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# The Role of Body Surveillance, Body Shame, and Body Self-Consciousness during Sexual Activities in Women's Sexual Experience

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THE ROLE OF BODY SURVEILLANCE, BODY SHAME, AND BODY SELF-  
CONCIOUSNESS DURING SEXUAL ACTIVITIES IN WOMEN'S SEXUAL  
EXPERIENCE

by

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Bachelor of Arts in Psychology  
Boston College  
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A thesis submitted in partial fulfillment  
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**August 2013**

## ABSTRACT

The Role of Body Surveillance, Body Shame, and Body Self-Consciousness during  
Sexual Activities in Women's Sexual Experience

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Objectification theory is a social constructivist framework that aims to explain how sociocultural and intrapersonal variables impact women's mental health. To date, however, few studies have used an objectification framework to examine the relationship between body image and sexual functioning in ethnically diverse samples of women. Consequently, the present study used the tenets of objectification theory to examine body image and sexuality in women. Specifically, this study investigated the relationships between body surveillance, body shame, body self-consciousness during sexual activities, and sexual satisfaction in American female college students. Participants completed self-report measures of demographic information, body shame, body surveillance, body self-consciousness during sexual activity, and sexual satisfaction. Bivariate correlations suggested that body surveillance, body shame, and body self-consciousness during sexual activity were negatively correlated with sexual satisfaction. Additionally, path analysis indicated that body surveillance predicted increased body self-consciousness during sexual activity, which was partially mediated by body shame. Body self-consciousness, in turn, predicted decreased sexual satisfaction. Overall, study findings suggest that it is important to assess for and address body surveillance, body shame, and body concerns

during sexual activity in clinical contexts with women presenting with sexual dissatisfaction.

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## TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGMENTS .....	v
CHAPTER 1 INTRODUCTION.....	1
CHAPTER 2 REVIEW OF RELATED LITERATURE.....	5
Body Image and Sexual Functioning in Women .....	5
Using Objectification Theory to Understand Body Image Problems and Sexual Functioning .....	16
Additional Variables That May Influence the Sexual Functioning of Women .....	26
Study Objectives .....	34
CHAPTER 3 METHODOLOGY .....	36
Participants .....	36
Procedure .....	36
Measures .....	37
Data Analyses .....	39
CHAPTER 4 RESULTS .....	42
CHAPTER 5 SUMMARY, CONCLUSIONS, AND DISCUSSION .....	46
APPENDIX 1: FIGURES .....	54
APPENDIX 2: FORMS .....	58
REFERENCES .....	72
VITA .....	90

## CHAPTER ONE

### INTRODUCTION

The sexual objectification of women is pervasive in Western cultures. Sexualized images of the ideal-looking female body are proliferated throughout film, advertisements, television shows, music videos, and women's magazines in the United States (American Psychological Association [APA], 2010; Frederickson & Roberts, 1997). Not only do sexualized images propagated by Western media depict women as sexual objects, but they concurrently promote sociocultural values and ideals of appearance that suggest that the ideal woman is young, thin, fit, White, and sexually attractive (Levine & Smolak, 1996; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). For example, Levine & Smolak (1996) found that in the April 1994 issue of *Teen* magazine, none of the 95 girls or women that were depicted in magazine articles or advertisements were heavy or overweight and almost all appeared to be White (with two perceived as African American). Furthermore, the age of models portrayed in fashion magazines typically ranges from 16-22 (Santonastaso, Mondini, & Favaro, 2002; Shaw, 1995).

Objectification theory provides a conceptual framework to understand how women's objectification experiences may contribute to an array of mental health problems, including eating pathology and sexual dysfunction (Frederickson & Roberts, 1997; Moradi & Huang, 2008). Objectification theory (Frederickson & Roberts, 1997) posits that through sexual objectification experiences, women are socialized to view themselves as objects to be viewed, evaluated, and consumed by others. By living in a cultural context that sexually objectifies women while simultaneously emphasizing the



importance of attaining the ideal appearance, women learn to view themselves from an objectifying observer's perspective (Frederickson & Roberts, 1997). The internalization of this observer's perspective is referred to as *self-objectification* (Frederickson & Roberts, 1997), which is characterized by habitual monitoring of the body's appearance or *body surveillance*. According to objectification theory, body surveillance is posited to lead to *body shame*, or the perceived failure to meet internalized, cultural body ideals. Existing research supports the role of body surveillance in the development of body shame in college-aged women (McKinley & Hyde, 1996; Noll & Frederickson, 1998; Tiggemann & Slater, 2001). Moreover, body surveillance and body shame are linked to increased body image concerns for women (e.g., Forbes, Jobe, & Revak, 2006; Frederickson, Roberts, Noll, Quinn, & Twenge, 1998; McKinley, 1995; McKinley & Hyde, 1996; Noll & Frederickson, 1998; Tiggemann & Kuring 2004, Tiggemann & Slater, 2001; Tylka, 2004).

Given the heightened attention inherently placed on the body in the context of sexual activity, body image concerns may play a significant role in women's sexual experiences. Extant research suggests that body dissatisfaction may inhibit sexual behavior and interfere with the quality of women's sexual experiences (Ackard, Kearney-Cooke, & Peterson, 2000; Davison & McCabe, 2005; Steer & Tiggemann, 2008; Wiederman, 2011). However, existing research is limited in at least three important ways. First, the majority of existing research examines the role of global, trait-level body image on sexual experience. Although this research is important, some authors argue that it is important to distinguish between trait-level body image and context-specific body image (Cash & Smolak, 2011; Cash et al., 2004; Wiederman, 2000). In particular, one form of

contextual body image that may play an important role in women's sexual experiences is *body exposure anxiety and avoidance during sexual activity*, which is conceptualized as physical self-consciousness and increased attentional focus on appearance and body exposure during sexual activity (Cash et al., 2004). While dispositional or trait level body dissatisfaction is only weakly related to sexual functioning after controlling for other variables such as self-esteem, depression, anxiety, and body mass index (Yamamiya, Cash, & Thompson, 2006), a small body of recent research suggests that body exposure anxiety and avoidance in a sexual context is moderately associated with decreased sexual functioning (i.e., less consistency and quality in sexual arousal and orgasm; Cash et al., 2004; Davison & McCabe, 2005).

Second, although extant findings underscore an association between body image and sexual experience, few studies have examined the exact mechanisms that link body image to sexual difficulties. One hypothesized phenomenon that may link body image to disrupted sexual functioning in women is cognitive distraction (e.g., Dove & Wiederman, 2000; Meana & Nunnink, 2006). When women are distracted by concerns about their physical appearance, they may be unable to relax and focus on their own sexual pleasure, which can influence sexual performance and related outcomes (Adams, Haynes, & Brayer, 1985; Cash, 2004; Dove & Wiederman, 2000; Elliot & O'Donohue, 1997; Ellison, 2001; Geer & Fuhr, 1976; Meana & Nunnink, 2006; Przybyla & Byrne, 1984). In support of this phenomenon, empirical findings demonstrate that cognitive distraction due to appearance-related thoughts is indicative of poorer sexual functioning, lower sexual esteem, and less sexual satisfaction (Dove & Wiederman, 2000; Pujols, Meston, & Seal, 2009).

Finally, previous studies that have applied the principle tenets of objectification theory to the study of women's sexual functioning examine these constructs in predominantly homogenous samples of White, European American, college-aged women (e.g., Calogero & Thompson, 2009; Steer & Tiggemann, 2008). Research indicates that college-aged women are particularly at risk for developing body image disturbance, and thus an important population in which to study these constructs. However, the generalizability of findings from the few studies examining the effects of body image on sexual functioning in this population may be limited due to the homogeneity of the samples examined.

Consequently, to build upon existing research, the overarching goal of the present study was to investigate the negative effects of self-objectification on women's sexual experience. Specifically, this study examined body surveillance, body shame, and body self-consciousness during sexual activity as they apply to women's sexual satisfaction in an ethnically diverse sample of female undergraduate college students.

## CHAPTER 2

### LITERATURE REVIEW

The following sections review literature relevant to the proposed study investigating body image and sexual satisfaction in women. Key areas reviewed include: (a) body image and sexual functioning, (b) objectification theory as a theoretical framework to understand body image problems and sexual dysfunction, and (c) additional variables that may influence the relationships between body image and sexual functioning in women.

#### **Body Image and Sexual Functioning in Women**

Women's sexual functioning is a complex phenomenon influenced by many factors, including the number and types of sexual experiences one has had in the past; interpersonal factors (e.g., relationship status, relationship satisfaction); biological factors (e.g., nerve damage, androgen insufficiency); individual psychological variables (e.g., body image, self-esteem); and the sociocultural context in which sexual activity occurs (Althof et al., 2005; Tiefer, 2001). Although the term *sexual functioning* can have a variety of meanings, it generally describes the amount and types of sexual experience one has had; the ability to become physically aroused and experience orgasm; or the degree of sexual pleasure or satisfaction one experiences during sexual activity (Wiederman, 2011).

Research indicates that sexual functioning is highly variable among individual women (Basson, 2008). As a result, much debate and discussion surrounds defining normal and abnormal sexual function in women. Despite our limited understanding of women's sexual functioning, research suggests that sexual functioning plays an important

role in women's overall wellbeing. For example, in a large-scale survey of sexual behavior in men and women ages 40-80 in Western Europe, Canada, and Australia, approximately one-third of women reported that sex was extremely or very important for their overall life satisfaction (Laumann et al., 2006). Therefore, understanding variables that contribute to sexual functioning has significant implications for women's psychological health.

Independent from the exact definition used to describe sexual health, problems with sexual functioning are quite common in women. According to the DSM-IV-TR, *sexual dysfunction* is characterized by disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty (American Psychiatric Association, 2000). The sexual response cycle is divided into the following phases: desire, excitement, orgasm, and resolution. Desire is the phase that consists of fantasies about sexual activity and the desire to have sexual activity. The excitement phase consists of a subjective sense of sexual pleasure and accompanying physiological changes. The orgasm phase consists of a peaking of sexual pleasure, with release of sexual tension. Finally, in the resolution phase of sexual activity, there is a sense of muscular relaxation and general wellbeing. The sexual diagnoses outlined in the DSM-IV-TR are classified as sexual desire disorders (hypoactive sexual desire disorder, sexual aversion disorder), sexual arousal disorder (female sexual arousal disorder), orgasmic disorder (female orgasmic disorder), and sexual pain disorders (dyspareunia, vaginismus).

Despite the utility of the DSM-IV TR in defining clinically problematic types and levels of sexual dysfunction, it is important to broadly examine sexual dysfunction in

women for at least two primary reasons (i.e., not study only those with clinically-diagnosable sexual problems). First, some researchers argue that it is important to adopt such a sociocultural view of women's sexual problems in order to avoid specifying any one pattern of sexual experience as functional or dysfunctional (Tiefer, 2001). Second, clinically diagnosed disorders are more rare than general sexual problems, all of which may impact women's sexual experiences by contributing to infrequent sexual experiences and sexual dissatisfaction. For example, available estimates suggest that 43% of women in the United States report at least one sexual problem while 11-33% of both community and clinical samples fall within a specific problem category (e.g., arousal disorder, desire disorders, orgasmic disorder, sexual pain disorder; Laumann, Paik, & Rosen, 1999; Shifren, Monz, Russo, Segreti, & Johannes, 2008). Specifically, desire and arousal disorders are among the most commonly reported sexual problems in clinical samples of women whereas anxiety and inhibition during sexual activity are the most common forms of sexual problems reported in nonclinical samples (Rosen, Taylor, Leiblum, & Bachmann, 1993). Consequently, for this study I focus on the domain of *sexual satisfaction* in order to portray women's subjective sexual experiences related to their discontent with any personal (i.e., emotional, physical) or relational aspect of their sexual life (Tiefer, 2001).

