were contrary to predictions (see Table 13). Premenopausal status was the sole statistically significant predictor of the severity of vaso-somatic symptoms of menopause. Premenopausal women reported less severe vaso-somatic symptoms.

Table 13

The Relationship of Severity of Vaso-somatic Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-3.028	1.475	-0.148	-2.052	0.020
HRT Past	-3.035	1.654	-0.121	-1.835	0.033
BMI	0.128	0.065	0.100	1.957	0.025
Pre-Menopausal Status	-3.007	1.754	-0.113	-1.714	0.043
Peri-Menopausal Status	2.304	1.713	0.088	1.344	0.180
Post-Menopausal Status	-0.377	1.294	-0.019	-0.291	0.771
Intercept	14.424	2.276		6.336	0.00.

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index. Women currently taking HRT medication reported more severe vaso-somatic symptoms of menopause. Large BMI scores, especially in the obese range, were related to more severe vaso-somatic symptoms of menopause.

$R = .209$, $R^2 = .044$, Adj-$R^2 = .029$, $SE = 9.572$, $F(6, 391) = 2.984$, $P < .007$

Hypothesis 11

A multiple linear regression was used to test the hypothesis that the frequency of general menopause symptoms would be associated with menopausal status, such that more general menopause symptoms was expected to be related to peri-menopausal status (vs. pre- and post- menopause).

Frequency of general somatic symptoms of menopause was regressed on the predictor variable of menopausal status. The hypothesis was not supported overall because results for the predictors were contrary to predictions and probabilities for peri- and post-menopausal status were not sufficient to permit rejection of the hypothesis of no relationship (see Table 14.) Premenopausal status was the sole statistically significant predictor of the frequency of general somatic symptoms of menopause. Premenopausal women reported less frequent general somatic menopause symptoms.

Table 14

The Relationship of Frequency of General-somatic Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-1.669	1.461	-0.083	-1.142	0.254
HRT Past	-1.883	1.638	-0.076	-1.149	0.251
BMI	-0.005	0.065	-0.004	-0.070	0.945
Pre-Menopausal Status	-3.573	1.737	-0.136	-2.057	0.020
Peri-Menopausal Status	2.124	1.697	0.083	1.252	0.212
Post-Menopausal Status	0.150	1.282	0.008	0.117	0.907
Intercept	23.301	2.255		10.335	0.000

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index.

$R = .190$, $R^2 = .036$, Adj-$R^2 = .021$, $SE = 9.480$, $F(6, 391) = 2.445$, $P < .025$

Hypothesis 12

A multiple linear regression was used to test the hypothesis that severity of general menopause symptoms would be associated with menopausal status, such that more general menopause symptoms were expected to be related to peri-menopausal status (vs. pre- and post-menopause).

Severity of general somatic symptoms of menopause was regressed on the predictor variable of menopausal status. The hypothesis was not supported overall because the null hypothesis of no relationship could not be rejected for the peri-menopausal status (see Table 15). In contrast with the proposed hypothesis, premenopausal status was a statistically significant predictor of the severity of general somatic symptoms of menopause. Premenopausal women reported less severe general somatic symptoms.

Table 15

The Relationship of Severity of General-somatic Symptoms of Menopause and Selected Predictors

Variable	*B*	*SE*	*Beta*	*T*	*p*
HRT Never	-2.151	1.461	-0.107	-1.472	0.142
HRT Past	-2.152	1.638	-0.087	-1.314	0.190
BMI	0.056	0.065	0.044	0.866	0.387
Pre-Menopausal Status	-3.193	1.737	-0.122	-1.838	0.033
Peri-Menopausal Status	2.250	1.697	0.087	1.326	0.186
Post-Menopausal Status	0.358	1.282	0.019	0.279	0.780
Intercept	20.762	2.254		9.210	0.001

Note. SE = Standard Error. HRT = Hormone Replacement Therapy. BMI = Body Mass Index.

$R = .189$, $R^2 = .036$, Adj-$R^2 = .021$, $SE = 9.479$, $F(6, 391) = 2.405$, $P < .027$

Hypothesis 13: Path Analysis

Regression coefficients for the prediction of menopause attitudes are presented in Tables 16 and 17. In the path model where symptoms of menopause predicted attitudes toward menopause, body dissatisfaction-feel, premenopausal status, and ethnicity were significant predictors of attitudes toward menopause (see Table 16 and Figure 2). Women who reported higher levels of body dissatisfaction-feel reported more negative views of menopause, as did women who were premenopausal. In contrast, Black women reported more positive views toward menopause compared to their Caucasian counterparts. These findings provide moderate support for the path model that the body image variables predict attitudes toward menopause. The prediction that symptoms of menopause would predict menopause attitudes was shown to be insignificant.

In testing the model in the reverse direction, with the body image variables predicting attitudes toward menopause, which in turn predict symptoms of menopause, results moderately support the proposed path model (see Table 17 and Figure 2). Women who endorsed more negative attitudes toward menopause reported more frequent and more severe symptoms of menopause, including psychological, vaso-somatic, and general somatic symptoms.

Table 16

Path Coefficients for Symptoms of Menopause Predicting Menopause Attitudes

Variable	*Beta*	*T*	*p*
Body Dissatisfaction-Think	0.117	1.473	0.142
Body Dissatisfaction-Feel	-0.184	-2.251	0.025
Self-Objectification	0.043	0.809	0.419
Body Surveillance	-0.028	-0.490	0.624
Body Shame	-0.096	-1.523	0.129
Age	0.091	1.456	0.146
HRT Never	0.065	0.933	0.351
HRT Past	0.063	1.001	0.318
BMI	-0.078	-1.268	0.206
Pre-Menopausal Status	-0.118	-1.819	0.035
Peri-Menopausal Status	-0.038	-0.606	0.545
Post-Menopausal Status	0.010	0.157	0.875
Ethnicity	0.087	1.763	0.040
Symptom Frequency - Psychological	-0.180	-1.265	0.207
Symptom Frequency - Vaso-Somatic	0.040	0.277	0.782
Symptom Frequency - General Somatic	-0.063	-0.481	0.631
Symptom Severity - Psychological	-0.046	-0.313	0.754
Symptom Severity - Vaso-Somatic	-0.008	-0.051	0.959
Symptom Severity - General Somatic	-0.053	-0.383	0.702

Note. HRT = Hormone Replacement Therapy. BMI = Body Mass Index.

$R = .515$, $R^2 = .265$, Adj-$R^2 = .226$, $SE = 17.366$, $F(19, 356) = 6.754$, $P < .001$

Table 17

Path Coefficients for Menopause Attitudes Predicting Symptoms of Menopause

Variable	*Beta*	*T*	*p*
Symptom Frequency – Psychological	-0.398	-8.591	0.001
Symptom Frequency – Vaso-Somatic	-0.281	-5.794	0.001
Symptoms Frequency – General Somatic	-0.319	-6.665	0.001
Symptom Severity – Psychological	-0.386	-8.296	0.001
Symptom Severity – Vaso-Somatic	-0.284	-5.858	0.001
Symptom Severity – General Somatic	-0.321	-6.709	0.001

