TESTING AN EXTENSION OF OBJECTIFICATION THEORY AS APPLIED TO SEXUAL FUNCTIONING

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Elizabeth Anne Lehman
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TESTING AN EXTENSION OF OBJECTIFICATION THEORY AS APPLIED TO
SEXUAL FUNCTIONING

Elizabeth Anne Lehman

Dissertation

Advisor
Dr. David Tokar

Department Chair
Dr. Paul Levy

Committee Member
Dr. Dawn Johnson

Dean of the College
Dr. Chand Midha

Committee Member
Dr. Sandra Perosa

Dean of the Graduate School
Dr. George Newkome

Committee Member
Dr. John Queener

Date

Committee Member
Dr. Robert Schwartz

Committee Member
Dr. Ingrid Weigold
ABSTRACT

Objectification Theory (Fredrickson & Roberts, 1997) is a theoretically and empirically grounded framework used to describe the ways that sexual objectification in the social environment becomes internalized by women, and filters into psychological consequences and mental health risks for them in their personal lives. Of the three main mental health risks that are purported to emerge as outcomes in the model (eating disorder symptomology, depressive symptomology, and sexual dysfunction), sexual dysfunction has been least researched. The current study grew from a need to more fully explore the ways that self-objectification relates to women’s sexual experiences in multiple domains of functioning.

The current study expanded upon previous research by testing a model of Objectification Theory that focused on sexual experiences and included three new, potentially influential variables: sexual self-consciousness, sexual assertiveness, and relationship status. The construct of sexual functioning was explored via a Confirmatory Factor Analysis (CFA) of the Female Sexual Functioning Inventory (Rosen et al., 2000) and operationalized in terms of six outcomes: desire, arousal, lubrication, orgasm, satisfaction, and pain. Participants included women gathered from undergraduate psychology classes at a large midwestern university, as well as women recruited from social media. The makeup of the sample was a group of primarily White women who
identified as heterosexual and had experienced some form of sexual activity in their lifetime.

Path analyses were conducted to test the hypothesized relations between the following variables: self-objectification, body shame, appearance anxiety, sexual self-consciousness, sexual assertiveness, relationship status, and the six sexual functioning outcomes. Results indicated that the hypothesized model fit the data well, and most hypothesized relationships were supported. One relationship that was not supported by the model was relationship status’s role as a covariate in sexual self-consciousness. Results provide evidence for the mediating roles of sexual self-consciousness (full) and sexual assertiveness (partial) in the relationships of body shame and appearance anxiety with most domains of sexual functioning. The findings provide support the inclusion of sexual self-consciousness and sexual assertiveness in future models of Objectification Theory as applied to sexual functioning. Future research ought to focus on the replication of results with a more diverse sample of women, and on exploration into a more detailed definition of relationship status in order to capture its contribution to the constructs of interest.
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CHAPTER I

INTRODUCTION

Objectification Theory

Objectification Theory (Fredrickson & Roberts, 1997) is a comprehensive framework used to investigate women's experiences of living in a culture that evaluates them largely based upon their appearance. It acknowledges women's sexual objectification experienced in the external environment, the internalization of that objectification which occurs when women turn a critical eye toward their own appearance, and the host of sequelae that emerge as a result of sexual- and self-objectification. Fredrickson and Roberts organize this theory in a conceptually causal way, such that cultural experiences ultimately lead to negative individual psychological experiences and an increased risk for the development of certain mental health disorders.

Objectification Theory (Fredrickson & Roberts, 1997) is composed of four different layers of experiences: 1.) Throughout their lives, women experience sexual objectification from the environment which emphasizes the importance of their appearance. 2.) They internalize that objectification, such that they become socialized to view themselves as outsiders and engage in self-objectification/self-surveillance. 3.) Self-objectification predicts negative psychological consequences, which include body
shame, appearance anxiety, disrupted flow (i.e. the ability to lose oneself in intense focus while completing a task or performing and activity; Quinn, Chaudoir, & Kaallen, 2011), and lack of interoceptive awareness. 4.) Negative psychological consequences predict mental health risks, including risk for eating disorders, depression, and sexual dysfunction. These four layers of Objectification Theory are organized such that sexual objectification leads to self-objectification, which then leads to psychological consequences, which consequently create an increased risk for the aforementioned mental health outcomes.

Figure 1. Model of Objectification Theory. Note. from Fredrickson and Roberts (1997).

Objectification Theory (Fredrickson & Roberts, 1997) has been widely reviewed and supported in recent literature. In a 2011 edition of The Counseling Psychologist, the many manifestations of sexual objectification were explored as they related to women's self-objectification (Szymanski, Moffitt, & Carr, 2011), substance abuse (Carr & Szymanski, 2011), and work in objectifying environments (Moffitt & Szymanski, 2011).
Furthermore, Objectification Theory was evaluated for its relevance to minority populations and couples (Heimerdinger-Edwards, Vogel, & Hammer, 2011). In addition to sexual objectification, self-objectification has been studied extensively in its relationship to women's experiences.

The negative psychological consequences of self-objectification (i.e., body shame and appearance anxiety) have been studied extensively via both experimental and correlational studies. For example, under experimental conditions in which primarily Caucasian women's self-objectification was temporarily increased by engaging in an activity that primed objectification (i.e. trying on a bathing suit), they experienced greater body shame (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998). Correlational studies build upon these findings, resulting in consistent positive relationships of self-objectification (and/or its manifestation of self-surveillance) with appearance anxiety (Steer & Tiggemann, 2008; Tiggemann & Slater, 2001; Tiggemann & Williams, 2011) and body shame (Calogero & Thompson, 2009; Moradi, Dirks, & Matteson, 2005; Noll & Fredrickson, 1998; Tiggemann & Slater, 2001).