Although little is known about the relationship between sexual satisfaction and sexual dysfunction, sexual satisfaction appears to be associated with increased sexual frequency and relationship quality (e.g., Byers & Demmons, 1999; Laumann et al., 1994; Nicolosi, Moreira, Villa, & Glasser, 2004; Sprecher, 2002). Research also indicates that sexual satisfaction (Kahneman, Krueger, Schkade, Schwartz, & Stone, 2004) and sexual

frequency (Blanchflower & Oswald, 2004) are highly correlated with women's general happiness. Given the influence of sexual satisfaction on women's sexual experience and wellbeing, research examining psychological factors that contribute to sexual satisfaction is necessary to guide prevention and intervention efforts.

### **The Influence of Body Image on Sexual Functioning**

Although sexual functioning is influenced by a number of factors, body image receives considerable attention in research studies and clinical practice because it contributes to overall sexual health in both men and women (Althof et al., 2005). *Body image* is a multidimensional construct that incorporates one's attitudes and perceptions about one's own body and physical appearance, including global subjective satisfaction (evaluation of the body), affective experiences (feelings associated with the body), and cognitions, or beliefs about the body (Cash & Smolak, 2011). In Western cultures, body image concerns are considered normative among women (Rodin, Silberstein, & Striegel-Moore, 1984). This is particularly troublesome because a substantial body of research indicates that poor body image is associated with decreased psychosocial functioning in multiple domains, including disordered eating, depression, and sexual functioning (Cash & Smolak, 2011).

Given the heightened attention inherently placed on the body in the context of sexual activity, dispositional and contextual body image appear to play a significant role in women's sexual experiences in various ways. To date, the majority of existing research investigates the influence of *dispositional* or trait-level evaluations of one's body on sexual functioning and suggests that increased body image concerns may (a) cause an individual to avoid particular sexual activities and (b) become distracting during sexual

interactions (Wiederman, 2011). For example, in a sample of female college students, Weaver & Byers (2006) found that women with poorer body image were more likely to report more problems of sexual functioning, greater anxiety around sex, and lower sexual esteem than women with a more positive body image when controlling for body mass index (BMI; weight in kg/height in m<sup>2</sup>). Similarly, Wiederman and Hurst (1998) explored the relationship between self-perceived physical attractiveness and body image in relation to sexual experience and sexual esteem in a sample of undergraduate women ages 18-21. In this study, women who received oral sex perceived their bodies to be more attractive when compared to women who had never experienced oral sex. Furthermore, women who were higher in sexual esteem believed themselves to be more attractive.

Furthermore, findings suggest that women who are chronically dissatisfied with their bodies may be less sexually skilled (Holmes, Chamberlin, & Young, 1994), report more sexual distress (L. Berman, J. Berman, Miles, Pollets, & Powell, 2003), and even avoid sexual activities altogether (Faith & Schare, 1993). In a sample of undergraduate and graduate psychology students, Faith and Schare (1993) conducted multiple regression analyses to determine whether body image concerns would predict sexual avoidance. Their findings indicated that males and females who conceptualized or described their bodies in more negative terms reported less sexual experience. Ackard, Kearney-Cooke, and Peterson (2000) examined the relationship between body image, sexual practices, and self-evaluation among a large sample of female readers of *Shape* magazine. Results indicated that satisfaction with one's body significantly correlated with the frequency of initiating sex and achieving orgasm, comfort engaging in new sexual acts, and confidence



in one's ability to pleasure a partner sexually. Greater body satisfaction was also linked with higher frequency of sexual activity.

Although body image research has historically measured the relationship between trait, dispositional evaluations of the body (e.g., overall body image satisfaction-dissatisfaction) and sexual functioning (e.g., Ackard et al., 2000; Faith & Schare, 1993), recent advances in body image assessment provide a more comprehensive evaluation of body image, such as *context-specific body image evaluations* or body image experiences in specific situational contexts (Cash, 2011). This newer area of research considers how body image experiences may change for women in different contexts and in relation to certain situations or events. For example, while a woman may be dissatisfied with her weight after trying on a pair of jeans that no longer fit, she may feel good about her weight after exercising at the gym.

Research suggests that body image is increasingly negative in situations in which there is greater focus on the body (e.g., Haimovitz, Lansky, & O'Reilly, 1993).

Therefore, it is likely that body image concerns are particularly salient during sexual activities with a partner given the high degree of focus on the body in this context.

Although research investigating situational factors that influence context-specific body image experiences during sexual activity is limited, extant research suggests that contextually-specific body image is inversely associated with sexual functioning (i.e., less consistency and quality in sexual arousal and orgasm) whereas dispositional body dissatisfaction is only weakly related to sexual functioning after controlling for other variables such as self-esteem, depression, anxiety, and BMI (Cash, Maikkula, & Yamamiya, 2004; Yamamiya et al., 2006; Davison & McCabe, 2005). Consequently,

there is likely an important distinction to be made between trait-level body image and context-specific body image when investigating sexual functioning (Cash & Smolak, 2011; Cash et al., 2004; Wiederman, 2000). In fact, when researchers have statistically accounted for body concern during sexual activity, correlations between dispositional body image and sexual functioning have decreased substantially or disappeared altogether. For example, in a sample of sexually active, heterosexual male and female college students, Cash, Maikkula, and Yamamiya (2004) found that context-specific body concern during sexual activity correlated with sexual functioning more strongly than trait body-image measures for both men and women.

### **Cognitive Distraction and Spectatoring**

Although previous research underscores an association between body image and sexual experience, few studies have examined the exact mechanisms that link body image to sexual difficulties. One hypothesized phenomenon that may link body image to disrupted sexual functioning in women is cognitive distraction during sexual activity (e.g., Dove & Wiederman, 2000; Meana & Nunnink, 2006). This phenomenon, known as *spectatoring*, is a type of self-focus characterized by attending to how one physically looks to an observer rather than immersing oneself in the sensory aspects of sexual activity (Masters & Johnson, 1970).

Spectatoring was first theorized as a problem that might affect a males' ability to obtain an erection during sexual activity. Masters and Johnson (1970) postulated that if a man has experienced difficulty obtaining or maintaining an erection during a sexual encounter in the past, a sexual interaction with a partner might trigger concerns about his erection during that particular sexual encounter. Such concerns may cause the man to

monitor his erection during sexual activity, thereby distracting him from his partner and the current sexual experience. As a result, this distraction may further impair his erection by removing him mentally from the sensual experience at hand. Initial research on spectating in men suggested that cognitive distraction and performance demands have an arousal-inhibiting effect for men (Abrahamson, Barlow, & Abrahamson, 1989; Beck & Barlow, 1986; Farkas, Sine, & Evans, 1979; Heiman & Rowland, 1983; Lange, Wincze, Zwick, Feldman, & Hughes, 1981).

Comparatively, much less research examines the influence of distraction on the sexual arousal of women. However, several laboratory studies using a combination of self-report and physiological measures of arousal indicate that distraction also interferes with women's sexual arousal (Adams et al. 1985; Elliot & O'Donohue, 1997; Przybyla & Byrne, 1984). Cash, Maikkula, and Yamamiya (2004) suggest that thoughts about appearance may act in the same way as thoughts about performance in interfering with sexual functioning. Given the sociocultural messages women receive in Western cultures, for a woman, being a successful sexual partner may have less to do with performance and more to do with being an attractive visual stimulus (Wiederman, 2000). Specifically, spectating for a woman may often involve monitoring how her body might appear to her sexual partner (Meana & Nunnink, 2006).

Researchers measure spectating as the extent to which one feels self-conscious about physical appearance during sexual intimacy with a partner, and some term this phenomenon *body image self-consciousness*, defined as focusing one's attention on how one's body appears to one's partner (Wiederman, 2011). Evidence suggests that such spectating, or body image self-consciousness, reduces focus on one's own sexual

arousal and pleasure. Research illustrates that women who report greater body image self-consciousness during physical intimacy with a partner also report higher levels of sexual problems and less pleasure and enjoyment of sexual activities (e.g., Wiederman, 2000). More specifically, studies indicate that women with increased body image self-consciousness during sexual activity report decreased arousal, less frequent orgasm, greater aversion to sex, less desire for sex, and increased anxiety during sex (Cash et al., 2004; Davison & McCabe, 2005; Yamamiya et al., 2006). For example, Wiederman (2000) found that one third (35%) of heterosexual women in his college-aged sample experienced body image self-consciousness during sexual activity. Even after controlling for BMI, general body dissatisfaction, and general sexual anxiety, women who reported the greatest degree of body image self-consciousness during sexual activity with a partner had less heterosexual experience; were less sexually assertive with partners; and reported more avoidance of sexual activity with a partner.

Additionally, extant research suggests that body image self-consciousness during sexual activity mediates the relationships between more general, dispositional body image and sexual functioning (e.g., Steer & Tiggemann, 2008). When a woman becomes a spectator, she becomes distracted by thoughts about her performance or appearance instead of immersing herself in the sensory aspects of sexual activity. Research suggests that negative body image may lead to women being distracted by concerns about their physical appearance during sexual activity (Meana & Nunnink, 2006; Wiederman, 2000). For example, in a study investigating gender differences in the report of cognitive distraction during sexual activity, Meana and Nunnink (2006) found that negative body image predicted appearance-based distraction during sexual activity in a sample of

undergraduate men and women under age 30 who had coital experience. This cognitive distraction is theorized to inhibit sexual arousal and orgasm because a spectator cannot properly attend to erotic cues that are necessary for arousal (Barlow, 1986; Masters & Johnson, 1970).

Several studies indicate an association between cognitive distraction and decreased sexual arousal (Adams et al., 1985; Elliott & O'Donohue, 1997; Karafa & Cozzarelli, 1997; Koukounas & McCabe, 1997; Przybyla & Byrne, 1984); poorer sexual functioning; lower sexual esteem; and less sexual satisfaction (Dove & Wiederman, 2000; Pujols et al., 2009). For example, Dove & Wiederman (2000) examined cognitive distraction and sexual functioning in a sample of young adult women. Results indicated that women who reported greater cognitive distraction due to appearance-related thoughts reported lower sexual esteem, less sexual satisfaction, less consistent orgasms, and higher incidence of pretending orgasm after controlling for affect, sexual desire, general self-focus, general sexual attitudes, and dispositional body dissatisfaction. Pujols and colleagues (2009) conducted an Internet survey assessing sexual functioning, sexual satisfaction, and body image in a sample of women between the ages of 18-49. Correlational findings indicated significant positive relationships between sexual functioning, sexual satisfaction, and all body image variables (sexual attractiveness, weight concern, body esteem, and appearance-based distraction). Moreover, multiple regression analyses revealed that high body esteem and low frequency of appearance-based distraction during sexual activity predicted increased sexual satisfaction.

### **Body Exposure Anxiety and Avoidance during Sexual Activity**

One form of contextual body image that is akin to spectating and body image self-consciousness is *body exposure anxiety and avoidance during sexual activity*, which is marked by physical self-consciousness and attentional focus on appearance and body exposure during sexual activity (Cash et al., 2004). In a study of sexually active, heterosexual college women, Yamamiya, Cash, and Thompson (2006) found that body dissatisfaction was modestly associated with a lack of general self-efficacy to refuse sex, sexual unassertiveness, and lower confidence in sexual functioning during a first-time sexual encounter with a partner. Furthermore, contextual body image during sexual activity was moderately related to less sexual assertiveness and confidence in sexual functioning. Moreover, contextual body image mediated the relationship between general body dissatisfaction and sexual assertiveness and self-efficacy. Similarly, in their study of sexually active, heterosexual male and female college students of European American and African American descent, Cash et al. (2004) found that higher body concern and exposure avoidance during sexual activity scores were associated with poorer sexual functioning. More specifically, women and men who reported higher levels of body concern during sexual activity had less enjoyment of their sex life, less frequent desire for sex, and less consistency and quality in experiences of sexual arousal and orgasm.