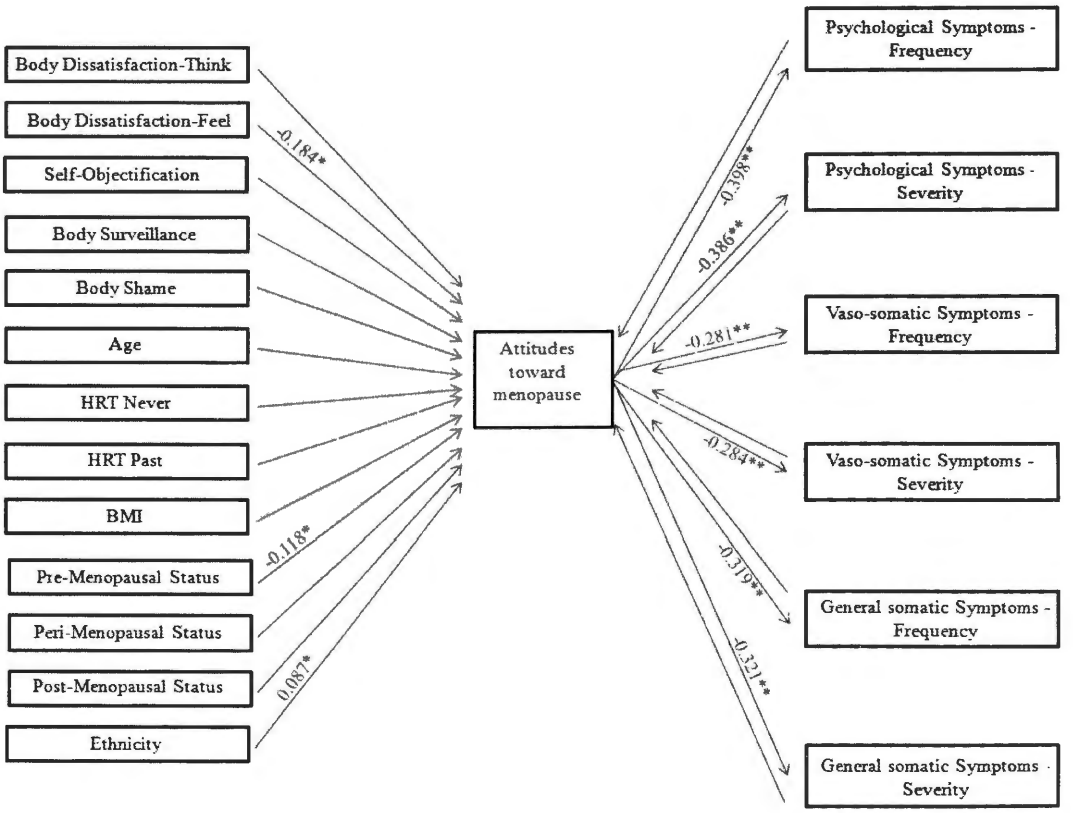

Figure 2. Bi-directional path diagram illustrating predictors of attitudes toward menopause and symptoms of menopause.

*$p < .05$. ** $p < .001$.

Summary

Several hypotheses received partial support while many hypotheses were not supported due to insufficient evidence against the null hypothesis of no relationship and/or results that were in a direction opposite of that predicted. The path analysis, which was generally a regression model predicting a dependent variable, showed several elements of the path model receiving support with beta weights that were large enough to reject the hypothesis of no relationship and to be meaningfully interpreted.

CHAPTER V

DISCUSSION

The current study sought to expand understanding of women's body image and experiences of menopause during midlife and beyond. Past researchers have noted that much of the research on body image has been conducted with samples of young, often college-aged, women (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003), from a medical perspective (Im, 2007; Harris, 2008; Kaufert, 1982; Wilk & Kirk, 1995), using samples of White women (Im et al., 2008), and that few studies address the possible relationships between menopause and women's experiences of their bodies (McKinley & Lyon, 2008). Given these gaps in current knowledge of these important issues, the current study proposed that attitudes towards menopause, symptoms of menopause, and body image variables would be significantly related and impacted by demographic variables including age, menopausal status, and ethnicity. Multiple linear regressions were used to test the major hypotheses in the study and a path analysis was conducted in order to assess a proposed pattern of relationships between all of the major variables. Results of the study were mixed, where several hypotheses were supported, several were not supported, and several were the reverse of what was expected. Similarly, some relationships in the path model were shown to be significant and consistent with predictions, while several aspects of the proposed model did not hold up to statistical testing.

Summary of Major Findings

Hypotheses 1, 2, and 3

It was proposed that younger, premenopausal, White women would report higher levels of self-objectification, body shame, and body surveillance. Results were mixed, with some finding supporting this prediction and some that were opposite of what was expected. As expected, younger women reported higher levels of body shame and body surveillance and White women reported more body shame compared to African American women. In contrast to the proposed hypotheses, the results of the current study showed that ethnicity and menopausal status were unrelated to self-objectification and older women reported significantly higher levels of self-objectification than younger women. Menopausal status was not related to body shame. Ethnicity and menopausal status were not related to body surveillance.

Hypotheses 4 and 5

It was proposed that White women would report significantly higher levels of body dissatisfaction compared to their African American counterparts, while women of all ages and across all three menopausal statuses would report similar levels of body dissatisfaction. Results for body dissatisfaction-think supported this hypothesis. African American women reported lower levels of body dissatisfaction-think, while age and menopausal status were not predictive of body dissatisfaction-think.

In contrast, results for body dissatisfaction-feel did not support the proposed hypothesis. There were no differences between White and African American women in level of body dissatisfaction-feel. However, younger women reported significantly higher

levels of body dissatisfaction-feel compared with older women while pre-menopausal women reported lower levels of body dissatisfaction-feel compared with peri- and post-menopausal women.

Hypothesis 6

It was proposed that more negative attitudes toward menopause would be related to younger age, Caucasian ethnicity (vs. African American), pre-menopausal status (vs. peri- and post-menopause), and higher scores for self-objectification, body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel. Results indicated that younger women, Caucasian women, women who reported more body shame, and women who experience more body dissatisfaction-feel also tend to experience more negative views of menopause. These findings are consistent with the proposed hypothesis. However, results also indicated that women who reported higher levels of body dissatisfaction-think did not report more negative views of menopause as expected. Instead, high scores on body dissatisfaction-think were associated with more positive views of menopause, which is opposite of what was predicted.

Hypotheses 7 and 8

It was proposed that White, pre-menopausal women, women who report more self-objectification, more body shame, more body surveillance, more body dissatisfaction (think and feel), and more negative attitudes about menopause would also report more frequent and severe psychological symptoms of menopause. Results indicated that women who reported more frequent psychological symptoms of menopause also reported higher levels of body shame and body dissatisfaction-feel. Additionally, they endorsed

more negative attitudes toward menopause, and they were more likely to be peri-menopausal. Similarly, women in peri-menopause, women who reported more body shame and more body dissatisfaction-feel, and women who reported more negative views of menopause also reported more severe psychological symptoms of menopause. Contradictory to the proposed hypothesis, lower levels of body dissatisfaction-think were associated with more severe psychological symptoms of menopause.

Hypotheses 9 – 12

It was proposed that women who were peri-menopausal would report more frequent and severe vaso-somatic and general somatic symptoms of menopause compared to pre- or post-menopausal women. The hypotheses were not supported by the results of the current investigation as peri-menopausal status was unrelated to the experience of vaso-somatic or general somatic menopause symptoms. Results indicated that premenopausal status was the sole statistically significant predictor of the frequency or the severity of vaso-somatic or general somatic symptoms of menopause. Premenopausal women reported less frequent and less severe vaso-somatic and general somatic symptoms of menopause compared to peri- and post-menopausal women.

Hypothesis 13

A path model was proposed where age, ethnicity, and menopausal status would be predictive of body image, which would in turn predict both symptoms and attitudes toward menopause. The model was tested in two ways, with menopause symptoms predicting attitudes toward menopause and with attitudes of menopause predicting the symptoms. Results showed women who reported higher levels of body dissatisfaction-

feel reported more negative views of menopause, as did women who were premenopausal. In contrast, Black women reported more positive views toward menopause compared to their Caucasian counterparts.

In testing the model in the reverse direction, with the body image variables predicting attitudes toward menopause, which in turn predict symptoms of menopause, results showed that women who endorsed more negative attitudes toward menopause reported more frequent and more severe psychological, vaso-somatic, and general somatic symptoms of menopause.

Integration with Past Literature

Body Image at Midlife and Beyond

While it is clear that body dissatisfaction is pervasive (Peat at al., 2008; Rodin et al., 1984), research on body image at midlife has presented opposing perspectives – that difficulties with body image improve (Franzio & Koehler, 1998), remain the same (Grippo & Hill, 2008; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003), or worsen (Deeks & McCabe, 2001) as women age. On one hand, it is thought that as women age, they become freer from the constraints of oppressive beauty norms (Franzio & Koehler). Objectification theory holds that physical appearance becomes less important as women get older (Clarke, 2001; Tiggemann & Lynch) and aging has a positive impact on women's body image, with self-objectification, body shame, appearance anxiety, and eating pathology decreasing significantly with age (Tiggemann & Lynch). In fact, several studies have shown that self-objectification does decrease with age (McKinley, 2006; Szymanski & Henning, 2007; Tiggeman & Lynch). It was

expected that the current study would replicate these findings. In part, the results of the current study do support the hypothesis that younger women feel more negatively about their bodies. Younger women reported significantly higher levels of body shame, body surveillance, and body dissatisfaction-feel.