Much of the research in the area of Objectification Theory (Fredrickson & Roberts, 1997) has been conducted with samples of Caucasian women (Calogero, Tantleff-Dunn, & Thompson, 2010). One reason why researchers may have focused on this population is because there is a societal belief that women of color, and particularly African American women, embrace a greater acceptance of their bodies despite variations in weight or shape (Lovejoy, 2001). Recent research does not support this claim, however, and suggests that, although women of color may not experience body image in the same way as Caucasian women, they do suffer from concerns about their bodies and
their appearance to others, particularly as they are increasingly portrayed by the media in ways that reflect Caucasian ideals for beauty (Capodilupo & Kim, 2014). Research within Objectification Theory is sparse, but it supports this claim. There is some indication that that women of color experience less overall self-objectification in comparison to Caucasian women; however, when placed in objectifying environments, their patterns of self-objectification and negative body evaluations increase in ways that are similar to Caucasian women (Hebl, King, & Lin, 2004; Quinn, Kallen, Twenge, & Fredrickson, 2006).

Although the role of appearance anxiety and body shame has been largely supported in Objectification Theory (Fredrickson & Roberts, 1997), other psychological factors have received mixed support. The role of internal awareness and flow, for example, is less clear. According to the proposed model, both internal awareness and flow mediate the relationships between self-objectification and the proposed outcomes of depressive symptoms, eating disorder symptomatology, and sexual dysfunction. Despite their placement in the model, neither internal awareness nor flow has consistently mediated the relationship between self-objectification and eating disorder symptomology (Daubenmeir, 2005; Greenleaf, 2005; Tiggemann & Kuring, 2004; Tiggmann & Slater, 2001). Similar inconsistencies in the predictive value of internal awareness and flow have arisen in studies examining depressive symptomology as the criterion variable (Szymanski & Henning, 2007; Tiggemann & Kuring, 2004). These mixed findings seem to indicate that internal awareness and flow are less reliable predictors of mental health outcomes in Objectification Theory.
Despite the inconsistency of self-objectification's relationship to some of its proposed psychological correlates, it has been supported in its relationship to many mental health outcomes. The relationship between self-objectification and eating disorder symptomology has been studied and empirically supported (McKinley & Hyde, 1996; Noll & Fredrickson, 1998; Prichard & Tiggemann, 2005; Tiggemann & Lynch, 2001). Research has further supported self-objectification's relationship with depression and low body-esteem in a variety of populations including adolescent racially and ethnically diverse girls (Tolman, Impett, Tracy, & Michael, 2006), and White college women (Miner-Rubino, Twenge, & Fredrickson, 2002).

The outcome variable that has been least studied in Fredrickson and Roberts's (1997) Objectification Theory is sexual functioning (Moradi & Huang, 2008; Calogero, Tantleff-Dunn, & Thompson, 2011). Although the number of studies is limited, preliminary results suggest that women's experiences of self-objectification, body shame, and appearance anxiety may also relate to disrupted sexual functioning (Calogero & Thompson, 2009; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008; Tiggemann & Williams, 2011). One challenge in examining sexual functioning's relationship to objectification is that sexual functioning has been defined in a variety of ways. Researchers have generally explored it as one construct (i.e., Calogero & Thompson; Steer & Tiggemann), rather than examining the individual components of that construct. Although it has not been conclusively defined, researchers have examined desire, arousal, and orgasm (Sanchez & Kiefer), as well as sexual satisfaction (Calogero & Thompson) as they relate to sexual functioning. As of yet, no researchers have examined sexual functioning in a comprehensive way that explores multiple areas of functioning without
collapsing them into one construct. Future research that explores different expressions of sexual functioning in their own right may help to promote increased understanding about the way that self-objectification is related to sexual experiences.

In addition to defining sexual functioning in a comprehensive way, future investigators could conduct further research in this area by exploring additional factors that may explain and/or transmit the way that self-objectification relates to sexual functioning. One such variable is the expression of body shame and appearance anxiety that appears in a specifically sexual context. Sanchez and Kiefer (2007), as well as Steer and Tiggemann (2008), have suggested that the body shame and appearance anxiety women experience in a general way may be specifically and keenly expressed in sexual contexts due to the exposure of their bodies. This body discomfort in the sexual setting, which has been called both sexual self-consciousness (Sanchez & Kiefer) as well as body image self-consciousness during sex (Wiederman, 2000), has been identified as a mediator between the negative psychological consequences in Objectification Theory (i.e., body shame and appearance anxiety) and sexual dysfunction.

In addition to sexual-self-consciousness, research suggests that both sexual assertiveness and relationship status may play a role in women's sexual functioning. According to Wiederman (2000), the self-consciousness many women feel in sexual settings inversely relates to the amount of assertiveness they show during sexual activities. Women's sexual assertiveness is an important part of their sexual experience, such that it often relates to more pleasurable and satisfying sexual experiences (Ferroni & Taffe, 1997; Hurlbert, 1991). Furthermore, women's relationship status may influence the amount of sexual self-consciousness they experience (Steer & Tiggemann, 2008) and
the health of their sexual functioning (Sanchez & Kiefer, 2007). Women who are in long-term relationships experience lower levels of sexual self-consciousness than women who are not involved in long-term relationships (Steer & Tiggmann). Long-term relationships, then, may buffer the effects of objectification on women's sexual functioning. The combination of sexual self-consciousness, sexual assertiveness, and relationship status, therefore, merit further exploration in regard to the role that they play in women's objectification and subsequent sexual functioning.