### **Summary**

Existing literature investigating body image as it relates to sexual functioning uses several terms and measures to describe the extent to which one feels self-conscious about one's body during sexual activity with a partner (i.e., cognitive distraction, spectating, body image self-consciousness during sexual activity, body exposure anxiety and avoidance,). Although these constructs are often labeled as distinct phenomenon

independent of the term used to describe the construct, research consistently suggests that women who report greater body concerns during sexual activity also report more sexual problems (e.g., decreased arousal, less frequent orgasms, greater aversion to sex, increased anxiety during sex) and less pleasure and enjoyment in sexual activity. As such, these variables (i.e., cognitive distraction, spectating, body exposure anxiety and avoidance during sexual activity) may all reflect a similar construct of body self-consciousness during sexual activity (which includes cognitive, behavioral, affective, and experiential experiences). Furthermore, body self-consciousness during sexual activity appears to mediate the relationship between dispositional body image and sexual functioning.

### **Using Objectification Theory to Understand Body Image Problems and Sexual Dysfunction**

Objectification theory offers a unique framework to understand how women's socialization experiences simultaneously encourage body image problems and sexual dysfunction in women. Sexualized images of the ideal-looking female body are proliferated throughout film, advertisements, television shows, music videos, and women's magazines in the United States (APA, 2010; Frederickson & Roberts, 1997). For example, Krassas, Blauwkamp, and Wesselink (2003) reported that 80.5% of women depicted in photographs in men's magazines (e.g., *Maxim*, *Stuff*) appeared in sexually objectifying roles and positions (e.g., reclining to suggest sexual availability or sexual invitation, appearing in decorative roles and/or partially nude). Not only do images propagated by Western media depict women as sexual objects, but they concurrently promote sociocultural values and ideals of appearance that suggest that the ideal woman

is young, thin, fit, White, and sexually attractive (Hesse-Biber, Leavy, Quinn, & Zoino, 2006; Thompson et al., 1999). For example, in a study of media exposure and body image in adolescent girls, Nichter and Nichter (1991) asked participants to describe the ideal teenage girl as depicted in fashion magazines. Participants described the ideal girl as being 5'7", 100 pounds, and size 5 with long blonde hair and blue eyes.

Furthermore, women's bodies are also often depicted in isolated body parts, such as a bare stomach, buttocks, or cleavage, in the absence of a focus on the rest of the woman (e.g., Kolbe & Albanese, 1996; Sommers-Flanagan, Sommers-Flanagan, & Davis, 1993), sending the message that women are to be viewed as body parts and objects to be desired. Research also suggests that the most common theme in popular television programs in the United States includes men valuing and selecting women as a romantic and sexual partner based on their physical appearance, and that women are aware that looking good is an important asset for attracting a partner (Ward, 1995). Taken together, Western media sends the message that in order to be socially desirable as a woman one must attain the ideal physical appearance and be attractive to men.

Given these culturally reinforced messages about beauty and sex, objectification theory argues women are socialized to view themselves as objects to be viewed, evaluated, and attractive to men (Frederickson & Roberts, 1997). As this occurs, feminist social-constructivist theorists argue that women are at risk for a variety of negative mental health consequences, including body image problems and sexual dysfunction (Bartky, 1990). *Sexual objectification* occurs when a woman's entire being is identified with her body—she is treated as a body or a collection of body parts (Bartky, 1990). Theoretically, women experience objectification through two central mediums: 1)



exposure to sexualized media images of the ideal-looking female (e.g., those that are depicted in film, advertisements, television shows, music videos, and women's magazines) and 2) being the object of visual inspection that occurs in social and interpersonal encounters, also referred to as the objectifying male gaze (APA, 2010; Frederickson & Roberts, 1997). As a result of exposure to objectifying messages through these mediums, women learn to equate their personal worth with their physical appearance. Additionally, objectification theory posits that through objectification experiences, women learn to view themselves from an objectifying observer's perspective (Calogero, Tantleff-Dunn, & Thompson, 2011; Frederickson & Roberts, 1997; McKinley & Hyde, 1996; See Figure 1). With increased exposure over time, women begin to internalize this objectifying perspective, which is referred to as *self-objectification* (Frederickson & Roberts, 1997). Through objectification experiences, women and men learn to evaluate women based on whether or not they conform to these societal body standards (Kaschak, 1992).

Heightened self-objectification often behaviorally manifests in *body surveillance*, or the habitual monitoring of how one's body appears. According to objectification theory, women may use body surveillance as a strategy to determine how other people will view and treat them. Researchers often conceptualize body surveillance as a cognitive behavioral manifestation of objectification (Slater & Tiggemann, 2010; Steer & Tiggemann, 2008; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001) and extant research suggests that surveillance often predicts outcomes above and beyond the construct of self-objectification (e.g., Greenleaf & McGreer, 2006; Tiggemann & Kuring, 2004; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). As such, body

surveillance is one of the proposed mechanisms through which self-objectification leads to psychological disturbances in women (e.g., Fredrickson and Roberts 1997; Slater & Tiggemann, 2002). For example, utilizing an objectification model proposed by Frederickson and Roberts (1997) to investigate disordered eating in college-aged women (see Figure 1), Tiggemann and Slater (2001) found that body surveillance was uniquely related to all other variables in the model, including body shame, appearance anxiety, and disordered eating, while general self-objectification was not.

According to objectification theory, self-objectification results in a host of negative consequences for women (see Figure 1). Frederickson and Roberts (1997) propose that self-objectification and surveillance lead to (a) increased body shame, (b) increased appearance anxiety, (c) interference with peak motivational states, and (d) decreased awareness of internal bodily states. Theoretically, preoccupation with the body from an observer's perspective (as occurs in body surveillance) can lead a woman to compare herself to an internalized physical standard (Frederickson & Roberts, 1997). In a culture in which the body standard is unobtainable (e.g., very thin, young, fit), comparisons may lead to feelings of shame and inadequacy for many women. *Body shame* is defined as the perceived failure to meet internalized, cultural body ideals. As such, women who internalize cultural body standards are likely to associate the achievement of these standards with their self-worth (McKinley & Hyde, 1996).

As individuals become more preoccupied with their physical appearance, *appearance anxiety* or the anticipation of threats and fear about when and how one's body will be evaluated increases. Objectification theory also posits that surveillance interrupts the ability to achieve peak motivational states (termed "flow")—a state in

which one is completely and totally involved in an enjoyable activity (Csikszentmihalyi, 1990). Surveillance may also use up a woman's attentional resources such that it interferes with her ability to attend to her inner body experience, thereby disrupting her *awareness of internal bodily states*. For example, it may disrupt her ability to detect and accurately interpret physiological sensations, such as hunger cues and physiological sexual arousal. As a whole, objectification theory postulates that the combination of these factors puts women at increased risk for mental health disorders such as depression, eating disorders, and sexual dysfunction.

A rich body of research provides empirical support for the role of self-objectification in women's body experiences, particularly through body shame. Although appearance anxiety, awareness of internal body states, and disruption of flow are specified in objectification theory, researchers have not found these variables to consistently contribute to proposed outcome variables above and beyond body shame (Slater & Tiggemann, 2002; Tiggemann & Slater, 2001). Therefore, the present study will be concerned primarily with the role of body shame in an objectification theory model.

### **Self-objectification and Mental Health Consequences**

According to objectification theory, self-objectification and its negative consequences can accumulate in a way that contributes to mental health risks in women. This may explain, in part, why certain disorders occur with disproportionately greater frequency in women: mainly, major depression, sexual dysfunction, and eating pathology. Since Frederickson and Roberts (1997) proposed objectification theory, the majority of empirical research has investigated its constructs in predominantly White

samples of college-aged women in the United States and Australia. Moreover, the majority of studies have utilized objectification theory to understand disordered eating and body image disturbance (e.g., Greenleaf, 2005; McKinley & Hyde, 1996; Moradi, Dirks, & Matteson, 2005; Noll & Frederickson, 1998; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001; Tylka & Hill, 2004). Comparatively, a smaller body of research has investigated objectification theory as it relates to depression (e.g., Miner-Rubino, Twenge, & Frederickson, 2002; Muehlenkamp & Saris-Baglama, 2002; Tiggemann, & Kuring, 2004), while little research has examined an objectification theory model as it relates to the development of sexual dysfunction in women (e.g., Calogero & Thompson, 2009; Steer & Tiggemann, 2008).

**Body Image and Eating Pathology.** Several studies suggest a positive relationship between self-objectification and eating pathology (including body image disturbance and disordered eating) using experimental research designs. *Eating pathology* is a broad term to describe any disordered eating behaviors (e.g., restricting diet, bingeing, purging) or body image disturbance (e.g., overvaluation of weight and shape, extreme fear of weight gain) that meet threshold for any of the eating disorders (i.e., anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified; Thompson et al., 1999). Frederickson, Roberts, Noll, Quinn, and Twenge (1998) conducted the seminal study that investigated the influence of self-objectification on body image and disordered eating in a laboratory environment. In their study, Frederickson et al. (1998) experimentally manipulated self-objectification by having undergraduate women try on either a swimsuit (heightened self-objectification condition) or sweater (control condition) in front of a full-length mirror. Results indicated that women in the swimsuit

condition reported significantly more body shame and appearance-related thoughts than those in the control condition. Furthermore, body shame positively predicted eating pathology in the form of restrained eating of cookies in the latter phase of the study such that women who reported the highest levels of body shame consumed less chocolate chip cookies than women lower in body shame. Quinn, Kallen and Cathey (2006) extended this research by having participants complete outcome measures after having changed out of a bathing suit. Results indicated that self-objectification continued to produce increased body-related thoughts even after participants redressed approximately ten minutes later, and that the relationship between self-objectification and body-related thoughts was mediated by body shame.

In another experimental investigation of self-objectification and eating pathology, Calogero (2004) manipulated self-objectification by telling female participants they were going to interact with a male (heightened self-objectification) or female (control) stranger. Calogero (2004) found that women who were told that they were going to interact with a male stranger reported more body shame and appearance anxiety than women who were told they were going to interact with a female stranger. Furthermore, Roberts and Gettman (2004) investigated the effects of self-objectification by assigning women to unscramble sentences with objectification-related words (e.g., slender, figure) or body competence-related words (e.g., fitness, health). They found that women assigned to the objectification condition reported more body shame and appearance anxiety than women assigned to the body-competence condition.

In one of the only studies to examine self-objectification in a relatively diverse U.S. sample, Hebl, King, and Lin (2004) investigated the influence of self-objectification

in undergraduate men and women who self-identified as African American, Hispanic, European American, or Asian American. After experimentally inducing a state of self-objectification by having participants wear a bathing suit, men and women of every ethnicity experienced lower self-esteem and increased body shame than those in the control condition.

Consistent with results of investigations using experimental designs, cross-sectional research also supports the role of self-objectification in women's body image and disordered eating. Research indicates that higher body surveillance is associated with greater body dissatisfaction and increased disordered eating (e.g., Forbes et al., 2006; McKinley, 1996; McKinley, 2006; Moradi et al., 2005). For example, in a study of college women, men, and their middle-aged mothers (ages 38-58), McKinley (2006) found that body surveillance and body shame were negatively correlated with body esteem for both college-aged men and women. In a study of female college students, Tylka and Hill (2004) found that body surveillance predicted unique variance in body shame using structural equation modeling (SEM) analyses. Finally, in a sample of predominantly White college women, Noll and Frederickson (1998) tested a mediational model of disordered eating by having participants complete self-report questionnaires assessing self-objectification, body shame, symptoms of anorexia nervosa and bulimia nervosa, and dietary restraint. Findings from this study indicated that body shame partially mediated the relationship between self-objectification and eating pathology such that self-objectification was related to greater body shame, which in turn led to greater disordered eating, after controlling for BMI.