In contrast, other studies have shown that body dissatisfaction stays the same across the lifespan (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003) and that self-objectification and body surveillance remain constant as women age (Grippo & Hill, 2008) instead of decreasing as Objectification Theory would suggest. In the current study, older women reported higher levels of self-objectification, which contradicts both the expectation that self-objectification decreases with age and the alternative expectation that levels of self-objectification would be the same across age groups. These results are consistent with findings by Deeks and McCabe (2001), whose study showed that older women experience more body dissatisfaction than younger women. Together, these findings suggest that aging does not necessarily protect women from oppressive expectations about appearance. By contrast, results from the current investigation demonstrate that self-objectification may be a phenomenon that persists across the lifespan. Several possible explanations for these unexpected findings are outlined below.

First, given that women show physical signs of aging sooner than men (Berk, 2007; Whitbourne, 2001) and face a harsh double standard of aging (Lauzen & Dozier, 2005; Winterich, 2007), they are doubly stigmatized as they depart from cultural ideals more quickly than men and are judged more harshly for it. The increased self-objectification scores for older women in the current study could be a result of this

challenging situation. If women are evaluated more harshly for transgressing beauty norms, perhaps higher self-objectification scores reflect women's awareness of their predicament. Additionally, the current study was focused on middle-aged and older women's experiences of menopause, a developmental period in women's lives that is associated with getting older and often, depending on cultural considerations, with losing value (Bloch, 2002). The focus of the current study may have triggered higher levels of state self-objectification for older women by triggering negative thoughts about their aging bodies.

Second, the finding that older women reported higher levels of self-objectification could be an artifact of the sample and due to a restriction of range. The current study only included women who were age 40 and older. Previous studies that found that self-objectification decreases with age compared 20 and 30 year olds with midlife and older women (e.g. Tiggemann & Lynch, 2001). It is possible that comparing self-objectification scores reported by participants in the current study with the scores of women younger than 40 would support the tenets of Objectification Theory. Even though older women in the current study reported more self-objectification that their relatively younger counterparts, self-objectification scores for the sample as a whole could be lower than self-objectification scores of women younger than 40. Thus, these results that seemingly discount Objectification Theory must be interpreted hesitantly, especially given the mixed results that younger women in the current sample did report more body shame and surveillance, which are thought to be corollaries of self-objectification (Fredrickson et al., 1998).

Third, the finding that older women reported more self-objectification than their younger counterparts could be a reflection of cohort effects. Instead of indicating a developmental pattern with regard to body image and self-objectification that holds true across generations, the current findings could be limited to the specific group of women who participated in the study. Furthermore, viewing ads with thin beautiful people triggers self-objectification (Harper & Tiggemann, 2008). Thus, with the onslaught of ads targeting older women to buy products to help them look younger, higher levels of self-objectification may be a logical result of living in a culture that devalues aging women.

Additionally, it is important to consider the finding that younger women in the current study reported higher levels of body shame, body surveillance, and body dissatisfaction-feel alongside the finding that older women reported higher levels of self-objectification. While seemingly contradictory on the surface, these findings may suggest that age serves as a mediator in the relationship between self-objectification, body image problems, and the other negative psychological outcomes that appear to be caused by self-objectification (Fredrickson et al., 1998). It is possible that for younger women, self-objectification leads more directly to the negative outcomes that Objectification Theory predicts. For older women, however, self-objectification may not lead as directly or strongly to body shame, surveillance, or dissatisfaction.

Finally, many studies have demonstrated that there may be cultural differences with regard to body image experiences, with African American women reporting less body image disturbance in general (e.g Grabe & Hyde, 2006; Kronenfeld, Reba-Harrelson, Von Holle, Reyes, & Bulik, 2010; Roberts, Cash, Feingold, & Johnson, 2006).

The current study partially replicated these findings such that White women reported more body shame and more body dissatisfaction-think compared to African Americans. However, only partial support can be given to this idea because White and African American women reported similar levels of body surveillance, self-objectification, and body dissatisfaction-feel, which contradicts previous findings and the proposed hypotheses in the current study. Yet it is important to note that there were no instances of Black women reporting higher scores on any of the negative body image scales compared to White women in the current investigation. Because of these mixed results, firm conclusions about the nature of body image across the lifespan and across different ethnic groups cannot be made at this time. More research is needed to further clarify these questions, but the current results suggest that African American women may experience resilience in the face of negative cultural messages about appearance and age, which is consistent with past qualitative work conducted by Im et al. (2010).

Experiences of Menopause

Menopause is often viewed in a negative light, as a harbinger of old age and unbearable symptoms (Bloch, 2002; Sampselle et al., 2002), yet past research has suggested that symptoms of menopause vary greatly (Bloch; Neugarten & Kraines, 1965; Roberts, 2007) and are impacted in part by expectations (Derry, 2004) and culture (Avis et al., 2001; Im et al., 2010; Marvan et al., 2008). It seems that certain physical symptoms, including hot flashes, night sweats, and vaginal dryness may be more likely to be caused by physiological changes that happen during the climacteric (Elavsky & McAuley, 2009; Im et al., 2008). Psychological reactions to menopause may be more

heavily influenced by culture, expectation, and social construction (Collins, 1997; Kaufert, 1982) than by physical changes that take place during the menopause transition.

In the current study, psychological symptoms (e.g. irritability, worry, moodiness, and depression) of menopause were more prevalent compared to physiological (vaso-somatic and general somatic) symptoms. Overall, the women in the sample reported that they were experiencing many menopausal symptoms, but often in ways that were minimally troublesome. Additionally, as expected, pre-menopausal women reported the least frequent and least severe vaso-somatic and general somatic symptoms of menopause and peri-menopausal women reported more frequent and severe psychological symptoms of menopause. Peri-menopausal status was not significantly related to reporting more frequent and severe vaso-somatic or general somatic symptoms of menopause. These findings are congruent with past research that has concluded that symptoms of menopause are diverse and vary significantly from person to person (Bloch, 2002; Neugarten & Kraines, 1965; Roberts, 2007) and are based on many factors (Avis et al., 2001; Derry, 2004; Marvan et al., 2008).

Several studies have shown that White women tend to have more negative reactions to menopause compared to women from other ethnic backgrounds (Dillaway et al., 2008; Holmes-Rovner et al., 1996). Results of the current study were consistent with these previous findings, with White women reporting more negative attitudes about menopause compared to African American women. These results add support to the research that shows that African American women have more positive views of menopause; see it as a natural, welcome part of life; and are more resilient than White

women with regards to the negative aspects of aging within a culture that values youth and beauty (Holmes-Rovner et al.; Sampselle et al., 2002). It is possible that African American women are less negatively impacted by the appearance norms of mainstream culture because such norms are White standards of beauty (Sampselle et al.) Aging has a different, more positive meaning in African American culture (Im et al., 2010), which may lead to more positive views about menopause and the aging process in general. Additionally, African American women are taught to endure hardship (Im et al.), which may be a socialization process that instills resiliency to potentially difficult life experiences, including menopause.

Menopause and Body Image

Body image issues and the menopause transition are experiences that most women face during their lives. In spite of this, relatively little research has looked at how body image concerns and menopause interact (McKinley & Lyon, 2008). The few studies that have looked at the relationships among body image, menopausal status, symptoms of menopause, and attitudes toward menopause have shown several trends that are noteworthy and important to consider in understanding results of the current investigation.

McLaren et al. (2003) examined how BMI and body satisfaction are impacted by age in a longitudinal study that followed women from age 7 to 54. They found that body dissatisfaction increased at menopause, while post-menopausal women were more satisfied with their weight compared to same-age women who were pre- or peri-menopausal. In the current study, older women reported more self-objectification, but

younger women reported more body dissatisfaction-feel and body shame. The finding that older women report higher levels of self-objectification is consistent with the idea that menopause may be a time of increased difficulty around body image concerns. It is seemingly counterintuitive that younger women reported more shame and affective body dissatisfaction while older women reported more self-objectification. However, it is possible that menopause is indeed a time of increased awareness about the body, particularly how it looks from a third-person perspective in a culture that largely devalues aging in women. Simultaneously, older women may have developed some degree of cognitive resilience, emotional intelligence, maturity, and/or psychological hardiness that yields less shame, less dissatisfaction, and possibly less distress about being further away from cultural appearance ideals. Older women may be cognitively better able to recognize the negative cultural messages regarding appearance compared to younger women. Older women may still experience self-objectification, but they may feel less shame because they are better able to challenge the devaluation of bodies that do not fit into the cultural ideal. This idea is supported by Bauld and Brown's (2009) finding that women with greater emotional intelligence tend to have more positive views about menopause as well as less stress, less psychological distress, less severe menopausal symptoms, and better physical health during midlife.