The purpose of this dissertation is to study women's sexual functioning via Objectification Theory in a way that clarifies past research, is comprehensive in its definition of sexual functioning, and takes into account additional variables that may play a role in the objectification-sexual functioning link. This study will focus on the psychological factors that have shown the strongest relationship to sexual functioning (body shame and appearance anxiety), and will explore how individual sexual functioning outcomes relate to the objectification model. It will also include additional variables that are empirically and/or conceptually related to body shame, appearance anxiety, and sexual functioning. These additional variables – sexual self-consciousness, sexual assertiveness, and relationship status – will be explored as potential extensions of the Objectification Theory model, particularly when it is used to predict sexual functioning.
CHAPTER II

LITERATURE REVIEW

This study investigates a model of Objectification Theory (Fredrickson & Roberts, 1997) and its relationship to women's sexual functioning. It explores new ways of examining sexual functioning among women, and incorporates three additional variables – sexual self-consciousness, sexual assertiveness and relationship status – as an extension of the original theory. First, I provide an overview of Objectification Theory. Second, I provide a selective review of the empirical research on sexual functioning based on this theory. Third, I examine limitations of the extant body of research on sexual functioning related to Objectification Theory, and present my conclusions and recommendations for theory extensions, as well as provide my hypotheses for the current study.

Objectification of Women

The sexual objectification of women has long been interwoven in the cultural fabric of the United States' social practices and norms. One realm in which this objectification is highly prevalent is the media. In the media, women are perpetually depicted in a sexualized way via television shows, commercials, music videos, and magazines (APA, 2010). Prime-time television regularly broadcasts programs that feature women being ogled, sexually remarked upon regarding their body parts, and
called offensive names such as "broad," "babe," or "bimbo" (APA, 2010). An analysis of these shows reveals that they also often include regular incidents of sexual harassment aimed at women, and highlight the sexualization of women's bodies (Grauerholz & King, 1997). Our media representation of women reflects a cultural norm of treating women's bodies as their most valued asset. As a society, we identify, judge, and separate out women's individual body parts as a representation of the whole of their essence (Bartky, 1990). We also use their body parts in instrumental ways, employing views of women's legs and breasts as a way to sell clothing, cigarettes, and alcohol. The combination of critical, evaluative focus on women's bodies, as well as the emphasis on visual consumption of their body parts, paints women as one-dimensional objects (Calogero, Tantleff-Dunn, & Thompson, 2011). It negates women's status as whole beings, complete with thoughts, feelings, desires, and abilities (above and beyond their physical appearance).

In addition to valuing women primarily for the pieces and parts of their bodies, Western society puts forth an ideal of female bodily perfection that is nearly impossible to achieve (Calogero, Tantleff-Dunn, & Thompson, 2011). Research on the media portrayal of women indicates that television shows of the past two decades have consistently presented a distorted image of the female body by featuring actresses that are thinner than the average woman (Fouts & Burggraf, 2000). Because only one in 40,000 women has the body size and shape of the typical model (Wolf, 1991), women constantly view valued representations of female bodies that look nothing like their own bodies, via television screens and magazine pages. With the rise of air brushing techniques used to alter women's appearance in the media, women often compare themselves to female
images that do not even approach realistic figures. Consequently, their idealized body shape becomes grounded in fantasy and practically unattainable (Fredrickson & Roberts, 1997)

**Objectification Theory**

Objectification Theory (Fredrickson & Roberts, 1997) provides a theoretical framework explaining how the external sexualized environment can become internalized to affect women's self-image and mental health. According to Objectification Theory, women experience sexual objectification that originates in their patriarchal sociocultural environment and flows into personal areas of their lives. The external sexual objectification they experience occurs in a nearly universal way, because it impregnates the Western culture. Women experience constant evaluation of their bodies by others, and receive perpetual evaluative messages about women's bodies via media and advertising. As a result, they can feel as if they are constantly being gazed at by others, and particularly by (heterosexual) men (Calogero, Tantleff-Dunn, & Thompson, 2010). Women's exposure to sexual objectification is also intensified through sexist interactions with men in their own lives. Consistent with Fredrickson and Roberts's theory, women report experiencing sexist incidents once or twice a week on average (Swim, Hyers, Cohen, & Ferguson, 2001), and about a quarter of these incidents involve an element of male initiated sexual objectification. Women report uncomfortable incidents of flirtation, being stared at, or touched by unknown men (Swim et al.). The high prevalence of these incidents supports Fredrickson and Roberts's claim that sexual objectification is deeply ingrained in the patriarchal nature of Western society.
According to Objectification Theory (Fredrickson & Roberts, 1997), many women respond to cultural and personal experiences of sexual objectification by normalizing the bodily observation they experience, and imitating it in their own lives. Indeed, they often experience an omni-present self-evaluative relationship with their bodies, that has been described as an internalized (heterosexual) male gaze (Calogero, Tantleff-Dunn, & Thompson, 2010). Fredrickson and Roberts call this experience self-objectification, and claim that it arises when women learn the importance and power of being physically attractive, which prompts them to become yet another critical observer of their own appearance (Fredrickson & Roberts, 1997). Self-objectification is also reflected in women's regular self-surveillance and monitoring of their bodies (Moradi & Huang, 2008). This self-objectification becomes detrimental for women within the context of an environment that promotes unrealistic models of the female body (Fouts & Burggraf, 2000). It results in a game that cannot be won, in which women critically evaluate their bodies as an outsider and strive to meet cultural beauty ideals that are nearly unattainable (Calogero et al., 2011).