Findings from varied populations provide further evidence for the role of self-objectification in the development of eating pathology. Tiggemann and Slater (2001) instructed 50 former students of classical ballet and 51 undergraduate psychology students to complete self-report measures of self-objectification, surveillance, and disordered eating. For both samples of women, body shame mediated the relationship between self-objectification and disordered eating. These findings have been replicated in a sample of Australian, adolescent girls (Slater & Tiggemann, 2002), in which appearance anxiety and body shame both partially mediated the relationship between self-objectification and eating disorder symptomatology. Furthermore, Tiggemann and Lynch (2001) found developmental trends in these relationships such that, in a sample of women ranging from ages 20-84, body shame was a stable correlate of self-objectification. Similarly, in a sample of physically active ( $n = 115$ ) and sedentary ( $n = 70$ ) women, self-objectification directly and indirectly (via body shame and appearance anxiety) predicted disordered eating in both groups of women (Greenleaf & McGreer, 2006). Moreover, women high in self-objectification reported higher levels of body surveillance, body shame, appearance anxiety, and self-reported disordered eating attitudes.

**Sexual Dysfunction.** Objectification theory posits that shame and anxieties associated with the body may carry over into the context of sexual activity. Constant body surveillance consumes mental energy, which leaves fewer mental resources for concentrating on sexual activity. Several studies using an objectification theory framework to examine the role of body surveillance and body shame in the sexual functioning of women suggest that body shame is associated with fewer and less

satisfying sexual experiences, decreased sexual satisfaction, and decreased sexual functioning (Calogero & Thompson, 2009; Faith, Cash, Schare, & Hangen, 1999; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Steer and Tiggemann (2008) were the first researchers to test a complete model of objectification theory as it applies to women's sexual functioning. In their seminal study, 116 undergraduate women completed self-report measures of self-objectification, body image self-consciousness during sexual activity, and sexual functioning. Path analysis results were consistent with predictions: self-objectification and surveillance were directly related to body shame and appearance anxiety, which were related to greater self-consciousness during sexual activity and decreased sexual functioning. Notably, self-consciousness during sexual activity was shown to fully mediate the relationship between both body shame and appearance anxiety and general sexual functioning.

A small body of subsequent research is consistent with results linking self-objectification to body image concerns during sexual functioning and decreased sexual functioning. In a study of heterosexual men and women ages 17-71, Sanchez and Kiefer (2007) used structural equation modeling to test whether adult men and women's body shame was linked to greater sexual problems (i.e., lower sexual arousability and ability to reach orgasm) and less pleasure from physical intimacy. Results indicated that the relationship between body shame and sexual pleasure and problems was mediated by sexual self-consciousness during physical intimacy. Furthermore, men and women's body shame was related to greater sexual self-consciousness, which predicted lower sexual pleasure and sexual arousability when controlling for relationship status and age.



Researchers have also investigated objectification variables as they relate to other areas of women's sexual experience. In a study investigating the relationships between objectification, disordered eating, and the sexual wellbeing of British and American college women, Calogero and Thompson (2009) found that sexual self-esteem was negatively correlated with self-objectification and body shame. Furthermore, path analysis results indicated that self-objectification led directly to body shame, which was directly linked to sexual self-esteem. Overall, women in their sample who reported higher self-objectification also reported lower sexual esteem. Finally, in an experimental investigation, Roberts and Gettman (2004) found that women primed with objectification-related words self-reported that the physical aspects of sex were significantly less appealing than women who were primed with body competence words.

### **Summary**

Extant research supports the predictions put forth by objectification theory as it applies to eating pathology and sexual functioning in women. Specifically, substantial research indicates that body shame mediates the relationship between self-objectification and disordered eating. Several studies also indicate that body shame mediates the relationship between self-objectification and body concerns during sexual activity. The few studies investigating the role of body surveillance and body shame in the sexual functioning of women suggest that body shame is associated with decreased sexual functioning and sexual satisfaction. Furthermore, body concern during sexual activity appears to mediate the relationship between self-objectification variables and sexual functioning.

### **Additional Variables that May Influence Women's Sexual Experience**

Many additional variables may influence the relationships between self-objectification, body image concerns, and women's sexual health. Both body image and sexual functioning are multidimensional constructs that are influenced by intrapsychic and environmental factors. As such, three factors that warrant further commentary include relationship status, body mass, and age.

### **Relationship Status**

Sexual activity mostly takes place in the context of a relationship; therefore, relationship status may play a significant role in women's sexual experiences. Some authors argue that the relational context should be taken into account when considering women's sexual problems (Byers, 2002) and a large body of literature provides evidence that relationship factors are an important determinant of women's sexual functioning (e.g., McCabe, 1991; Oberg & Fugl-Meyer, 2005; Witting et al., 2008). Not only does the availability of a partner influence sexual expression and sexual frequency, but research also indicates that women place greater emphasis on committed relationships as a context for sexual behaviors than do men (e.g., Peplau, 2003). For example, Rosen and colleagues (1993) surveyed 329 women in an outpatient gynecological clinic, ranging in age from 18-73. In this sample, single women reported greater incidence of sexual problems than those in a primary relationship, and relationship status was a significant predictor of sexual satisfaction. Furthermore, in a sample of women ages 18-92, Herbenick and colleagues (2010a) found that being in a partnered relationship was associated with greater frequency of sexual behaviors, including intercourse and oral sex.

Extant research also suggests that being in a relationship may influence women's self-consciousness during sexual activity. Theoretically, women who have serious body

image concerns may avoid sexual activity, and thus avoid dating and sexual relationships with men (e.g., Faith & Schare, 1993). Additionally, women who are in a partnered relationship may become less concerned about their appearance during sexual activity by habituating to their partner (Wiederman, 2000). In support of this hypothesis, Steer and Tiggemann (2008) found that participants in an exclusive relationship had significantly lower levels of self-consciousness during sexual activity than participants currently not in a relationship. Similarly, Wiederman (2000) found that undergraduate women who were not in a relationship reported higher levels of self-consciousness during sex than those who were in a relationship. Likewise, in a sample of 322 heterosexual men and women, Sanchez and Kiefer (2007) found that relationship status predicted self-consciousness during sexual activity and orgasm difficulty, such that both men and women who were not currently in a relationship reported greater self-consciousness and orgasm difficulty than those involved in a romantic relationship. Conversely, being in a relationship was associated with less self-consciousness during sexual activity and less orgasm difficulty for both men and women. Meana and Nunnink (2006) also found that relationship status was predictive of appearance-based distraction during sexual activity for both men and women, such that women and men who reported being in a relationship reported less appearance-based distraction than those who were not in a relationship.

Overall, relationship factors appear to contribute significantly to women's sexual functioning. Research indicates that relationship status affects women's body image during sexual activity, such that women who are not in a relationship appear to experience more body self-consciousness during sexual activity than women who are in a relationship. Furthermore, being in a relationship may influence women's sexual

functioning such that women who are not in a relationship may have less frequency of sexual activity, report less sexual satisfaction, and report more sexual problems than women who are in a relationship.

### **Body Mass Index (BMI)**

Research consistently suggests that body mass index (BMI) is strongly associated with women's body image experiences in collegiate and community samples (e.g., Pingitore, Spring, & Garfield 1997; Presnell, Bearman, & Stice, 2004; Stice & Whitenton, 2002). Theoretically, women with larger body masses deviate from mainstream Western cultural ideals of beauty that emphasize thinness, youth, and sex appeal. As such, they likely experience higher levels of dissatisfaction and anxiety regarding their body weight and shape because of internalized, negative societal messages about weight and weight-based discrimination (e.g., Presnell, et al., 2004). For example, in a sample of adolescent girls, Presnell, Bearman, and Stice (2004) found that increased BMI was associated with increased body dissatisfaction. Similarly, in a sample of 320 college men and women, Pingitore and colleagues (1997) found that satisfaction with body weight and shape decreased as BMI increased for both sexes. Furthermore, as BMI increased, women (only) attributed more importance to weight and shape to their self-esteem.

Despite these compelling data on body image and weight, the relationship between BMI and women's sexual functioning is not well understood to date. Several studies provide evidence for a relationship between BMI and women's sexual functioning (e.g., Wiederman & Hurst, 1998; Ackard et al., 2000), while others demonstrate evidence to the contrary (e.g., Cash et al., 2004; Pujols et al., 2009; Weaver & Byers, 2006). For

example, in a sample of 232 college-aged women, Wiederman and Hurst (1998) found that women with higher BMIs were less likely to be in a dating relationship, have experienced intercourse, or to have received oral sex. Conversely, BMI was not associated with sexual attitudes, lifetime number of sexual intercourse partners among those who had experienced intercourse, sexual esteem, or self-evaluation as a sexual partner. Similarly, in a sample of 3,267 *Shape* magazine readers, BMI was negatively associated with frequency of sexual intercourse such that increased BMI was associated with less frequency of sexual intercourse (Ackard et al., 2000). However, in this sample, BMI did not predict one's comfort undressing in front of her partner or frequency of initiating sex. Moreover, in a study investigating body image and sexual functioning in heterosexual college women, Weaver and Byers (2006) found that women with higher BMIs were more dissatisfied with their bodies and more likely to avoid certain situations that involve focus on the body because of their body image concerns. However, BMI was not significantly associated with any of the sexual functioning variables measured (i.e., sexual assertiveness, sexual arousability, sexual esteem, sexual problems).

Despite these equivocal data, some preliminary research suggests that BMI may influence contextual body concerns during sexual activity. In a community sample of 159 women involved in a dating relationship (ages 18-49), Pujols and colleagues (2009) found that BMI was not significantly correlated with sexual functioning, but was correlated with appearance-based cognitive distraction during sexual activity and body esteem such that women with higher BMI experienced more cognitive distraction during sexual activity and decreased body esteem. Similarly, in a sample of college students, Cash, Maikkula, and Yamamiya (2004) found that BMI was not directly associated with

sexual functioning, but was modestly associated with body image variables, such that heavier persons reported somewhat more anxious/avoidant body focus during sexual activity and body dissatisfaction.

Overall, extant literature indicates that BMI is a significant predictor of women's body image (both dispositional and contextually-specific). Although the results are mixed, preliminary research suggests that BMI is not directly associated with sexual functioning beyond its association with sexual frequency. Findings suggest that BMI may play a role in women's sexual experience to the extent that it influences body image concerns during sexual activity.

### **Age**

The vast majority of the literature investigating eating pathology and sexual functioning in women has focused on traditional college-aged samples between the ages of 18 and 24 (Cash et al., 2004; Calogero & Thompson, 2009; Steer & Tiggemann, 2008; Yamamiya et al., 2006). This may be, in part, due to the convenience of using college samples for research. However, it is also because body image research is particularly relevant for this age range because young women are at high risk for developing eating pathology (Stice, 2002). Theoretically, because the ideal feminine body is youthful, young women may feel increased pressure to match the cultural ideal. Furthermore, mass media play a powerful role in communicating cultural beauty standards to women. Consequently, research demonstrates that exposure to media is directly linked to a variety of harmful body-related consequences, such as body dissatisfaction (see Grabe, Ward, and Hyde, 2008 for a review). Notably, images of the ideal female body are publicized in Western media outlets that are typically aimed at adolescents and young adult women

(e.g. Cusumano & Thompson, 1997). As a result, college-aged women are often exposed to objectifying messages that promote the cultural standards of beauty and potentially lead to negative body image experiences.

Existing research suggests that body image concerns vary by age (e.g., Augustus-Horvath & Tylka, 2009). Thus, one limitation to research that investigates body image in college women is that the results cannot be generalized to older women. Typically, as women age, they move farther away from the young, thin ideal. For instance, on average, women gain approximately 10 pounds of body fat per decade, change shape, and lose skin elasticity (Andres, 1989). As a result, older women may be more shameful of their bodies as they divert from the prototypical ideal. Recent research demonstrates that women in their 30s and 40s report lower satisfaction with their bodies and more frequent attempts to conceal their bodies than younger women (ages 18-29; Davison & McCabe, 2005). However, other researchers have found that body dissatisfaction remains relatively stable across the life span (e.g., Tiggemann & Lynch, 2001).