McKinley and Lyon (2008) conducted a study of menopausal attitudes, appearance-related menopausal attitudes, body esteem, and self-objectification. Attitudes toward menopause and anxiety about aging were related to body surveillance and in turn, body shame. They suggested that high levels of self-objectification may be related to

feeling more negatively about menopause and viewing it as a marker of loss of attractiveness. In the current study, younger women, White women, women who reported more body shame and women who reported more body dissatisfaction-feel also endorsed more negative views of menopause. The path analysis showed similar results, with pre-menopausal women, White women, and women who experienced more body dissatisfaction-feel also reporting more negative attitudes toward menopause. Women who reported more negative attitudes, in turn, reported more severe and frequent menopausal symptoms. These findings are congruent with McKinley and Lyon's supposition that feeling worse about one's body is related with feeling worse about menopause, adding that younger women and White women may be more likely to both feel worse about their bodies and to feel negatively about menopause. These results suggest that older women and African American women may be more resilient with regard to both body image and menopause concerns, which is an important finding of the current study.

Bloch (2002) looked at the relationships among body image, self-esteem, and estrogen levels with symptoms of menopause. Results indicated that having more negative attitudes about menopause and more dissatisfaction about one's body was related to having more severe menopausal symptoms. It seems likely that both body image and expectations about menopause play a large role in the experience of menopause symptoms. However, DeSoto (2003) warned that fully assuming that attitudes toward menopause impact the symptoms that women experience might be problematic for women. Making this assumption could lead to an "it's all in your head" mentality,

which could circumscribe the legitimacy of women's menopausal experiences. The current study found that women who are peri-menopausal and women who experience more body shame, more body dissatisfaction-feel, and more negative views about menopause also report more frequent and severe psychological symptoms of menopause. These results are consistent with Bloch's findings and suggest that symptoms of menopause are impacted by expectation. However, it is important to heed DeSoto's warning and keep in mind that internalized expectations about menopause may be related to a more difficult menopause experience, but this does not discount the very real physical struggle that some women endure during menopause. Even if psychological symptoms of menopause can be exacerbated by holding negative views toward menopause, these symptoms are likely genuine and potentially problematic for women in midlife.

While previous studies have found body image disturbance to be related with negative views of menopause and more problematic symptoms of menopause (e.g. Bloch, 2002; McKinley & Lyon, 2008), results of the current study showed that body dissatisfaction-think and body dissatisfaction-feel have opposing relationships with views of menopause and symptoms of menopause. In the current investigation, it was expected that having greater body dissatisfaction of any type would be related to more negative attitudes about menopause and more problematic symptoms. While this held true with body dissatisfaction-feel, women who reported more body dissatisfaction-think reported more positive views of menopause and less severe psychological symptoms. These results were unexpected.

In this study, body dissatisfaction was measured using the Figure Rating Scale (Stunkard et al., 1983), following the procedure outlined by Thompson and Altabe (1991). Specifically, participants chose from a set of nine standard figures that ranged from very small to very large. Participants were asked to choose their ideal figure, the figure that represents how they think they look, and the figure that represents how they feel most of the time. The difference between how a participant thinks she looks and her ideal figure was the score for body dissatisfaction-think. The difference between how a participant feels and her ideal figure was the score for body dissatisfaction-feel, which was consistent with Thompson and Altabe's use of the scale. One measure captures how a woman thinks about her body while the other measure assesses her affective sense of her body. While it was expected that cognitive and affective aspects of body satisfaction would be similar and thus have similar relationships with other variables, this did not turn out to be the case. Instead of being overlapping measures of the same construct, it appears that cognitive and affective aspects of body satisfaction may be distinct constructs. For example, some women may think positively about their bodies but continue to feel shame or other negative emotions in spite of the positive cognitions they have. Alternatively, these unexpected findings could be the result of limits with the measure that was used or a circumstance unique to the sample of women who participated in the study.

Implications for Theory

The findings of the current investigation have important implications regarding Fredrickson and Robert's objectification theory (1997), as well as general understanding

of women's body image during the developmental transition of menopause. While objectification theory has been supported by many studies over the past decade (Clarke, 2001; Fredrickson et al., 1998; Gapinski et al., 2003; Gay & Castano, 2010; Hebl et al., 2004; McKinley, 2006; Quinn et al., 2006; Szymanski & Henning, 2007; Tiggemann & Lynch, 2001), the results of the current study raise important questions about the theory. If self-objectification actually increases with age in the way results from the current study seem to reflect, then the original theory may need to be modified to address this unexpected finding.

Taking developmental theory into consideration may help elucidate why self-objectification could increase with age, in opposition to what objectification theory would predict. Midlife is thought to be a period where people reflect on where they have been in life and think about where they are yet to go (Lachman, 2004; Levinson,1977), checking to see if their lives are on track with what they had planned and wanted. It is possible that comparing where one is to where one expected or wanted to be may be a time of heightened self-awareness and anxiety, especially of not fitting in to restrictive appearance standards.

Additionally, the high levels of self-objectification among older women in the current sample and the high levels of body shame and body surveillance among younger women indicate that many of the women in the current study experience a negative relationship with their bodies. These negative body image experiences could be a reflection of how automatic body-dislike becomes for women, which is consistent with Rodin et al's (1984) assertion that body dissatisfaction is widespread in U.S. culture. This

pervasiveness may suggest that body image problems run deeper than an affective or cognitive level, possibly becoming encoded neurologically.

Research has shown that body perception is related to and influenced by the neural representation of the body within the brain (Linkenauger, Witt, Bakdash, Stefanueei, & Proffitt, 2009). Several studies have shown important differences between healthy women and women with anorexia or bulimia with regard to how the body is neurologically represented. Where healthy women underestimate their body size, women with eating disorders tend to overestimate their body size (Vocks, Busch, Grönemeyer, Schulte, Herpertz, & Suchan, 2010). Women with eating disorders show different brain activation patterns with regard to body image compared to their healthy counterparts (Sachdev, Mondraty, Wen, & Gulliford, 2008; Seeger, Braus, Ruf, Goldberger, & Schmidt, 2002; Uher et al., 2005). Thus, the neurological aspects of body image and body dissatisfaction are important to consider.

Implications for Research

While the current investigation added clarity to the extant literature on body image and experiences of menopause during midlife, several questions for future research remain First, the unexpected findings that body dissatisfaction-think and -feel have opposite relationships with both menopause attitudes and symptoms might indicate some sort of problem with the measure that was used to assess body dissatisfaction. Thompson and Altabe (1991) reported that the Figure Rating Scale, though widely used to measure body dissatisfaction, has rarely been used in a consistent, standardized fashion. More research is needed to further test the validity and reliability of the measure, as well as to

further elucidate the different sub-constructs of body dissatisfaction. It may be possible that how someone thinks they look differs significantly from how they feel about their body. While it was expected that these constructs would reflect the same underlying issue (body dissatisfaction), results of the current study suggest that this may not be the case. These findings highlight the need for more research in this area.

Results of the current study are inconsistent with past literature that shows that self-objectification decreases with age (McKinley, 2006; Szymanski & Henning, 2007; Tiggeman & Lynch, 2001). This unexpected finding that older women reported higher scores for self-objectification elucidates the need for additional research on middle-aged and older women's body image experiences. In general, more studies on self-objectification among diverse samples of women are needed. Longitudinal studies may be especially well-suited to test the developmental trajectory of body dissatisfaction, self-objectification, and other body image corollaries. While the current study shows that older women reported more self-objectification, it is impossible to know whether this finding represents a developmental pattern or a factor unique to the cohort of older participants in the study.

Next, there are several possible areas of research that could follow from the current study to contribute to the literature. For example, future researchers could experimentally test the causal relationship between self-objectification and experiences of menopause. By triggering a state-self-objectifying situation, researchers could then measure attitudes toward and symptoms of menopause. This type of experiment would be important, especially given the onslaught of advertisements for youth promoting products

that are targeted towards middle aged and older women. Extant research shows that media exposure has been shown to induce state-self-objectification (Harper & Tiggemann, 2008), which is damaging to women's psychological health (Noll & Fredrickson, 1998; Fredrickson et al., 1998; Steer & Tiggeman, 2008; Szymanski & Henning, 2007). It would be interesting and helpful to determine if state self-objectification has a causal impact on menopausal attitudes and symptoms. This type of research could address whether problems with menopause should be added to the list of negative outcome associated with an objectifying, appearance-focused, youth-focused environment.