Self-objectification, as manifested by self-surveillance, has been posited to result in a variety of psychological consequences, including increased body shame and appearance anxiety, fewer experiences of flow (i.e., less immersion in activities to the point of decreased inhibition and awareness), and decreased internal bodily awareness (Fredrickson & Roberts, 1997). Each of these consequences, in turn, has been posited to relate to mental health risks including the development of eating disorders, depression, and sexual dysfunction in women (Fredrickson & Roberts).
Psychological Correlates of Self-Objectification

**Body Shame.** One of the most well documented psychological correlates of self-objectification is body shame (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Moradi & Huang, 2008; Noll & Fredrickson, 1998; Tiggemann & Kuring, 2004). According to Fredrickson and Roberts (1997), body shame emerges from the constant comparisons that women make between their bodies and the ideal female body presented by media models. Noll and Fredrickson have supported this link, finding a moderate relationship between self-objectification and body shame ($\beta = .51$). Tiggemann and Kuring also have found a relationship between the two variables, reporting that self-surveillance, a manifestation of self-objectification (Fredrickson & Roberts, 1997; Moradi & Huang), positively and moderately related to body shame ($\beta = .44$). Fredrickson et al. (1998) corroborated these results, and furthermore identified that self-objectification contributed to women's body shame above and beyond the contribution of Body Mass Index. Body shame, then, is a phenomenon that touches many women, regardless of their body shape and size.

Although body shame affects women in a nearly universal way, the experience of body shame varies based on the circumstances in which women find themselves. Fredrickson et al. (1998), for example, identified that contexts in which women's bodies are emphasized can create more intense feelings of body shame. Fredrickson et al. found that when women were placed in a body-conscious situation (trying on a bathing suit), their body shame was greater than if they were placed in a non-body-conscious situation (trying on a sweater). Fredrickson et al. reported that this increase in body shame is probably related to women's heightened awareness of their bodies in this situation, as
well as the awareness of how their bodies compare to the bodies of women who typically model swimwear in the media.

**Appearance Anxiety.** Another psychological correlate of self-objectification is appearance anxiety. According to Steer and Tiggemann (2008), appearance anxiety emerges alongside body shame when women realize that their bodies do not match societal models of perfection and they have limited ability to change their bodies to look more like that ideal. Fredrickson and Roberts (1997) suggest that this anxiety further emerges as a result of living with the omnipresent threat that one's body may be critically evaluated. Women's clothing often compounds this threat, due to certain styles which are considered both fashionable and revealing. Certain skirts or dresses may be considered both stylish and at the same time "too" short, which can promote constant appearance anxiety (Fredrickson & Roberts).

Research has supported the relationship between self-objectification (and/or its manifestation of self-surveillance) and appearance anxiety (Steer & Tiggemann, 2008; Tiggemann & Slater, 2001; Tiggemann & Williams, 2011). Steer and Tiggemann found a moderate relationship between self-objectification and appearance anxiety in former dancers ($\beta = .57$) and non-dancers ($\beta = .37$). Tiggemann and Kuring (2004) corroborated these results with a sample of undergraduate women, also finding a substantial relationship between self-surveillance (a manifestation of self-objectification) and appearance anxiety ($\beta = .59$). Furthermore, they identified that this appearance anxiety mediated the relationship between self-surveillance and eating disorder symptomology, as well as the relationship between self-surveillance and depressed mood symptomology.
Flow. Self-objectification has been purported to negatively relate to the experience of flow, or the ability to "lose oneself" in intense focus while completing a task or performing an activity (Quinn, Chaudoir, & Kallen, 2011). Flow is commonly experienced while completing challenging physical, intellectual, or artistic tasks. According to Csiksentmihalyi (1990), when individuals enter a state of flow, they experience a sense of freedom, joy, and alive-ness due to immersing themselves in activities that are meaningful to them. Fredrickson and Roberts (1997) propose that the relationship between self-objectification and lack of flow occurs because women often struggle to shed their self-consciousness while completing tasks. This perpetual self-monitoring makes it nearly impossible for them to fully lose themselves in the keenly focused mindset of flow. Research has supported the link between self-objectification and flow. Tiggemann and Kuring (2004) as well as Szymanski and Henning (2007) found that self-objectification was significantly related to flow via the mediating factor of self-surveillance. The relationship between these factors has been smaller than the relationships found between self-objectification and body shame or appearance anxiety; however, a relationship remains (i.e., $\beta = .22$; Tiggemann & Kuring).

Awareness of internal bodily states. Self-objectification has been linked to a lack of awareness of one's internal bodily sensations (i.e. interoceptive awareness), such as heartbeat and stomach contractions, as well as having a difficult time using those cues to determine how one feels (Fredrickson & Roberts, 1997). Women struggle more to identify these internal states than men (Harver, Katkin, & Bloch, 1993). This difficulty identifying internal states and the feelings associated with those states may stem from the limited attentional abilities at women's disposal (Fredrickson & Roberts). Because
women allot much of their attention to their external appearance, they are less able to attend to their internal experiences, propose Fredrickson and Roberts. Another potential reason for their lack of internal awareness is women's culture of dieting and restrained eating. A lifestyle of dieting requires women to ignore and suppress internal cues of hunger. Women may, consequently, develop a more generalized lack of internal awareness that could affect multiple areas of their lives (Heatherton, Polivy, & Herman, 1989).