Research investigating objectification theory constructs in women over the age of 25 is limited, and findings are inconclusive. Some studies indicate that older women experience less self-objectification than college-aged women (e.g., Greenleaf, 2005; McKinley, 1999; Tiggemann & Lynch, 2001), while others have not found any age differences (e.g., Hill, 2003). Furthermore, some studies show that older women report less body shame than young adult college women (Deeks & McCabe, 2001; Greenleaf, 2005; McKinley, 1999), while others have not found such differences (Tiggemann & Lynch, 2001; Webster & Tiggemann, 2003). For example, Augustus-Horvath and Tylka (2009) examined an objectification theory model in two age groups of women: ages 25-

68 ( $n = 330$ ) and 18-24 ( $n = 329$ ). Their findings indicated that women in the older age group reported less body surveillance than the college-aged women and reported similar levels of body shame as younger women. Similarly, Tiggemann and Lynch (2001) also found in a sample of 322 women ranging in age from 20-84, that reported levels of body shame for older and younger women were similar, but that older women reported less body surveillance than younger women.

Age may also influence sexual functioning and satisfaction in women. For instance, results from a population-based survey of U.S. women ages 18 and older indicated that overall, for women, sexual problems increase with age (Shifren et al., 2008). Relatedly, Rosen and colleagues (1993) surveyed 329 women in an outpatient gynecological clinic, ranging in age from 18-73. Findings from this study indicated that age was a significant predictor of sexual satisfaction and functioning, with older women reporting higher incidence of sexual problems than younger women and less sexual satisfaction. More specifically, findings suggested that younger women have higher desire for sexual intercourse and fewer problems with lubrication during intercourse than older women (Rosen et al., 1993). Furthermore, findings from Herbenick and colleagues' (2010b) survey of 3,990 women and men ages 18-94 indicated that problems with women's lubrication were positively associated with age. In a similar study of women's sexual behaviors, Herbenick et al. (2010a) found that sexual behavior was less frequent among older women.

In sum, body image disturbance and sexual functioning are particularly important issues for college-aged women. Research indicates that college-aged women are at high risk for developing eating pathology and may experience increased objectification and



pressure to match the cultural ideal. Although findings in this population are difficult to generalize to women of other ages due to potential differences in body image, objectification experiences, and sexual functioning and satisfaction, studying these constructs in college-aged women is critical for guiding prevention and intervention efforts for this population.

### **Study Objectives**

Given the importance of sexual satisfaction for women's overall happiness and wellbeing, understanding the psychological and contextual factors that contribute to women's sexual satisfaction has important implications for prevention and treatment efforts aimed at ameliorating women's mental health. Despite compelling findings suggesting that objectification theory is a viable model for understanding the body image and sexual functioning of women, few studies apply the tenets of objectification theory to the study of women's sexual experience (e.g., Calogero & Thompson, 2009; Steer & Tiggemann, 2008). More research is necessary to elucidate the role of self-objectification and contextual body image in women's sexuality. Furthermore, most researchers fail to incorporate important contextual factors in their models of female sexual functioning, including body mass index and relationship status. Finally, the few studies that investigate self-objectification, body image, and sexual functioning in women examine their relationships in homogenous samples of predominantly White women, limiting the generalizability of their findings.

To build on existing research, the overarching goal of this study was to examine the negative effects of self-objectification on women's sexual experience in an ethnically diverse sample of female college students. Specifically, the study investigated the

relationships between body surveillance, body shame, body self-consciousness during sexual activity, and sexual satisfaction in an ethnically representative sample of female college students using path analysis (see Figure 2). Consistent with previous research, I conceptualized body surveillance in the present study as a cognitive and behavioral manifestation of self-objectification (Slater & Tiggemann, 2010; Steer & Tiggemann, 2008; Tiggemann & Lynch, 2001; Tiggemann & Slater, 2001). The specific study hypotheses were as follows:

Hypothesis 1: The model proposed in Figure 2 would fit the data, with all specified paths yielding statistically significant explanatory variance.

Hypothesis 2: Body shame would partially mediate the link between body surveillance and body self-consciousness during sexual activity.

Hypothesis 3: Body self-consciousness during sexual activity would fully mediate the relationship between body shame and sexual satisfaction.

## CHAPTER 3

### METHODOLOGY

#### **Participants**

Participants were recruited from the Psychology Department Subject Pool at University of Nevada, Las Vegas (UNLV) and awarded research credit for their participation. To participate in the study, women needed to be between age 18 and 24; endorse being predominantly heterosexual; and report that they were sexually active. A final sample of 403 women completed study questionnaires, which exceeds the minimum number of cases of 160 required to estimate the proposed model as determined by the conservative cases-to-parameter ratio of 10 participants for each model parameter estimated (Hu & Bentler, 1999). Of the study sample, 41% ( $n = 151$ ) self-identified as White or European American, 27.2% as Hispanic ( $n = 100$ ), 20.1% as Asian American ( $n = 74$ ), 11.7% as African American ( $n = 43$ ), 6.3% as Other ( $n = 23$ ), and 3.3% as Native American ( $n = 12$ ). Seven participants did not provide their primary ethnic identification.

#### **Procedure**

Participants completed all study measures through an online computerized data collection system (Qualtrics). Participants received a website link that directed them to an online battery of questionnaires that took approximately an hour to complete. A description of the study and the contact information of the research investigators appeared on the website. Willing participants then provided informed consent before completing any study measures.

To ensure participants were attending to the questionnaire content, I embedded three validity questions in the questionnaire battery to ensure participants were not

randomly responding or being inattentive (e.g., “Please answer [highest rating possible] if you are paying attention.”). Any participants who failed any of the validity items were not included in data analyses ( $n = 35$ ). Participants were free to complete the study material at their convenience through any access point to the Internet.

## **Measures**

### **Demographics**

Participants completed a demographic questionnaire to measure self-identified gender, age, ethnicity, weight, and height. This information was used to calculate the body mass index (BMI;  $\text{kg/m}^2$ ) of each participant. Additionally, Kinsey’s Heterosexual-Homosexual Rating Scale (Kinsey, Pomeroy, & Martin, 1948) measured self-identified sexual orientation. This scale ranges from 0 (exclusively heterosexual) to 6 (exclusively homosexual), with scores of 1-5 for those who identify themselves with varying levels of desire or sexual activity with either sex.

### **Relationship status**

Participants provided information on their relationship status. In particular, they were asked to define their relationship status from the following options: (a) not dating anyone currently, (b) casually dating one or more people, (c) dating one person exclusively, (d) living with romantic partner, (e) engaged or planning to marry, (f) married, or (g) other. If participants selected the “other” option, they were prompted with a text box to describe their relationship status in their own words. Relationship status was dummy coded such that 1 = in an exclusive relationship, and 0 = not in an exclusive relationship.

### **Body surveillance**

The Surveillance subscale of The Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996) measured body surveillance. The Surveillance subscale measures the frequency with which participants monitor their physical appearance (e.g., “During the day, I think about how I look many times.”). The scale consists of eight items, which participants respond to on a 7-point scale from *strongly disagree* to *strongly agree* but have the option of responding *N/A* if the question does not pertain to them. Total scores on this subscale range from 8-56, with higher scores indicating higher levels of body surveillance. In a study of undergraduate women, McKinley and Hyde (1996) demonstrated adequate test-retest reliability over a 2-week period ( $r = .79$ ) and internal consistency reliability ( $\alpha = .89$ ) of this subscale. In the current sample, Cronbach’s alpha was .79.

### **Body shame**

The Body Shame subscale of The Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996) measured body shame. This subscale measures the extent to which a participant experiences shame if she does not meet cultural body standards (e.g., “I feel like I must be a bad person when I don’t look as good as I could.”). This subscale consists of eight items, which are rated in the same manner as the Surveillance subscale described previously. Possible scores range from 8-56, with higher scores indicating higher levels of body shame. McKinley and Hyde (1996) demonstrated adequate internal consistency ( $\alpha = .75$ ) and test-retest reliability ( $r = .84$ ) of this subscale over a 2-week period in a sample of young adult women. Cronbach’s alpha for the current sample was .83.

### **Body self-consciousness during sexual activity**

The Body Exposure during Sexual Activities Questionnaire (BESAQ; Hangen & Cash, 1991) measured the construct of body self-consciousness during sexual activity. The BESAQ is a 28-item measure of an anxious attentional focus on and avoidance of body exposure during sexual activities. Items are scored on a 5-point frequency scale from *never* (0) to *always* (4). Items that reflect positive body image experiences during sexual activity are reverse scored. Total scores are calculated, with higher scores reflecting increased self-consciousness and avoidance. Research by Cash and colleagues (2004) indicates the BESAQ has strong internal consistency reliability ( $\alpha = .96$ ) and validity in college samples of women. Cronbach's alpha for the current sample was .97.

### **Sexual satisfaction**

The Sexual Satisfaction Survey for Women (SSS-W; Meston & Trapnell, 2005) measured sexual satisfaction. This 30-item self-report measure includes five domains of sexual wellbeing: contentment, communication, compatibility, personal concern, and relational concern. Participant's rate items from *strongly disagree* (5) to *strongly agree* (1). Items are summed to comprise a total score, with higher scores indicating higher levels of sexual satisfaction. This scale demonstrated excellent reliability (Cronbach's  $\alpha = .94$ ) and construct validity in samples of women with and without sexual dysfunction (Christopher, 1999). Cronbach's alpha for the current sample was .94.

### **Data Analyses**

Prior to analyses, I examined the data to determine whether they were normally distributed. Visual examination of normal Q-Q plots, skewness, and kurtosis statistics indicated that sample data were generally normally distributed on all outcome variables with no severe violations. Missing data were removed using listwise deletion. In addition

to calculating basic descriptive information (including mean values of and bivariate correlations between body surveillance, body shame, body self-consciousness during sexual activity, BMI, and sexual satisfaction), I tested the primary study hypotheses (see Figure 2) through path analysis using the EQS 6.1 program. To test Hypothesis 1, I examined path coefficients and tested the fit of the proposed model presented in Figure 2. Only participants that responded to all indicators were included in these analyses ( $n = 305$ ). Despite this reduction in participants, the remaining sample still exceeded the minimum number of participants necessary to test the proposed model (i.e.,  $N = 160$ ). Total scores on the measures served as the observed variables in the model using the Maximum Likelihood method of estimation. Adequacy of model fit to the data was determined by three indexes recommended by Hu and Bentler (1999) and provided by the EQS program. According to Hu and Bentler: values greater than .95 on the comparative fit index (CFI), values lower than .08 on the standardized root-mean square residual (SRMR), and values lower than .06 on the root mean square error of approximation (RMSEA) indicate a good fit, whereas values of .90-.94 for CFI, .07-.10 for RMSEA, and .09-.10 for SRMR indicate an acceptable fit.

In order to test Hypotheses 2 and 3, I conducted two sets of linear regressions following Baron and Kenny's (1986) procedures. According to Baron and Kenny (1986), for a variable to be tested as a mediator, the predictor, mediator, and criterion variables must all be significantly related. According to these authors, mediation occurs when the effect of the predictor variable on the criterion variable is reduced (partial mediation) or no longer significant (full mediation) after controlling for the mediating variable.

Additionally, I conducted Sobel tests to determine whether decreases in beta values were significantly different, thus indicating mediation (Sobel, 1982).