DeSoto (2003) pointed out the importance of attending to biological changes during menopause, especially related to changing estrogen levels. While the aim of the current study was primarily focused on looking at the impact of cultural messages about women's bodies and about menopause, it is important to note that attending to women's physiologically-based symptoms is of ongoing importance to women. Future research would benefit from addressing both the biological aspects of menopause as well as the sociocultural context. It might be useful to conduct a broad-ranging study in order to highlight whether and how biological and sociocultural variables account for most of the variance in menopausal attitudes and symptoms.

Additionally, future studies should address potential sources of resiliency that help women to negotiate positive identities in the face of negative cultural messages about their aging bodies. Winterich (2007) noted that more traditional women tend to have more difficulty during midlife. More traditional women are likely to have

internalized cultural messages regarding gender roles and appearance standards to a greater extent, which may place them at a greater risk for body dissatisfaction in midlife. Future research should look at the relationship between gender roles and experiences menopause and body dissatisfaction at midlife. It would be interesting to study the relationships between feminist identity, psychological hardiness, and other factors that may contribute to resiliency with regard to how these factors impact women's body image and menopause experiences at midlife.

Previous research has addressed the concept of menstrual joy, which is the idea that women's actual experiences of menstruation may challenge numerous negative stereotypes that are prevalent in Western cultures (e.g. Aubeeluck & Maguire, 2002; Chrisler, Johnston, Champagne, & Preston 1994). In the same way that research about possible positive experiences of menstruation has emerged in the literature, exploring the idea of menopausal joy might help to elucidate positive experiences of menopause. In particular, a qualitative research design would be useful in exploring the positive aspects of menopause in order to give voice to women's lived experiences.

It might also be helpful to consider the impact of familial learning on women's experiences of menopause. Knowing what one's mother went through during menopause may shape expectations and attitudes, which in turn could have important implications for the actual experiences that women have when going through menopause themselves. Dillaway (2007) noted that menopause is more than a biological process, that it involves a "contextual backdrop" (p. 80) that is often left out of research about women's

menopausal experiences. She argued that learning about menopause from mothers is a part of that context and therefore, important to address.

Cooper and Koch (2007) conducted a grounded theory qualitative study to explore the menstrual experiences of low-income African American women. The women in their study reported a distrust of the medical field and indicated that they had very limited sources of information about menopause in particular. While some studies suggest that women turn to one another for information and support (Bannister, 1999), Cooper and Koch's findings suggest that, at least among low-income African American communities, women simply do not learn accurate information about menopause from their mothers or from medical providers. As a result, Cooper and Koch claim that negative views of menopause abound. In their study, women reported that menopause was associated with being mean, cranky, depressed, and having year-long PMS.

In another study about the impact of women learning about menopause from their mothers, Dillaway (2007) found different results. She noted that the women in her study "used their knowledge of mothers' experiences as a benchmark for understanding, defining, and maneuvering this reproductive transition" (p. 91). In Dillaway's study, learning from mothers seemed central to women's understanding of their own menopausal experiences. It is important to note that the women in her sample were mostly White and from higher SES backgrounds. This suggests that there may be important differences in how mothers communicate with their daughters about menopause based on education, socioeconomic status, access to quality health care, and other factors. Research is needed in order to shed light on these issues.

Finally, additional research on body image and menopause should explore the experiences of more diverse groups of women. Latina, Asian American, Native American, other ethnic groups of women, and women of more varied class backgrounds were underrepresented in the current study. Furthermore, the current study did not assess differences between heterosexual, lesbian, and bisexual women and participants who reported being surgically menopausal were not included. Future research should elaborate on the similarities and differences in menopausal experiences among these different groups of women. For example, it is possible that Asian American women may somatisize emotional difficulties (Lee, Lei, & Sue, 2001), which might suggest that they would experience more somatic symptoms of menopause and fewer psychological symptoms of menopause. Additionally, lesbian women, large women, and other women who challenge the norms of femininity may have menopausal experiences that differ from more privileged groups of women. Women who have undergone hysterectomy also likely have unique experiences of menopause and midlife. Research that addresses the experiences of women who have had their uterus and/or ovaries removed is needed in order to clarify the impact of experiencing menopause due to surgical intervention. In general, more research is needed to address all of these important and under researched areas. Understanding the experiences of diverse women is vital to ethical and multiculturally-competent research and practice in the field of psychology (APA, 2002; 2003; 2007).

Implications for Practice

Cultural messages about the importance of women's appearance abound (Gosselink et al., 2008) and self-objectification has been linked with many negative outcomes that include depression (Szymanski & Henning, 2007), risk of eating pathology (Noll & Fredrickson, 1998; Szymanski & Henning), decreased creative flow (Szymanski & Henning), diminished cognitive ability (Fredrickson et al., 1998), and sexual dysfunction (Steer & Tiggeman, 2008). Menopause is a developmental stage that is surrounded with negative stereotypes and assumptions. It has been considered a "hormone deficiency disease" (Wilk & Kirk, 1995, p. 233) that is a "catastrophic event" in women's lives (Voda & Ashton, 2006, p. 403). Past research (e.g. Bloch, 2002) and the findings of the current study suggest that having such negative views of menopause is related with having more negative symptoms of menopause. Furthermore, the current study showed that body image distress is related with more difficult menopausal experiences. Altogether, it seems clear that women exist throughout their lives within a cultural context that may impede their healthy development.

Yet, according to Wilk and Kirk (1995), therapists often fail to attend to menopause as an important developmental stage for women in midlife, in spite of the fact that fostering healthy development is a main goal of psychotherapy. Thus, it is crucial for therapists to attend to menopause, body image concerns, and the interaction of the two with their women clients who are in midlife. Failure to understand the cultural messages that female clients may internalize about their bodies, their age, and their developmental experiences seems at best, unwise, and at worst, unethical. The APA *Guidelines on*

Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003) stipulate that diversity factors should be taken into account in the therapy process. Gender, ethnicity, and age are important diversity factors that need careful consideration among psychologists and other mental health practitioners. Taking menopause, age, and body image concerns into account should be a requisite of competent, ethical care for women clients in midlife. This idea is also supported by the APA *Guidelines for Psychological Practice with Girls and Women*, which urges psychologists to "be aware of the effects of socialization, stereotyping, and unique life events on the development of girls and women across diverse cultural groups" (APA, 2007, p. 960). The pressures that U.S. culture places on women with regards to appearance standards, the effects of going through the menopausal transition, and the multiple experiences of marginalization which diverse women face all fit within this important call for increased awareness from psychologists.

Mental health practitioners should attend to the menopause transition, provide accurate information to clients within the boundaries of their competence area, assist clients in de-constructing the many messages about their changing bodies, and help to foster resiliency. While a part of this endeavor might involve direct work with individual clients (i.e., through psychoeducation), psychologists should also step outside of the therapy room in order to reach a broader audience. Outreach to the community as a whole and to physicians in particular seems warranted, given that women with concerns about menopause may be likely to feel disrespected, dismissed, or ignored by their doctors (Bannister, 1999). Also, encouraging women to talk with one another about their

menopausal and body image experiences may be important in breaking the silence that currently shrouds menopause (Nosek, Kennedy, & Gudmundsdottir, 2010). Discussions about menopause are apparently absent from the public discourse but how much women privately talk about menopause remains unclear. Cooper and Koch reported that "the communication that women engage in directly affects their menstrual health attitudes and beliefs (2007, p. 58). Thus, fostering such discussion is clearly important. Bannister noted that women are thirsty for accurate information about menopause and they want to talk with each other about their experiences. Supporting forums where groups of women could meet, converse about their experiences, and provide support for one another could be very helpful.

Strengths of the Study

The current study has several strengths that are important to note. First, this investigation attempted to add to the current literature on body image and menopause experiences. This is a noteworthy strength given that McKinley and Lyon (2008) claimed that studies about menopause and body image are surprisingly sparse. Additionally, the current study looked at experiences of women who have often been understudied (Im et al., 2008; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). One primary aim of the current study was to better represent the experiences of middle-aged and older women as well as ethnically diverse women. Increasingly, researchers are focusing on the intersections of "isms" such as racism, sexism, and ageism (Cole, 2009; Settles, 2006; Shields, 2008; Syed, 2010). While facing a double jeopardy of intersecting marginalizations might suggest that people who are located at these identity crossroads

suffer significantly, the current study attempted to point to possible resiliency among two marginalized groups – older women and Black women. This focus on the experiences of marginalized individuals who are often underrepresented in psychological research is consistent with the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002). It is important for psychologists to attend to issues of diversity, to seek to improve the world at large by striving toward a multicultural and socially-just environment, and to conduct research from which diverse individuals can benefit.