The relationship between self-objectification and low interoceptive awareness has been partially supported in empirical research. Some studies have found no relationship between self-objectification and interoceptive awareness (i.e. Tiggemann & Kuring, 2004; Tiggemann & Slater, 2001). Other studies have found that self-objectification, or self-surveillance, was related to lack of interoceptive awareness, but that interoceptive awareness was not related to other outcome variables in Objectification Theory in the way that Fredrickson and Roberts's (1997) model suggested (i.e., Muehlenkamp & Saris-Baglama, 2002). Other researchers, however, have found both a relationship between self-objectification and interoceptive awareness, as well as a mediating relationship in which interoceptive awareness explained the relationship between self-objectification and eating disorder symptomology (Myers & Crowther, 2008). At this time, then, interoceptive awareness has an ambiguous relationship to other Objectification Theory variables.
Mental Health Correlates of Self-Objectification

**Disordered eating.** Disordered eating is the most prolifically studied mental health correlate of self-objectification (Tiggemann, 2011). There is a large body of research supporting a positive relationship between self-objectification, or its manifestation of self-surveillance, and disordered eating symptoms (i.e., Daubenmier, 2005; Myers & Crowther, 2008; Piran & Cormier, 2005). As an example, Augustus-Horvath and Tylka (2009) found that there was a relationship between self-surveillance and disordered eating symptomology that was mediated by body shame and poor interoceptive awareness in both younger and older women. Moradi et al. (2005) similarly found support for a model in which self-objectification was significantly related to eating disorder symptoms, by means of self-surveillance and body shame. Most research on self-objectification's relationship with disordered eating has come from heterosexual, Caucasian women in non-clinical samples; however, the relationship between self-objectification/self-surveillance and disordered eating has been replicated in studies with individuals of color (Harrison & Fredrickson, 2003), lesbians (Haines et al., 2008), and women diagnosed with an eating disorder as well (Calogero, Davis, & Thompson, 2005).

**Depression.** In addition to disordered eating, many researchers have examined the links between self-objectification/self-surveillance and depression. The relationship of self-objectification to depressive symptomology has been well supported in research among college women (Tiggemann & Slater, 2001), women aged 20 to 84 (Tiggemann & Lynch, 2001), and women of diverse racial and ethnic backgrounds (Harrison & Frederick, 2003). The variables that Fredrickson and Roberts (1997) propose to mediate the relationship between self-objectification and depressive symptoms, however, have
only been partially supported. For example, Tiggemann and Kuring (2004) found that self-objectification related to increased symptoms of depression, via the mediating factors of increased body shame and appearance anxiety, but not flow or interoceptive awareness. Szymanski and Henning (2007) found similar results, with body shame, appearance anxiety, and flow mediating the relationship between self-objectification and depression, but not interoceptive awareness. Both flow and interoceptive awareness have shown inconsistent relationships to depressive symptomology (Tiggemann, 2011).

**Review of Objectification Theory Literature Related to Sexuality**

In addition to making women vulnerable to eating disorder symptomology and depressive symptoms, Frederickson and Roberts (1997) proposed that self-objectification may place women at increased risk for sexual dysfunction. There have been a limited number of studies that have investigated sexual dysfunction through the framework of Objectification Theory. Most of them have focused their area of inquiry on how body shame and appearance anxiety relate to women's sexual functioning, rather than interoceptive awareness or flow. Given that body shame and appearance anxiety show the greatest consistency in their relationship to Objectification Theory variables, this area of focus may be a particularly fruitful one (Tiggemann, 2011; Tiggemann & Kuring, 2004; Tiggemann & Williams, 2011).

Sanchez and Kiefer (2007) conducted one such study, exploring how body shame related to sexual functioning. They defined sexual functioning as sexual arousability, sexual pleasure, and ability to reach orgasm. Sanchez and Kiefer predicted that body shame would result in less sexual arousability and pleasure, as well as greater difficulty
reaching orgasm. They also predicted that these effects would occur by means of the mediating variables of sexual self-consciousness, relationship status, and age. Sanchez and Kiefer hypothesized that individuals who were sexually self-conscious, single, and of younger age would experience more sexual dysfunction.

Sanchez and Kiefer's (2007) study was unique in that it included a sexual self-consciousness variable. They operationalized this construct using the Body Image Self-Consciousness scale (BISC; Wiederman, 2000), which explores women's reactions to exposing their bodies during sexual acts. Sexual self-consciousness did not exist in Fredrickson and Roberts's (1997) original model; however, the inclusion of this variable allowed Sanchez and Kiefer to explore the manifestation of body shame within the context of sexual acts. They justified their inclusion of sexual self-consciousness by relating it to Masters and Johnson's (1970) concept of "spectatoring." Spectatoring, or focusing one's attention on the appearance of one's body during sexual acts, according to Masters and Johnson, was postulated to decrease individuals' ability to fully attend to sexual pleasure and, therefore, result in sexual dysfunction. Sanchez and Kiefer hypothesized that sexual self-consciousness would mediate the relationship between body shame and the three sexual (dys)function variables of arousibility, orgasm difficulty, and sexual pleasure.