## CHAPTER FOUR

### RESULTS

#### **Descriptive Information: Bivariate Correlations and Means of Outcome Variables**

Means (SDs) and bivariate correlations between BMI, body surveillance, body shame, body self-consciousness during sexual activity, and sexual satisfaction appear in Table 1. Participants in this study were about 19 years old ( $M_{\text{age}} = 19.13$ ,  $SD = 1.52$ , range 18-24) and of average weight ( $M_{\text{BMI}} = 22.68$ ,  $SD = 3.91$ , range 15.68-36.31). Over half of the sample reported being in an exclusive relationship (57.9%,  $n = 213$ ).

Table 1

*Pearson  $r$  Correlations and Means (SDs) of Outcome Variables*

	Mean (SD)	1	2	3	4	5
1 BMI	22.68 (3.91)	-				
2 SSSW	89.00 (19.89)	-.06	-			
3 OBCS-SURV	37.97 (8.85)	.08	-.13*	-		
4 OBCS Shame	26.11 (10.91)	.30**	-.19**	.46**	-	
5 BESAQ	40.80 (27.12)	.24**	-.48**	.41**	.51**	-

*Note.* BMI = Body Mass Index; SSSW = The Sexual Satisfaction Scale for Women;

OBCS-SURV = Surveillance subscale of the Objectified Body Consciousness Scale;

OBCS-SHAME = Body Shame subscale of the Objectified Body Consciousness Scale;

BESAQ = Body Exposure during Sexual Activities Questionnaire.

\* $p < .05$ ; \*\* $p < .01$ .

Bivariate correlations indicated that body surveillance was significantly positively correlated with body shame and body self-consciousness during sexual activity; and negatively correlated with sexual satisfaction. Body shame was also significantly

positively correlated with BMI and body self-consciousness during sexual activity.

Additionally, body self-consciousness during sexual activity was positively correlated with BMI; and was negatively correlated with sexual satisfaction.

### **Path Analysis**

To test the primary study hypotheses, I tested the path model presented in Figure 2 to determine the relationships between the observed variables: body surveillance, body shame, body self-consciousness during sexual activity, sexual satisfaction, BMI, and relationship status. Consistent with Hypothesis 1, the original model provided an acceptable fit to the data, accounting for 30% of the variance in women's sexual satisfaction: CFI = .952, RMSEA = .124, SRMR = .056. Standardized path coefficients between all observed variables appear in Figure 3. Contrary to hypotheses, the paths between BMI and body surveillance, body self-consciousness during sexual activity, and sexual satisfaction were not significant ( $p > .05$ ).

To improve model fit, I created a trimmed model in which BMI was taken out as a predictor of body surveillance, body self-consciousness during sexual activity, and sexual satisfaction, due to evidence that these paths were not significant in the original model. Results indicated that the trimmed model fit the data better (CFI = .987, RMSEA = .072, and SRMR = .034) and that all model paths were statistically significant ( $p < .05$ ). Overall, the model accounted for 31% of the variance in women's sexual satisfaction. Standardized path coefficients between all observed variables appear in Figure 4.

### **Mediation**

To test whether body shame and/or body self-consciousness during sexual activity served as mediators, I conducted mediational analyses. As shown in Table 1, the

preconditions for conducting meditational analyses were met (Baron & Kenny, 1986): All proposed predictor, mediator, and criterion variables were significantly related to one another. Consequently, I conducted two sets of linear regressions to examine the hypothesized meditational relationships. First, body surveillance was entered into a regression equation predicting body self-consciousness during sexual activity, which indicated that it was a significant predictor ( $\beta = .410, p < .01$ ). When body surveillance and body shame were entered together into a regression equation predicting body self-consciousness during sexual activity, the beta value for body surveillance decreased significantly from when it was entered on its own, but remained significant ( $\beta = .224, p < .01$ ). Results of a Sobel test indicated that this reduction was statistically significant ( $z = 6.10, p < .001$ ). In other words, results suggested that body shame partially mediated the relationship between body surveillance and body self-consciousness during sexual activity.

In the second regression, body shame significantly predicted sexual satisfaction when entered into a regression equation on its own ( $\beta = -.189, p < .01$ ). After controlling for body self-consciousness during sexual activity, only body self-consciousness during sexual activity was a significant predictor of sexual satisfaction ( $\beta = -.532, p < .01$ ; OBCS shame =  $\beta = .096, p > .10$ ). Results of a Sobel test indicated that this reduction was statistically significant ( $z = -6.97, p < .001$ ). These data suggested that body self-consciousness fully mediated the relationship between body shame and sexual satisfaction, as there was no significant direct effect of body shame on sexual satisfaction when controlling for body self-consciousness during sexual activity.

In sum, data from Figure 4 and mediation analyses suggest that, when controlling for relationship status and BMI, body shame partially mediated the relationship between body surveillance and body self-consciousness during sexual activity. In turn, body self-consciousness during sexual activity predicted decreased sexual satisfaction.

## CHAPTER FIVE

### SUMMARY, DISCUSSION, AND CONCLUSIONS

The present study aimed to address limitations in extant literature by using the tenets of objectification theory to examine the relationship between body image and sexual functioning in an ethnically diverse sample of female college students. As hypothesized, when controlling for body size and relationship status, body surveillance predicted increased body shame; body shame partially mediated the link between body surveillance and increased body self-consciousness during sexual activity; and body self-consciousness during sexual activity fully mediated the relationship between body shame and decreased sexual satisfaction. Specifically, model fit was adequate in the original model, accounting for 30% of the variance in college women's sexual satisfaction. After slightly revising the model by removing BMI as a predictor of body surveillance, body self-consciousness during sexual activity, and sexual satisfaction, it improved model fit and accounted for an additional 1% of the variance in sexual satisfaction.

These results yield at least four key findings that have important implications for clinical practice and research. First, these data are consistent with existing research highlighting a negative relationship between the psychological consequences of self-objectification (i.e., body surveillance and body shame) and women's sexuality (Calogero & Thompson, 2009; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008); and generally lend support for using the tenets of objectification theory to understand women's sexual satisfaction and body image (Frederickson & Roberts, 1997). Specifically, in the current study, body surveillance and body shame contributed to increased self-consciousness in the context of sexual activity, which predicted decreased sexual satisfaction for women.

This is similar to the results of Calogero and Thompson's (2009) study, in which researchers found that one-third of the variance in British college women's sexual satisfaction was explained by their objectification model, in which body surveillance led to increased body shame, which led to decreased sexual satisfaction.

Second, this study offers important data on mediating factors that influence the relationship between self-objectification and sexual satisfaction. Few studies have explicitly examined the underlying processes linking body concerns and women's sexual experiences (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Findings from this study suggest that body shame partially mediates the relationship between body surveillance and body self-consciousness during sexual activity. In other words, women who monitor their appearance more frequently experience higher levels of body shame; and both body monitoring and shame contribute to increased body self-consciousness during sexual activities. These data are consistent with previous research linking body surveillance and body shame to increased body self-consciousness during sexual activity (Claudat, Warren, & Durette, 2012; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). For example, Claudat and colleagues (2012) found that body shame partially mediated the relationship between body surveillance and body self-consciousness during sexual activity in a sample of ethnically diverse female college students. Furthermore, the current study found that body self-consciousness during sexual activity fully mediated the relationship between body shame and sexual satisfaction. This is consistent with some previous research demonstrating that self-consciousness during sexual activity fully mediated the relationship between body shame and general sexual functioning for women and men (e.g., Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008).

Third, study results suggest it is important to account for relationship status when examining women's subjective sexual experiences. Path analysis results indicated that not being in an exclusive relationship was associated with decreased sexual satisfaction and increased body concerns during sexual activity. These findings are similar to previous research indicating that women who are not in a romantic relationship report greater sexual problems and higher levels of self-consciousness during sexual activity than those involved in an exclusive romantic relationship (e.g., Faith & Schare 1993; Meana & Nunnink, 2006; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008; Wiederman, 2000). Theoretically, some researchers suggest that this occurs because when in a committed relationship with someone, a woman may habituate to her partner and therefore become less concerned about her appearance during sexual activity (Wiederman, 2000). Future research should explore this possibility and examine specific protective factors associated with being in an exclusive relationship to guide interventions for women's sexual problems.

Finally, the present study highlights that it is important to carefully consider the influence of BMI when investigating women's body image and sexuality. Although the relationship between BMI and women's body image is well documented (e.g., Presnell et al., 2004; Stice & Whitenton, 2002), scant research exists examining the relationship between BMI and female sexuality. In this study, BMI was not significantly correlated with body surveillance. This is consistent with objectification theory because, regardless of body size, women are likely to engage in body surveillance as a cognitive behavioral manifestation of self-objectification. As such, surveillance serves as the mechanism through which a woman can monitor her appearance and compare herself to the cultural

body ideal. Furthermore, in the current study, BMI was modestly associated with body shame. This is also consistent with objectification theory and research indicating that if a woman perceives she fails to meet the thin ideal, body shame is the result (e.g., Presnell et al., 2004; Stice & Whitenton, 2002). Contrary to study hypotheses, BMI was not significantly predictive of body self-consciousness during sexual activity or sexual satisfaction. As such, BMI may play a role in women's sexual experience to the extent that it influences body image experiences, such as body shame (Cash et al., 2004; Pujols et al., 2009). Further research investigating the relationship between BMI and female sexuality is warranted.

Although the present study offers important contributions to the body image literature, it is not without its limitations. This study utilized retrospective self-report measures, which may limit the accuracy of participant recall. These data are also cross-sectional, which limits my ability to infer causal relationships among study variables. Future studies utilizing a longitudinal or experimental design are warranted to truly understand causal relationships between self-objectification experiences, body image in the context of sexual activity, and sexual satisfaction in women. Additionally, a significant amount of variance in women's sexual satisfaction remained unaccounted for using the proposed model. This is likely because the study model only accounted for factors relevant to women's body image experiences that may contribute to female sexual satisfaction. That said, future researchers may want to examine the relationships between objectification experiences, body image, sexual satisfaction, and additional factors that have been shown to affect female sexual satisfaction, such as physical health, quality of life, and relationship factors (e.g., relationship satisfaction, stability, and communication;



Byers, 2005; Litzinger & Gordon, 2005; Rosen & Bachman, 2008; Sprecher, 2002; Young, Denny, Luquis, & Young, 1998).

Other limitations exist surrounding the sample selected for the current study. This study examined body image and sexuality in heterosexual women ages 18-24. Consequently, these findings may not be generalizable to women of other age groups or sexual orientations. Finally, this study was conducted with an ethnically heterogeneous sample of college women in Las Vegas, Nevada. Although I believe it is a significant contribution to the literature to include such a diverse sample, as existing research examines these constructs in predominantly White, European American samples (e.g., Calogero & Thompson, 2009; Steer & Tiggemann, 2008), it is possible that ethnic differences would emerge in model fit if I had a large enough sample to test the model by ethnic group. Furthermore, geographically, these women live in a highly sexualized atmosphere. Therefore, women in this study may be exposed to objectification experiences more so than woman from other regions of the United States. Consequently, study findings must be replicated with women from other geographical reasons in order to test their generalizability.

Finally, the model tested in the present study was also limited. Although it is important to consider women's subjective sexual experiences, this study only examined one domain of women's sexual health—sexual satisfaction. Future researchers could examine other domains of women's sexual functioning (e.g., desire, orgasm) using a model based on the tenets of objectification theory in order to gain a better understanding of how objectification experiences influence female sexuality. Furthermore, path analysis was used in this study to test specific hypotheses regarding the relationships among study

variables in the path model. It is important to note that alternative models with different assumptions about the relationships among the observed variables may fit the data equally well.

Despite the limitations of the current research, the present study extended research in the area of objectification theory by testing a model examining body image and sexuality in an ethnically diverse sample of heterosexual women. Approaching women's sexual health from an objectification theory framework may be clinically useful, as it places women's sexuality in its cultural context. The APA's 2007 Guidelines for Psychological Practice with Girls and Women (APA, 2007) encourage psychologists to maintain up-to-date awareness of social forces and their interactions with gender in determining mental health. By gaining a better understanding of the effects of self-objectification on women's sexual health, clinicians may be better equipped to provide culturally competent clinical services to women. For example, clinicians may be better informed in considering how living in a culture that sexually objectifies women contributes to a client's presenting problems, and how the interventions they implement may serve to maintain or challenge the status quo that promotes the sexual objectification of women (Szymanski et al., 2011).