The current study attempted to reframe menopause from being seen as a negative "hormone deficiency disease" (Wilk & Kirk, 1995, p. 233) to point out possible benefits of aging and going through the menopause transition. The current study pointed to possible resiliency factors, highlighted both the extant literature and current research findings that suggest that culture has a strong influence on menopause experiences, and looked at possible cultural differences by assessing differences between White and Black women's experiences of menopause and body image.

Other strengths include the large sample size, the reliability and validity of the instruments that were used, and the use of Body Mass Index and use of Hormone Replacement Therapy as control variables. The use of path analysis is a powerful, sophisticated statistical procedure (Boyle, 1970), which points to another strength of this study. Path analysis summarizes complex information, allows for the concrete, explicit expression and communication of complicated ideas, and enables elaborate theories to be tested (Wolfle, 1978). Each of these factors is indicative of a cogent research design and a well-conducted study. Finally, the findings themselves constitute another strength of the

study. The results of the current study provide new information that can further theory, research, and practice in the field of psychology.

Limitations of the Study

While making a significant contribution to the literature by addressing an under-researched area (McKinley & Lyon, 2008) with an underrepresented population (Im et al., 2008; Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003), the current study has several limitations. One important limitation of the current study involves the low number of Asian American and Latina participants, as well as the relatively low number of African American participants compared to the size of the Caucasian sample. The major aim of the current study was to look at how body image and experiences of menopause might be similar or different across different racial/ethnic groups of women. Several researchers have claimed that studies about menopause primarily utilize samples of White women and do not represent the experiences of other women (Avis et al., 2001; Im et al., 2008; Padonu et al., 1996; Sampselle et al., 2002). As previously noted, the current study attempted to provide a more inclusive assessment of women's experiences of menopause. However, recruiting diverse women to participate in the study proved even more difficult than anticipated.

Many researchers have noted that recruiting ethnic minority participants is often a difficult task (Gilliss et al, 2001; Im & Chee, 2005; Swanson & Ward, 1995). Im and Chee reported that recruiting ethnic minority participants for research projects is "rarely successful and take[s] longer than expected" (p. 923). Gillis et al. reported that African Americans may feel suspicious about research and Hispanic Americans may be unaware

of how research participation can be beneficial. With historical research studies, including the Tuskegee Study of Untreated Syphilis, that were of great harm to ethnic minority individuals, hesitancy with regards to research participation is unsurprising (Bates & Harris, 2004). Issues of social class, access to resources, discrimination, and racism may all impact individuals' access to research participation as well as their views of and willingness to get involved in research (Swanson & Ward). The current study utilized the Internet as both a means of recruiting participants and collecting data. Inherently, this requirement instilled a social-class bias into the study given that women from lower socio-economic status backgrounds are less likely to have access to computers or the Internet. Given that African American women are over-represented in lower socioeconomic statuses (Baum, Garofalo, & Yali, 1999), the limitation of using the Internet for the study likely contributed to the difficulty with recruiting ethnically diverse women. For these reasons, difficulty with recruiting ethnic minority participants is substantial.

Next, a significant proportion of participants dropped out of the study prior to completing the measures. Analyses were run to compare the participants who completed the study with the women who chose not to finish the study. Results of these analyses suggested that the women who dropped out of the study were younger and earlier in the menopause process compared to women who chose to complete the study. This difference presents an important limitation of the current study because the results may over-represent the experiences of older and post-menopausal women. It may be possible that women who have gone through menopause are more invested in speaking about their

experiences and were thus more likely to complete the survey. Additionally, younger, pre-menopausal women may be less inclined to answer questions about menopause. Another possible explanation is that younger, premenopausal women may be hesitant to report on an experience they have yet to have. Alternatively, it is possible that younger, pre-menopausal women dropped out as a result of internalized ageism; they may not wish to be reminded that they are nearing menopause, aging, and reaching the point where they lose the societal value associated with being young and pretty. Regardless of the explanation, older, post-menopausal women were more likely to complete the study and younger, pre-menopausal women were more likely to drop out, which means that the results of the study may not be representative or generalizable.

In addition to the problem with the number of participants who dropped out, the income and education level of the participants who completed the surveys poses another limitation to the generalizability of the study. The mean income for the sample was quite high and a majority of the participants were highly educated. Given that the sample was skewed towards higher socioeconomic status, the results of the study should be interpreted with some caution. The current study may not accurately represent the experiences of less wealthy or less educated women.

Another possible limitation involves the structure of the Menopause Attitude Scale, a semantic differential assessment created by Bowles (1986). In this measure, participants are asked to rate qualities like "clean or dirty" and "important or unimportant" with regards to how they feel when during menopause. The sentence stem leading into the list of qualities reads "during menopause a woman feels…" The phrasing

of this sentence stem may be problematic given that it makes reference to "a woman" instead of queuing participants to think about their own attitudes towards menopause (which is the underlying construct that the scale attempts to measure). It might make more sense to change the sentence stem to read "during menopause I feel…" However, because the scale was created by Bowles, any changes to the scale would have created problems with regards to the reliability and validity of the measure and violated the copyright.

Finally, the mixed results that were found in the current investigation may reflect limitations with regard to the research design or the measures that were used to tap into the different variables. Regardless, these mixed findings suggest that body image during midlife and beyond is complex. More theorizing and research will be needed in order to provide a more clear understanding of women's experiences of body image and menopause.

Conclusion

The current study sought to fill gaps in the extant literature on middle-aged and older women's body image and menopausal experiences. Research on body image (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003), and menopause (Harris, 2008; Im, 2007; Im et al., 2008; Kaufert, 1982; Wilk & Kirk, 1995) has been found lacking in important areas with regard to diversity and few studies have looked at the relationship between body image and experiences of menopause (McKinley & Lyon, 2008). To address these issues, this investigator proposed that attitudes towards menopause, symptoms of menopause, and body image variables (self-objectification,

body shame, body surveillance, body dissatisfaction-think, and body dissatisfaction-feel) would be significantly related and impacted by demographic variables including age, menopausal status, and ethnicity.

Results indicated that younger participants experienced more body shame and body surveillance compared to older women, but older women reported higher levels of self-objectification. White women reported higher levels of body shame and body dissatisfaction-think than African American women. Younger women, White women, women who experienced more body shame and body dissatisfaction-feel reported more negative views of menopause. Body shame and body dissatisfaction-feel were associated with more frequent and severe psychological symptoms of menopause. Women who were peri-menopausal in the current sample reported more psychological symptoms while pre-menopausal women reported the least vaso-somatic and general somatic menopause symptoms. The path analysis showed that premenopausal status, ethnicity, and body dissatisfaction-feel are related to menopausal attitudes such that White women, premenopausal women, and women who reported more body dissatisfaction-feel also reported more negative views about menopause. Finally, results of the current investigation showed that women who reported more negative views about menopause were more likely to experience more frequent and severe psychological, vaso-somatic, and general somatic symptoms of menopause.

This investigation showed that body image and menopause are important concerns for women during midlife, which was evidenced in the relationships that emerged in the path model that was tested. The findings of the current study

demonstrated that not all women experience their bodies or their menopausal transition in the same way. Most notable were the possible strengths associated with being older (and experiencing less body shame or surveillance) and African American (and experiencing more positive views about menopause and more positive body image). These findings have important implications for research, theory, and practice in the field of psychology and shed much needed light onto the midlife menopausal and body image experiences of African American and White women in the United States.

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APPENDIX A

Flyer for Study

****

CONTRIBUTE TO KNOWLEDGE ABOUT BODY IMAGE & MENOPAUSE

Are you:

- Female
- 40 or older
- Willing to fill out a few SHORT surveys?

If you answered YES to these questions, you are invited to participate in a study being conducted by Martha Bergen, who is a graduate student in Counseling Psychology at Texas Woman's University. You will fill out questionnaires about your experiences with menopause and your views about your body.

To participate, click below and follow the instructions. The study should take between 15 and 30 minutes to complete.

www. Martha's study website goes here.