Sanchez and Kiefer (2007) recruited widely to obtain their participants. They advertised their study on 150 different U.S. Yahoo groups and via 20 e-mail lists for a local university. Their study incorporated male and female participants who were relatively homogenous on all demographic variables except age. Their participants' ages ranged from 17 to 71 ($M=31.01$, $SD=12.96$). There were 122 men in the study and 198
women, who were the subsample of interest to this researcher. Sanchez and Kiefer used a variety of commonly employed objectification measures to operationalize their constructs and quantify participant experiences. They measured body shame using the Body Shame subscale of the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996). The Body Shame subscale of the OBCS measures multiple facets of body shame via a 7-point Likert scale. Sanchez and Kiefer measured sexual self-consciousness using the Body Image Self-Consciousness scale (BISC; Wiederman, 2000), which assesses how much anxiety individuals feel/would anticipate feeling during a variety of sexual activities. They evaluated arousability using the oral/genital stimulation and sexual intercourse subscales of the Sexual Arouasability Index (SAI; Anderson, Broffitt, Karlsson, & Turnquist, 1989). The SAI allows participants to rate their level of arousal in response to sexual scenarios that they read. Sanchez and Kiefer measured difficulty reaching orgasm via two questions asking how often individuals reach orgasm during sexual activity with their partners and how often they have difficulty reaching orgasm during sexual activity with their partners. Participants rated their answers on a scale of 1 (never) to 5 (always). Lastly, sexual pleasure was measured using three questions assessing individuals' pleasure in response to sexual intercourse, sexual activities and sexual intimacy. Reliabilities for all measures were .85 or higher.

Sanchez and Kiefer (2007) used SEM to test a model in which body shame related indirectly and inversely to sexual arousability and sexual pleasure, as well as indirectly and positively to difficulty achieving orgasm. Sexual self-consciousness was proposed to mediate all relationships, and relationship status and age were used as covariates. Their analysis revealed that increased body shame predicted greater sexual self-consciousness,
and that sexual self-consciousness fully mediated the relationships of body shame to sexual arousability and sexual pleasure. Sexual self-consciousness did not, however, mediate the relationship between body shame and orgasm difficulty. Although sexual self-consciousness did not mediate the relationship between body shame and orgasm difficulty, it did relate to orgasm difficulty indirectly through arousability. In fact, arousability fully mediated the relationship between sexual self-consciousness and orgasm difficulty. This relationship seems to suggest that sexual self-consciousness was related to orgasm difficulty; however, the relationship existed by means of lowered arousal. When considered together, then, sexual self-consciousness appeared to be a crucial, generative factor through which body shame affected sexual outcomes. It fully mediated the relationship between body shame and arousability as well as body shame and sexual pleasure. It also related to orgasm difficulty through the variable of arousability.

One important factor that influenced the impact of sexual self-consciousness was the variable of relationship status. Sanchez and Kiefer (2007) identified that women in long-term relationships were less sexually self-conscious than women who were not in long-term relationships. Presumably, this effect occurred because women in relationships had the opportunity to experience the exposure of their bodies on a regular basis with the same person. In essence, they experienced desensitization of their self-consciousness within the sexual realm. Another possibility is that women in committed relationships may experience a sense of stability and trust in their relationship which allows them decrease their bodily self-consciousness and explore different ways that they might assert themselves in their own sexual experiences. Increased assertiveness may allow them to
play a more active role in identifying sexual acts which are arousing, pleasurable, and related to orgasm.

One of the strengths of the Sanchez and Kiefer (2007) study is that they assessed sexual dysfunction in multiple ways, and did not combine arousability, sexual pleasure, and orgasm difficulty into one sexuality variable. Other researchers have examined sexual functioning via one composite measure of several sexual dimensions, assuming that these dimensions reflect a unified sexual functioning construct. Sanchez and Kiefer's study supports the practice of examining sexual functioning indicators individually. In their study, the experience of orgasm difficulty was predicted in a different way than were experiences of arousal and pleasure. Given that some elements of sexual functioning are more physiological in nature (i.e., orgasm), and others have a stronger psychological component (i.e., arousal and sexual pleasure), it seems reasonable to examine these outcomes separately.

Another reason why sexual functioning outcomes may be better studied individually is because researchers have been more able to predict some sexual outcomes than others. Sanchez and Kiefer (2007) were able to explain 16% of the variance in Arousability and 34% of the variance in Orgasm difficulty using their model; however, they were able to predict 66% of the variance in sexual pleasure. Examination of sexual functioning as a whole might obscure these individual relationships.

In a related study, Steer and Tiggemann (2008) also examined self-objectification and its relationship to women's sexual functioning via sexual self-consciousness. Their model incorporated more of the original Objectification Theory variables than did Sanchez and Kiefer (2007). Specifically, they included measures of self-objectification,
self-surveillance, body shame, and appearance anxiety. Steer and Tiggemann hypothesized that self-objectification was related to sexual dysfunction by means of self-surveillance, which they predicted would give rise to body shame and appearance anxiety. Their hypothesized model related all three of these intervening variables (self-surveillance, body shame, and appearance anxiety) to sexual dysfunction by means of the mediating variable, sexual self-consciousness. Similar to Sanchez and Kiefer, Steer and Tiggemann justified the addition of this mediator by suggesting that the generalized shame, anxiety, and surveillance that women felt in their everyday lives would filter into the shame, anxiety, and self-surveillance women would feel in a sexual context. They also explored the role of relationship status, and hypothesized that women in committed relationships would experience less sexual self-consciousness and, therefore, less sexual dysfunction.