Although a growing body of literature links objectification experiences and women's sexual health, further research is warranted to identify how self-objectification may translate in the sexual behavior and beliefs of women. Preliminary research suggests that sexual objectification may negatively impact how a woman conceptualizes her sexuality and expectations about sexual roles (APA, 2010). For example, research suggests that women who are exposed to sexual objectification may be significantly more

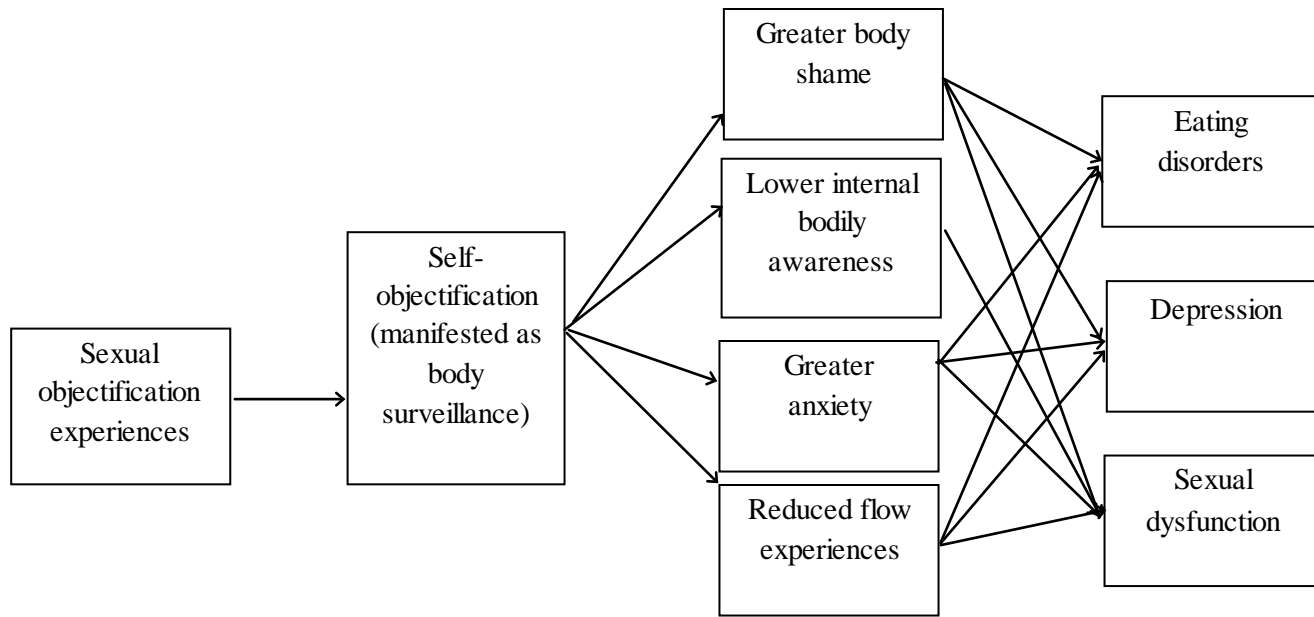
accepting of rape myths (such as the belief that women invite rape by engaging in certain behavior), sexual harassment, sex role stereotypes, interpersonal violence, and adversarial sexual beliefs about relationships (Kalof, 1999; Milburn, Mather, & Conrad 2000; Ward, 2002, as cited in APA, 2010). Further research in this area may be helpful in guiding prevention efforts and psychoeducational programs aimed at promoting healthy sexuality in women.

The current findings also highlight the importance of considering objectification experiences and body image when conceptualizing women's sexual problems in clinical contexts. Findings suggest that clinicians should assess for self-objectification experiences, body shame, and body surveillance when women present with concerns of sexual dissatisfaction (Szymanski, Carr, & Moffitt, 2011). For example, it may be important for clinicians to consider how living in a culture that sexually objectifies women influences clients and their sexuality. It may be useful for clinicians to encourage clients to examine how their culture and experiences with sexual objectification influence their body image and sexuality (Szymanski et al., 2011) in an effort to reframe their presenting problems by putting them into their sociocultural context (Worell & Remer, 2003 as cited in Szymanski et al., 2011).

Furthermore, due to their negative consequences, body surveillance, body shame, and body self-consciousness during sexual activity may be important intervention targets in clinical contexts with college women. Clinicians may be able to minimize the impact of sexual objectification on women's sexual satisfaction by implementing treatment strategies designed to address body surveillance, body shame, and body image concerns during sexual activity. For example, clinicians may help clients challenge the

internalization of unachievable standards of beauty, decrease how frequently a woman engages in body monitoring, and decrease the shame associated with not meeting the cultural body standard (Szymanski et al, 2011). Initial research suggests that cognitive behavioral strategies aimed at cognitive restructuring of one's body image, and techniques aimed to limit women's social comparisons of their bodies, may be useful in treatment settings to improve women's body image (Rubin, Nemeroff, & Russo, 2004; Williamson & Netemeyer 2000). Addressing women's body image concerns, particularly in the context of sexual activity, may in turn improve women's sexual satisfaction.

Finally, findings intimate that relationship factors are important to consider in the treatment of women's body image concerns and sexual dissatisfaction. The present findings underscore that being in an exclusive relationship may be associated with protective factors for body self-consciousness during sexual activity and sexual dissatisfaction. Furthermore, previous research suggests that romantic partners may be an important source of body image feedback for women (e.g., Tantleff-Dunn & Thompson, 1995). Thus, one clinical implication of such findings may be that clinicians could incorporate partners into the treatment of women's body image concerns during sexual activity. For example, Wiederman (2001) suggests that clients could be encouraged to engage their partner in conversation in nonsexual settings regarding client's appearance concerns. Clients could also be encouraged to use their partner's sexual arousal and response during sexual activity as feedback regarding the partner's perceptions of their bodies rather than to assume the partner's perception of them (Wiederman, 2001).



*Figure 1.* Objectification theory framework as proposed by Frederickson and Roberts (1997).

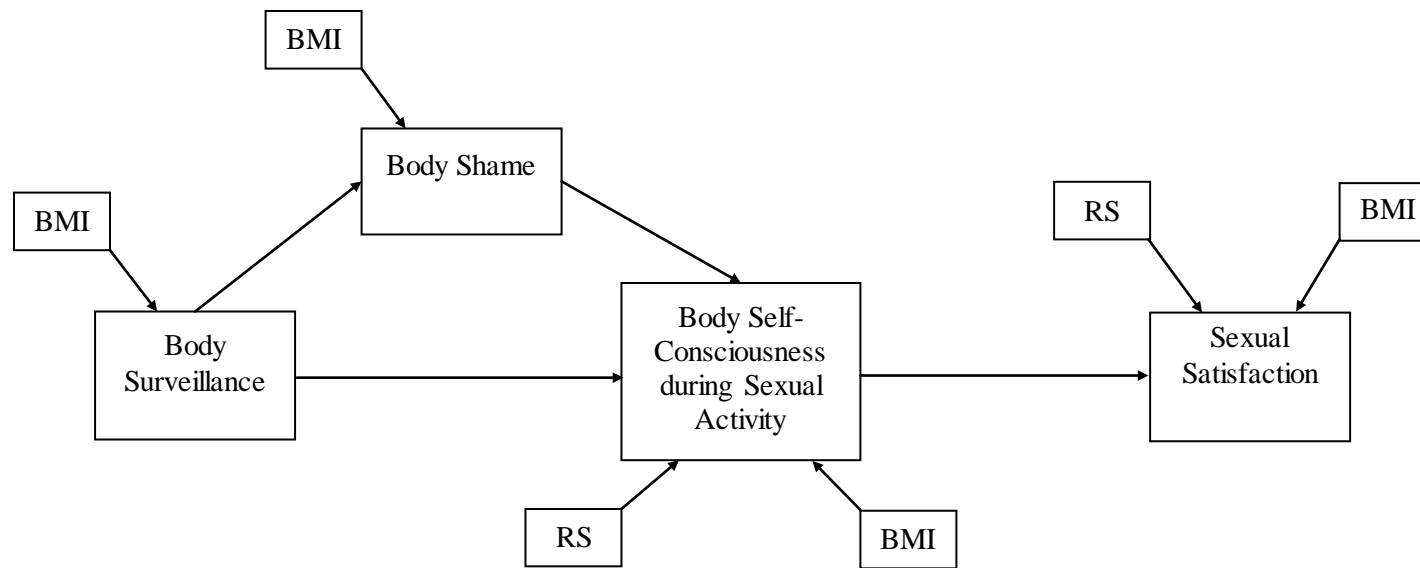


Figure 2. Hypothesized model tested in the present study.

Note. BMI = Body mass index; RS = Relationship status.

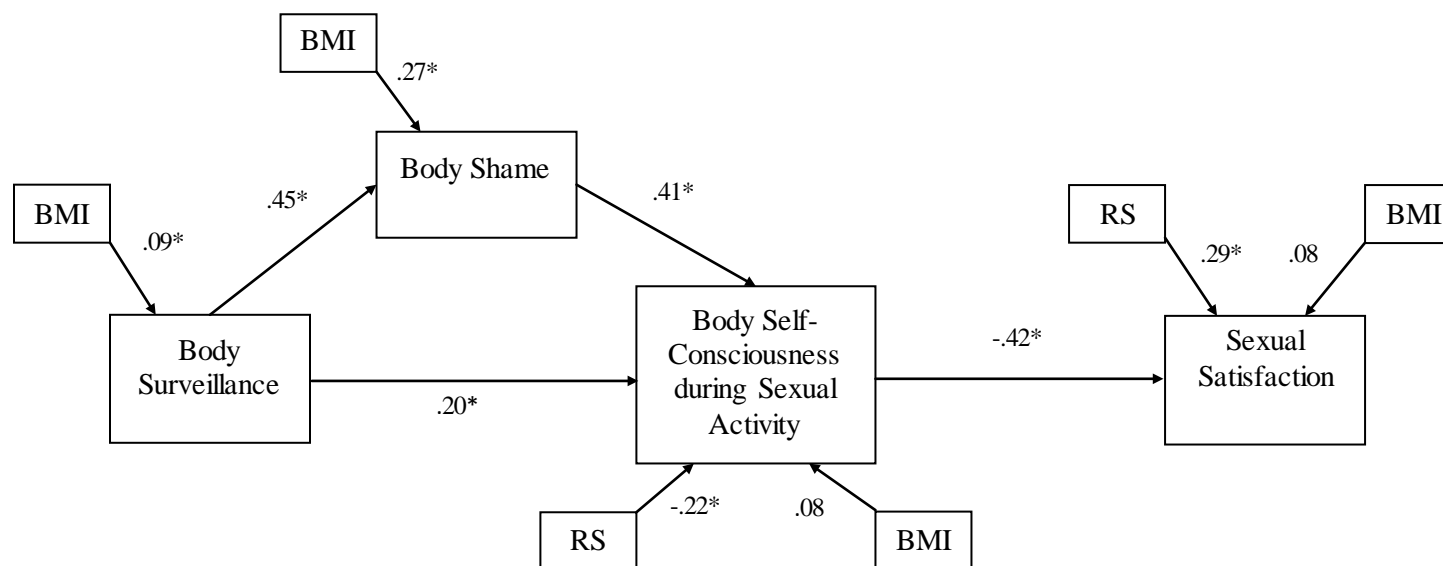


Figure 3. Original model with path coefficients.