In exchange for your participation, you will be entered into a drawing for one of four $25 Visa gift cards, and you can request a summary of the results of the study. Thanks for your interest!

This study has been approved by the Texas Woman's University Institutional Review Board and is under the supervision of Debra Mollen, Ph.D.

www.Martha'sstudywebsite
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APPENDIX B

Email Advertisement for Study

****

CONTRIBUTE TO KNOWLEDGE ABOUT BODY IMAGE & MENOPAUSE

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- Female
- 40 or older
- Willing to fill out a few SHORT surveys?

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APPENDIX C

Facebook Advertisement for Study

Menopause Study
Participate in research about menopause and body image. Take a few short surveys and enter to win 1 of 4 $25 Visa gift cards. Thanks!

APPENDIX D

Informed Consent Letter

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Diverse women aging in America: Experiences of menopause and self-objectification in midlife

Investigator: Martha Bergen, M.A. .... (817) 723-0730 or martha.bergen@gmail.com
Advisor: Debra Mollen, Ph. D..... (940) 898-2317

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Bergen's dissertation at Texas Woman's University. The purpose of this research is to explore women's body image and experiences of menopause during midlife.

Research Procedures

For this study, you will be presented with different types of questions about your views of menopause, experiences with menopause, and body image through a secure website designed for research purposes. A short demographic survey will also be included. When you get to the bottom of each screen, simply click "next" to move to the next set of questions. Your total time commitment in this study is estimated to be between 15 and 30 minutes.

Potential Risks

Potential risks related to your participation in the study include fatigue, embarrassment, and psychological or emotional discomfort while completing the survey packet. To avoid fatigue, you may take a break (or breaks) while completing the surveys as needed. If you experience discomfort or embarrassment regarding the survey questions, you may stop answering any of the questions at any time.

Another possible risk to you as a result of your participation in this study is release of confidential information. Confidentiality will be protected to the extent that is allowed by law. Completion of surveys will take place on a computer with internet access in any location of your choosing. Personal information and responses to questions are private and will be confidential. Your personal information, including your name and contact information, will be not be included in the actual survey materials. If you choose to enter into a drawing to win one of four $25 Visa gift cards or to receive a summary of the study upon completion of the study, you will be directed to a different website within PsychData to enter your name and email address. No personal information will be connected with your survey responses. A participant number, rather than your name, will be used on all survey material. No one but the principal investigator will have access to

your personal information. Aside from the principal investigator, only her advisor will have access to the summary of information. No personal information will be included in this summary.

Also, there is a potential risk of loss of confidentiality in all e-mail transactions. In order to minimize this risk, all e-mails will be deleted after completion of the investigation.

It is anticipated that the results of this study will be published in the investigator's dissertation as well as in other research publications. However, no names or other identifying information will be included in any publication.

Finally, loss of time is another potential risk of participating in this research project. Your participation is completely voluntary and you can withdraw from the study at any time without penalty.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. As a benefit for your participation, you can choose to enter into a drawing to win one of four $25 Visa gift cards. Another benefit to you is that at the completion of the study, a summary of the results will be emailed to you upon request.

Questions Regarding the Study

If you have any questions about the research study you may ask the researchers; their contact information is at the top of this form. If you have any questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu. Feel free to print a copy of this consent form to keep for your records.

By clicking the "I agree" button below, you acknowledge that you have read this information and are giving your informed consent to participate in this study.

(Button will go here)

APPENDIX E

Demographic Survey

Please complete the following questions by selecting the response that most correctly fits with your experience from the drop down boxes or by typing in your response.

1. Age:

2. Ethnicity:
    a. Caucasian
    b. Black
    c. Asian/Pacific Islander
    d. Latina
    e. Native American
    f. Biracial/Multiracial
    g. Other

3. Menopausal Status:
    a. Pre-menopausal (regular periods, no changes in frequency of periods)
    b. Peri-menopausal (irregular periods, changes in frequency of periods compared to last year)
    c. Post-menopausal (have not had a period for 12 consecutive months)
    d. Surgically menopausal (i.e., hysterectomy)
        i. If you selected (d.), how long ago was your surgery?

4. What is your experience with Hormone Replacement Therapy (HRT)?
    a. Never taken HRT
    b. Took HRT in the past
    c. Currently taking HRT
    d. If you selected (b) or (c), which medication do/did you take?

5. Height (in inches):

6. Weight (in pounds):

7. Sexual Orientation:
    a. Heterosexual
    b. Lesbian
    c. Bisexual
    d. Questioning
    e. Other

8. Relationship Status:
    a. Single
    b. Cohabitating
    c. Married/Domestic Partnership
    d. Separated
    e. Divorced
    f. Widowed

9. Number of children:

10. Yearly Household Income:

11. Highest education level completed:
    a. Some high school
    b. High school degree/ GED
    c. Some college
    d. Associate's degree
    e. Bachelor's degree
    f. Some graduate school
    g. Graduate degree

12. How did you find out about this study?
    a. Email from a friend or acquaintance
    b. Email from a listserv
    c. Flyer
    d. Facebook advertisement
    e. Facebook group or fan page
    f. Ad posted on a website

APPENDIX F

Menopause Attitudes Scale

(Bowles, 1986)

INSTRUCTIONS: The following sets of adjectives describe feelings some women may experience during menopause. There are no right or wrong answers, only your own opinion. You are asked to indicate the degree to which you think the sets of adjectives are related to feelings a woman may experience during menopause.

FOR EXAMPLE

If you think that feelings a woman has during menopause are extremely related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS

Good__X__:____:____:____:____:____:____ Bad

If you think that feelings a woman has during menopause are quite related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS

Good ____:____:____:____:____:__X__:_____Bad

If you think that feelings a woman has during menopause are slightly related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS

Good ____:____:__X__:____:____:____:_____ Bad

If you think feelings a woman has during menopause are related to both ends equally, place your check mark in the middle space.

DURING MENOPAUSE A WOMAN FEELS

Good____:____:____:__X__:____:____:_____Bad

DURING MENOPAUSE A WOMAN FEELS

Important	_____:_____:_____:_____:_____:_____:_____	Unimportant
Passive	_____:_____:_____:_____:_____:_____:_____	Active
Clean	_____:_____:_____:_____:_____:_____:_____	Dirty
Fresh	_____:_____:_____:_____:_____:_____:_____	Stale
Dumb	_____:_____:_____:_____:_____:_____:_____	Intelligent
Sharp	_____:_____:_____:_____:_____:_____:_____	Dull
Unsure	_____:_____:_____:_____:_____:_____:_____	Confident
Worthless	_____:_____:_____:_____:_____:_____:_____	Valuable
High	_____:_____:_____:_____:_____:_____:_____	Low
Strong	_____:_____:_____:_____:_____:_____:_____	Weak
Unattractive	_____:_____:_____:_____:_____:_____:_____	Attractive
Pessimistic	_____:_____:_____:_____:_____:_____:_____	Optimistic
Full	_____:_____:_____:_____:_____:_____:_____	Empty
Pleasant	_____:_____:_____:_____:_____:_____:_____	Unpleasant
Ugly	_____:_____:_____:_____:_____:_____:_____	Beautiful
Needed	_____:_____:_____:_____:_____:_____:_____	Unneeded
Useful	_____:_____:_____:_____:_____:_____:_____	Useless
Interesting	_____:_____:_____:_____:_____:_____:_____	Boring
Unsuccessful	_____:_____:_____:_____:_____:_____:_____	Successful
Alive	_____:_____:_____:_____:_____:_____:_____	Dead

APPENDIX G

Menopause Symptom List

(Perz, 1997)

For the symptoms listed place a tick ( ) in the box that best describes how *frequently* you had the symptom in the last three (3) months, as compared to previously, according to the following scale:

FREQUENCY RATING:

0	**NEVER – Not at all in the last 3 months**
1	**RARELY – Once or twice in the last 3 months**
2	**OCCASIONALLY – About 5 times in the last 3 months**
3	**REGULARLY – Between 5 to 10 times in the last 3 months**
4	**OFTEN -- More than 10 times in the last 3 months**
5	**ALMOST ALWAYS – Almost daily in the last 3 months**

If you had the symptom at all during this time, place a tick ( ) in the box that best describes how *severe* the symptom was when you experienced it according to the following scale:

SEVERITY RATING:

0	**NOT APPLICABLE – Symptom not experienced**
1	**SLIGHT – A just noticeable change or sensation**
2	**MILD – A small change or sensation**
3	**MODERATE – Quite a noticeable change or sensation**
4	**SEVERE – A strong change or sensation**
5	**EXTREME – A change or sensation that could not have been worse**

Please answer all questions and do not think too long before answering.