Steer and Tiggeman's (2008) participants were a rather homogenous group of 116 undergraduate women who were primarily (> 90%) Caucasian. Their ages spanned from 18 to 54 years, with a mean age of 22.74 (SD=8.44). In order to assess their levels of self-objectification, participants completed Noll and Fredrickson's (1998) Self-Objectification Questionnaire (SOQ). The SOQ compares the extent to which individuals focus on the appearance of their bodies with the focus they place on their bodies’ capabilities and competencies. Greater comparative emphasis on appearance is believed to relate to higher levels of self-objectification. Participants completed the Body Surveillance Subscale of McKinley and Hyde's (1996) Objectified Body Consciousness Scale (OBCS) as a measure of their levels of self-surveillance. The OBCS measures the extent to which individuals focus on how their body looks, rather than how it feels, by
means of a 7-point Likert scale. In order to assess body shame, participants completed the Body Shame subscale of the OBCS, which used a similar Likert scale. Appearance anxiety was assessed via the short form of the Appearance Anxiety Questionnaire (Dion, Dion, & Keelan, 1990), a 14-item measure that asks participants to rate their anxiety regarding the way that they look using a 5-point Likert scale. Lastly, self-consciousness during sexual activity was assessed using the BISC (Wiederman, 2000), described previously.

Regarding outcome variables, Steer and Tiggeman (2008) operationalized sexual functioning using the Female Sexual Function Index (FSFI; Rosen et al., 2000). They included three of the FSFI subscales - desire/arousal, orgasm, and satisfaction - which were used to assess for recent functioning (over the past four weeks) and general functioning. Steer and Tiggemann decided not to include the other subscales which make up the FSFI (lubrication and pain) because they believed those subscales might be too sensitive in nature for their participants. They compiled women's scores on these subscales, thereby obtaining two sexual functioning scores for each woman, one that reflected her recent sexual functioning and another that reflected her typical sexual functioning. Because not all women had been sexually active in the 4 weeks prior to this study, only about half (60) of the total (116) respondents answered the questions regarding recent sexual activity. In addition to reporting their sexual functioning, participants in Steer and Tiggemann's study were also asked to indicate their relationship status and satisfaction. Steer and Tiggemann hypothesized that women in satisfied, committed relationships would experience less sexual self-consciousness and better sexual functioning than those who were not in satisfied, committed relationships.
Steer and Tiggemann (2008) used path analysis to examine how well their variables fit the objectification model. They found that the paths in their hypothesized model fit their data well when predicting women's general sexual functioning. Self-objectification had a positive relationship with self-surveillance, which positively predicted both body shame and appearance anxiety. Body shame and appearance anxiety subsequently were related to self-consciousness during sex, and self-consciousness during sex was related to sexual dysfunction.

Steer and Tiggemann (2008) also examined the role of relationship status in their study by conducting a series of t-tests comparing the women who were currently in a relationship with the women who were not currently in a relationship. They identified that there were no significant differences between the two groups on measures of self-objectification, self-surveillance, body shame, or appearance anxiety; however, there was a significant different between the two groups on self-consciousness during sexual activity. Women in relationships experienced significantly less sexual self-consciousness than women who were not in relationships.

Steer and Tiggemann's (2008) results provided support for the structure of Objectification Theory (Fredrickson & Roberts, 1997) as it related to women's sexual functioning, and additionally highlighted the importance of relationship status and sexual self-consciousness. These results may indicate, as Steer and Tiggemann, and Sanchez and Kiefer (2007) suggested, that women in an exclusive relationship might become less concerned about their appearance during sexual activity due to a desensitization to the experience. Both Steer and Tiggemann's (2008), and Sanchez and Kiefer's (2007) findings also provided support for the inclusion of a sexual self-consciousness variable
when studying objectification and sexual functioning. Steer and Tiggeman proposed that sexual self-consciousness reflects the expression of appearance anxiety and body shame in a specific sexual context. Given that sexual self-consciousness fully mediated the relationships of both body shame and appearance anxiety to general sexual functioning in their model, it appears to be a driving mechanism through which body shame and appearance anxiety operate.

Despite the apparent importance of these findings, Steer and Tiggemann (2008) left room for future studies to provide additional clarification. Steer and Tiggemann suggested that their results may be interpreted to indicate that women in relationships may experience less sexual self-consciousness than women who are not in relationships. The women who were in exclusive relationships, however, were also about three years older than the women who weren't in exclusive relationships, on average. It is possible, then, that women's decrease in sexual self-consciousness was due to an increase in age, and increase in sexual experience, emotional maturity, etc., rather than current relationship status.

Calogero and Thompson (2009) also tested a model exploring the effects of Objectification Theory (Fredrickson & Roberts, 1997) predictors on sexuality. Like Steer and Tiggemann (2008), they strove to test a model of Objectification Theory that was more inclusive of the array of posited sexual dysfunction precursors, such as self-surveillance; however, their inclusion of a media internalization variable set them apart other studies. By examining media internalization, they acknowledged Fredrickson and Roberts's (1997) claim that self-objectification and self-surveillance tendencies ultimately come from the external environment, particularly media representations of women. In
addition to the inclusion of media internalization, Calogero and Thompson added to previous studies by exploring the role of sexual self-esteem. They identified that sexual self-esteem reflected women’s evaluation of their sexual qualities and the degree to which they valued themselves as sexual beings.

Calogero and Thompson (2009) used path analysis to test a model in which internalization of media was posited to relate to self-surveillance and body shame. Body shame was also posited to relate to sexual self-esteem, and both body shame and sexual self-esteem were posited to relate to sexual satisfaction. In other words, internalization of media was posited to directly relate to self-surveillance and body shame, as well as indirectly relate to sexual satisfaction, via self-surveillance, body shame, and sexual self-esteem.

Calogero and Thompson’s (2009) participants were 101 women enrolled in a UK university. In order to be included in the study, they had to have been sexually active at least twice in the past 12 weeks, and could not be involved in a long-term relationship (defined as lasting longer than 12 weeks). Calogero and Thompson opted to exclude women in long-term relationships because women who are not in a relationship may be more susceptible to self-objectification (i.e., Steer & Tiggemann, 2008). The women were ethnically diverse, such that they represented women who were British (65%), Southern European (13%), East Asian (9%), American (3%) and Other (10%). Their ages ranged from 18 to 39, with a mean of 22.13.