*Note.* BMI = Body mass index; RS = Relationship status, 1 = in an exclusive relationship, 0 = not in an exclusive relationship; Body Surveillance = the Surveillance subscale of The Objectified Body Consciousness Scale; Body Shame = the Body Shame subscale of The Objectified Body Consciousness Scale; Body self-consciousness during Sexual Activity = The Body Exposure during Sexual Activities Questionnaire; Sexual Satisfaction = The Sexual Satisfaction Scale for Women.

\* $p < .05$

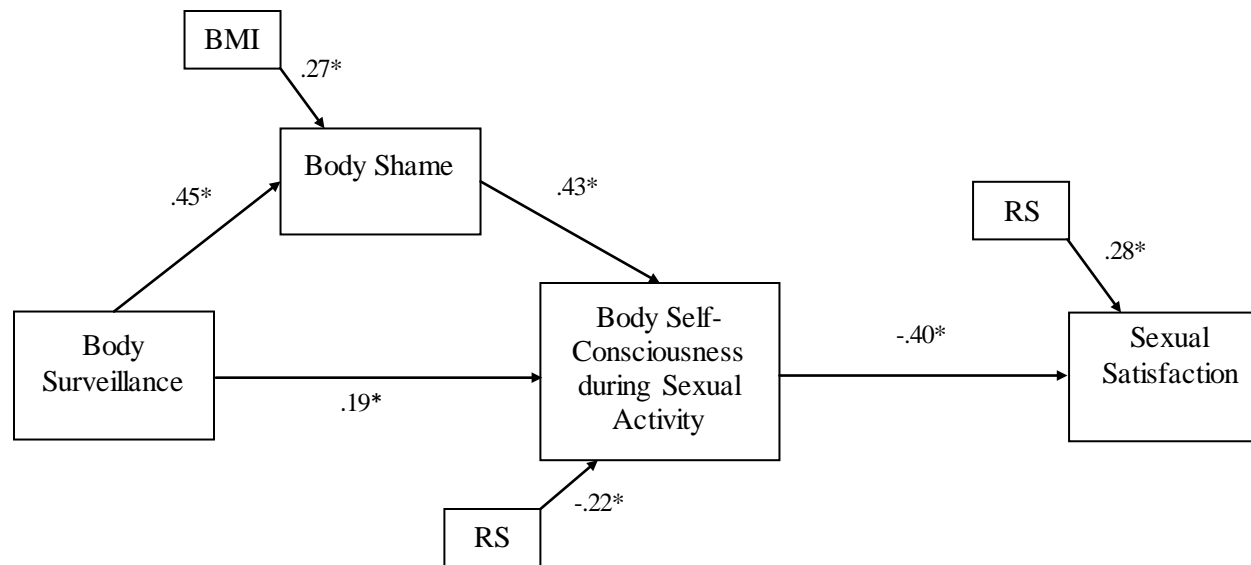


Figure 4. Trimmed model with path coefficients.

*Note.* BMI = Body mass index; RS = Relationship status, 1 = in an exclusive relationship, 0 = not in an exclusive relationship; Body Surveillance = the Surveillance subscale of The Objectified Body Consciousness Scale; Body Shame = the Body Shame subscale of The Objectified Body Consciousness Scale; Body self-consciousness during Sexual Activity = The Body Exposure during Sexual Activities Questionnaire; Sexual Satisfaction = The Sexual Satisfaction Scale for Women.

\* $p < .05$



## APPENDIX 2

### FORMS

#### Demographic Items

1. What is your age?
2. What is your gender?
  - a. Female
  - b. Male
  - c. Transgender
3. What is your current height?
4. What is your current weight?
5. What is your race?
  - a. White
  - b. Black
  - c. Asian
  - d. Hispanic/Latino
  - e. Native American
  - f. Other (please specify)
6. What is your ethnicity?
  - a. Euro-American (e.g., Irish, English, Scottish, French, Italian)
  - b. African American (e.g., African)
  - c. Hispanic/Latino (e.g., Mexican, South American, Puerto Rican)
  - d. Asian American/Pacific Islander (e.g., Chinese, Japanese, Indonesian)
  - e. Native American
  - f. Other (please specify)
7. What is your marital status?
  - a. Never married
  - b. Married
  - c. Separated
  - d. Divorced
  - e. Widowed
8. Do you have any children?
  - a. If yes, how many?
9. What is the highest education level you have completed?
  - a. Did not complete high school
  - b. Did not graduate from high school but obtained a GED
  - c. High school diploma
  - d. Some college (at least 1 year)
  - e. Degree from a 2 year college
  - f. Degree from a 4 year college

- g. Some graduate school (at least 1 year)
- h. Completed post-graduate degree

### Kinsey's Heterosexual-Homosexual Rating Scale

Using the following scale, please indicate your sexual identity:

- 0- Exclusively heterosexual
- 1- Predominantly heterosexual, only incidentally homosexual
- 2- Predominantly heterosexual, but more than incidentally homosexual
- 3- Equally heterosexual and homosexual
- 4- Predominantly homosexual, but more than incidentally heterosexual
- 5- Predominantly homosexual, only incidentally heterosexual
- 6- Exclusively homosexual

## Relationship Status

Please describe your relationship status.

- ☐ Not dating anyone currently
- ☐ Casually dating one or more people
- ☐ Dating one person exclusively
- ☐ Living with romantic partner
- ☐ Engaged or planning to marry
- ☐ Married
- ☐ Other
  - Please describe your relationship status

### Objectified Body Consciousness Scale (OBCS)

Please choose the most appropriate response from the following items.

Strongly disagree (0) Disagree (1) Somewhat disagree (2) Neither agree nor disagree (3)

Somewhat agree (4) Agree (5) Strongly agree (6)

1. I rarely think about how I look.
2. I think it's more important that my clothes are comfortable than whether they look good on me.
3. I think more about how my body feels than how my body looks.
4. I rarely compare how I look with how other people look.
5. During the day, I think about how I look many times.
6. I worry about whether the clothes I am wearing make me look good.
7. I rarely worry about how I look to other people.
8. I am more concerned with what my body can do than how it looks.
9. When I can't control my weight, I feel like something must be wrong with me.
10. I feel ashamed of myself when I haven't made the effort to look my best.
11. I feel like I must be a bad person when I don't look as good as I could.
12. I would be ashamed for people to know what I really weigh.
13. I never worry that something is wrong with me when I am not exercising as much as I should.
14. When I'm not exercising enough, I question whether I am a good enough person.
15. Even when I can't control my weight, I think I am an okay person.
16. When I'm not the size I think I should be, I feel ashamed.
17. I think a person is pretty much stuck with the looks they are born with.
18. A large part of being in shape is having that kind of body in the first place.
19. I think a person can look pretty much how they want to look if they are willing to work at it.
20. I really don't think I have much control over how my body looks.
21. I think a person's weight is mostly determined by the genes they are born with.

22. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same.
23. I can weight what I'm supposed to when I try hard enough.
24. The shape you are in depends mostly on your genes.

### Body Exposure during Sexual Activities Questionnaire (BESAQ)

We are interested in the thoughts and behaviors that an individual may experience or enact during sexual encounters. Read each statement carefully and identify how characteristic it is of you and your experience. If you have never been sexually active, please do not complete this questionnaire.

- | (1)   | (2)    | (3)       | (4)   | (5)    |
|-------|--------|-----------|-------|--------|
| Never | Rarely | Sometimes | Often | Always |
1. During sexual activity, I am constantly thinking that my partner will notice something about my body that is a turnoff.
  2. During sexual activity, I worry that my partner will find aspects of my physique unappealing.
  3. During sexual activity, I am aware of how my body looks.
  4. During sexual activity, something about the way my body looks makes me feel inhibited.
  5. I am uncomfortable when undressed by my partner.
  6. I prefer to keep my body hidden under a sheet or blanket during sexual activity.
  7. I am comfortable with my partner looking at my genitals during sexual activity.
  8. During sexual activity, I worry that my partner will find my body repulsive.
  9. During sexual activity, I worry that my partner will think the size and appearance of my sex organs are inadequate or unattractive.
  10. When it comes to my partner seeing me naked, I have nothing to hide.
  11. During sexual activity, I have thoughts that my body looks sexy.
  12. I don't like my partner to see me completely naked during sexual activity.
  13. During sexual activity, I expect my partner to be excited by seeing me without my clothes.
  14. I prefer to keep certain articles of clothing on during sexual activity.
  15. I am self-conscious about my body during sexual activity.
  16. During sexual activity, I worry that my partner will find the appearance or odor of my genitals repulsive.

17. During sexual activity, I try to hide certain areas of my body from my partner's view.
18. During sexual activity, I keep thinking that parts of my body are too unattractive to be sexy.
19. There are parts of my body that I don't want my partner to see during sexual activity.
20. During sexual activity, I worry about what my partner thinks about how my body looks.
21. During sexual activity, I worry that my partner could be turned off by the way parts of my body feel to his/her touch.
22. During sexual activity, it is hard for me not to think about my weight.
23. I feel self-conscious if the room is too well-lit during sexual activity.
24. I am generally comfortable having parts of my body exposed to my partner during sexual activity.
25. During sexual activity, I enjoy having my partner look at my body.
26. During sexual activity, there are certain poses or positions I avoid because of the way my body would look to my partner.
27. During sexual activity, I am distracted by thoughts of how certain parts of my body look.
28. Prior to or following sexual activity I am comfortable walking naked in my partner's view.



### Sexual Satisfaction Survey for Women (SSS-W)

Please choose the most appropriate response for each of the questions.

1. I feel content with the way my present sex life is.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

2. I often feel something is missing from my present sex life.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

3. I often feel I don't have enough emotional closeness in my sex life.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

4. I feel content with how often I presently have sexual intimacy (kissing, intercourse, etc.) in my life.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

5. I don't have *any* important problems or concerns about sex (arousal, orgasm, frequency, compatibility, communication, etc.).

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

6. Overall, how satisfactory or unsatisfactory is your present sex life?

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

7. My partner often gets defensive when I try discussing sex.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

8. My partner and I do not discuss sex openly enough with each other, or do not discuss sex often enough.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

9. I usually feel completely comfortable discussing sex whenever my partner wants to.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

10. My partner usually feels completely comfortable discussing sex whenever I want to.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

11. I have no difficulty talking about my deepest feelings and emotions when my partner wants me to.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

12. My partner has no difficulty talking about their deepest feelings and emotions when I want him to.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

13. I often feel my partner isn't sensitive or aware enough about my sexual likes and desires.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

14. I often feel that my partner and I are not sexually compatible enough.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

15. I often feel that my partner's beliefs and attitudes about sex are too different from mine.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

16. I sometimes think my partner and I are mismatched in needs and desires concerning sexual intimacy.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

17. I sometimes feel that my partner and I might not be physically attracted to each other enough.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

18. I sometimes think my partner and I are mismatched in our sexual styles and preferences.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

19. I'm worried that my partner will become frustrated with my sexual difficulties.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

20. I'm worried that my sexual difficulties will adversely affect my relationship.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

21. I'm worried that my partner may have an affair because of my sexual difficulties.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

22. I'm worried that my partner is sexually unfulfilled.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

23. I'm worried that my partner views me as less of a woman because of my sexual difficulties.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

24. I feel like I've disappointed my partner by having sexual difficulties.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

25. My sexual difficulties are frustrating to me.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

26. My sexual difficulties make me feel sexually unfulfilled.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

27. I'm worried that my sexual difficulties might cause me to seek sexual fulfillment outside my relationship.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

28. I'm so distressed about my sexual difficulties that it affects the way I feel about myself.

- 5 = Strongly disagree
- 4 = Disagree a little

- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

29. I'm so distressed about my sexual difficulties that it affects my own well-being.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

30. My sexual difficulties annoy and anger me.

- 5 = Strongly disagree
- 4 = Disagree a little
- 3 = Neither agree or disagree
- 2 = Agree a little
- 1 = Strongly agree

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