	FREQUENCY						SEVERITY					
SYMPTOM	**0**	**1**	**2**	**3**	**4**	**5**	**0**	**1**	**2**	**3**	**4**	**5**
1. Worrying needlessly (concerned and upset about things for no reason)												
2. Depressed feelings (feeling unhappy, miserable or sad without reason)												
3. Pressure or tightness in head or body (tense and tight feelings in the head or body)												
4. Sleeplessness (difficulty falling and staying asleep)												
5. Loss of feeling in hands and feet (numbness or loss of sensation in hands and feet)												
6. Loss of sexual interest (loss of interest and desire for sexual activity)												
7. Poor concentration (difficulty in keeping your mind upon tasks)												
8. Palpitations (heart beating quickly or strongly)												
9. Cold hands and feet (hands and feet feeling cold despite rest of body being warm)												
10. Moodiness (changes in moods and feelings for no reason)												
11. Excitable (easily aroused or stirred up)												
12. Poor appetite (loss of desire or interest in food and eating)												
13. Constipation (difficulty in emptying the bowels)												

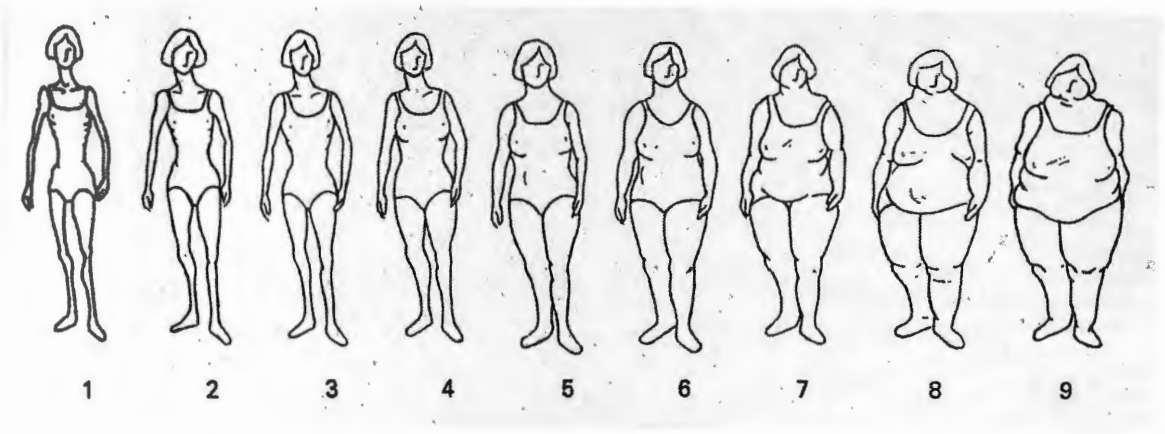
	FREQUENCY						SEVERITY					
SYMPTOM	**0**	**1**	**2**	**3**	**4**	**5**	**0**	**1**	**2**	**3**	**4**	**5**
14. Weight gain (weight increase in the last year of more than 5%)												
15. Irritability (upset or stirred up)												
16. Early morning awakenings (waking early in the morning and unable to fall back to sleep)												
17. Shortness of breath (running out of breath)												
18. Numbness and tingling (loss of feeling or tingling or prickling sensations in any part of the body)												
19. Hot flushes (a feeling of heat that suddenly occurs and may involve chest, neck and face)												
20. Headaches (pain in the head but not severe enough to be called a migraine)												
21. Tense feelings (feeling tense or wound up)												
22. Crying spells (crying or wanting to cry without reason)												
23. Dry eyes (feelings of dryness in the eyes)												
24. Dyspareunia (painful or difficult sexual intercourse)												
25. Involuntary sweating (sweating without exerting energy or during exercise)												

APPENDIX H

Figure Rating Scale

(Stunkard et al., 1983)

Using these figures, please complete the questions below.



(1) Choose your *ideal* figure
(2) Choose the figure that reflects how you *think* you look
(3) Choose the figure that reflects how you *feel* most of the time
(4) Choose the figure that you think is most *preferred* by *men*
(5) Choose the figure that you think is most *preferred* by *women*

APPENDIX I

Self-Objectification Questionnaire

(Noll & Fredrickson, 1998)

I am interested in how people think about their bodies. The questions below identify 10 different body attributes. I would like you to *rank order* these body attributes from that which has the *greatest impact* on your physical self-concept (rank this a "1"), to that which has the *least impact* on your physical self-concept (rank this a "10").

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

Please first consider all attributes simultaneously, and record your rank ordering by writing the ranks in the rightmost column.

IMPORTANT: *Do Not Assign The Same Rank To More Than One Attribute!*

1 = greatest impact
2 = next greatest impact
:
9 = next to least impact
10 = least impact

When considering your *physical self-concept*...

1. ... what rank do you assign to *physical coordination?* ____
2. ... what rank do you assign to *health?* ____
3. ... what rank do you assign to *weight?* ____
4. ... what rank do you assign to *strength?* ____
5. ... what rank do you assign to *sex appeal?* ____
6. ... what rank do you assign to *physical attractiveness?* ____
7. ... what rank do you assign to *energy level (e.g., stamina)?* ____
8. ... what rank do you assign to *firm/sculpted muscles?* ____
9. ... what rank do you assign to *physical fitness level?* ____
10. ... what rank do you assign to *measurements (e.g., chest, waist, hips)?* ____

APPENDIX J

Objectified Body Consciousness Scale

(McKinley & Hyde, 1996)

INSTRUCTIONS:

Select the number that corresponds to how much you agree with each of the statements on the following pages.

Select NA only if the statement does not apply to you. Do not circle NA if you don't agree with a statement.

For example, if the statement says "When I am happy, I feel like singing" and you don't feel like singing when you are happy, then you would select one of the disagree choices. You would only select NA if you were never happy.

	Strongly Disagree			Neither agree nor disagree			Strongly Agree	Does not apply
1. I rarely think about how I look.	1	2	3	4	5	6	7	NA
2. When I can't control my weight, I feel like something must be wrong with me.	1	2	3	4	5	6	7	NA
3. I think it is more important that my clothes are comfortable than whether they look good on me.	1	2	3	4	5	6	7	NA
4. I think a person is pretty much stuck with the looks they are born with.	1	2	3	4	5	6	7	NA
5. I feel ashamed of myself when I haven't made the effort to look my best.	1	2	3	4	5	6	7	NA
6. A large part of being in shape is having that kind of body in the first place.	1	2	3	4	5	6	7	NA
7. I think more about how my body feels than how my body looks.	1	2	3	4	5	6	7	NA
8. I feel like I must be a bad person when I don't look as good as I could.	1	2	3	4	5	6	7	NA
9. I rarely compare how I look with how other people look.	1	2	3	4	5	6	7	NA
10. I think a person can look pretty much how they want to if they are willing to work at it.	1	2	3	4	5	6	7	NA
11. I would be ashamed for people to know what I really weigh.	1	2	3	4	5	6	7	NA
12. I really don't think I have much control over how my body looks.	1	2	3	4	5	6	7	NA

	Strongly Disagree			Neither agree nor disagree			Strongly Agree	Does not apply
13. Even when I can't control my weight, I think I'm an okay person	1	2	3	4	5	6	7	NA
14. During the day, I think about how I look many times.	1	2	3	4	5	6	7	NA
15. I never worry that something is wrong with me when I am not exercising as much as I should.	1	2	3	4	5	6	7	NA
16. I often worry about whether the clothes I am wearing make me look good.	1	2	3	4	5	6	7	NA
17. When I'm not exercising enough, I question whether I am a good enough person.	1	2	3	4	5	6	7	NA
18. I rarely worry about how I look to other people	1	2	3	4	5	6	7	NA
19. I think a person's weight is mostly determined by the genes they are born with.	1	2	3	4	5	6	7	NA
20. I am more concerned with what my body can do than how it looks.	1	2	3	4	5	6	7	NA
21. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same.	1	2	3	4	5	6	7	NA
22. When I'm not the size I think I should be, I feel ashamed.	1	2	3	4	5	6	7	NA
23. I can weigh what I'm supposed to when I try hard enough	1	2	3	4	5	6	7	NA
24. The shape you are in depends mostly on your genes.	1	2	3	4	5	6	7	NA