Calogero and Thompson (2009) used the Internalization-General subscale from the Sociocultural attitudes Toward Appearance Questionnaire-3 (SATAQ-3; Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004) to measure the extent to which the
women had internalized appearance ideals from media sources. They used the Body Surveillance subscale of the OBCS to measure how much their participants focused on the appearance of their bodies. When measuring body shame, they also used the OBCS Body Shame subscale. For their Sexual Self-Esteem variable, they altered Rosenberg's (1986) Global Self-Esteem Scale items by relating them to the sexual context. Participants' scores showed adequate reliability (α=.86) despite this alteration. Lastly, they used the Sexual Satisfaction Scale, which is a three-item scale of how satisfied individuals are with their sexual experiences and activities (Dove & Wiederman, 2000; α=.86), to measure the participants' sexual satisfaction.

The results of Calogero and Thompson's (2009) path analysis revealed that, as predicted, internalization of media was positively and directly related to both self-surveillance and body shame. It was also indirectly related to sexual satisfaction and sexual self-esteem (both of which maintained negative relationships with body shame and self-surveillance). Although both body shame and sexual self-esteem were predicted to relate to sexual satisfaction, only body shame had a significant relationship with that factor. Sexual self-esteem was not significantly related to sexual satisfaction. An additional interesting finding, although unpredicted, was that self-surveillance related directly and inversely to sexual satisfaction. Self-surveillance's relationship to sexual satisfaction, although unpredicted by Calogero and Thompson's model, is not entirely surprising. Steer and Tiggemann (2008) found a relationship between self-surveillance and sexual functioning (mediated by sexual self-consciousness) in their study, too. In total, Calogero and Thompson's model predicted 30% of the variance in sexual satisfaction.
Calogero and Thompson's (2009) findings differ from other studies that have suggested that self-surveillance is indirectly, but not directly, related to sexual functioning (Steer & Tiggemann, 2008). One reason why self-surveillance may have been directly related in this study is because Calogero and Thompson did not include other explanatory variables that may have mediated the relationship between self-surveillance and sexual satisfaction. Other studies have identified intermediary constructs such as appearance anxiety and sexual self-consciousness that mediated the relationship between self-surveillance and sexual functioning (i.e., Steer & Tiggemann).

Although Calogero and Thompson predicted 30% of the variance in sexual satisfaction, which is substantial, 70% of the variance was left unexplained. Future studies might expand upon their results by adding appearance anxiety and sexual self-consciousness into their model. Future studies might also include other measures of sexual functioning beyond sexual satisfaction. Previous research has indicated that sexual functioning is a multi-faceted construct (i.e. Sanchez & Kiefer, 2007). By including additional appearance anxiety and sexual functioning variables, future researchers could increase the percentage of variance explained in the model.

Another interesting finding from this study is the non-significant relationship between sexual self-esteem and sexual satisfaction. Calogero and Thompson (2009) hypothesized a positive relationship between these two variables because that they believed that the evaluation that women place on the sexual aspects of themselves would relate to the amount of satisfaction that they receive during sexual acts; however, their study did not support this hypothesis. One reason for this non-significant relationship might be that valuing one's own sexuality (i.e., sexual self-esteem) is a relatively passive
experience, and does not necessarily entail a behavioral action. Perhaps, in order to increase women's sexual satisfaction, they must take on a more active role to ensure that their needs are met.

The aforementioned studies all tested Objectification Theory as it related to women's sexual functioning in a partial manner. Each of them included some of the Objectification Theory's predicted mediators (i.e., body shame, appearance anxiety); however, none of them included all of the mediators. Tiggemann and Williams (2011) examined the full Objectification Theory model, as proposed by Fredrickson and Roberts (1997), including all intermediary variables (body shame, appearance anxiety, interoceptive awareness, and flow) and outcomes (disordered eating, depressed mood and sexual functioning). Tiggemann and Williams hypothesized that self-objectification would be related to self-surveillance, and that self-surveillance would be related to increased body shame, increased appearance anxiety, decreased internal awareness, and fewer flow experiences. They furthermore hypothesized that these intermediary variables would in turn relate to an increase in disordered eating, depressed mood, and decrease in sexual functioning.

In their study, Tiggemann and Williams (2011) included a homogenous sample of 146 undergraduate student women who ranged from 18 to 30 years of age ($M=20.4$), and were primarily (>90%) Caucasian. The majority of them were of normal weight, as measured by their BMI ($M=23.61$, $SD=4.93$). 31.5% of the women were not dating, 13.7% were casually dating, and 54.8% were in some sort of a serious relationship with their partner. Tiggemann and Williams used the Self-Objectification Questionnaire (SOQ; Noll & Fredrickson, 1998) to measure women's level of self-objectification. They
used the Body Surveillance subscale of the OBCS (McKinley & Hyde, 1996) to measure women's levels of self-surveillance. For body shame, they used the Body Shame subscale of the OBCS. For appearance anxiety they used the short form of the Appearance Anxiety Questionnaire (Dion, Dion, & Keelan, 1990). This measure requires participants to read 14 statements reflecting appearance-related worry and rate how often the statements apply to their personal experience. To measure internal awareness, Tiggemann and Williams administered the Interoceptive Awareness subscale of the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983). This 10-item scale asks participants to rate how often they experience awareness of their internal experiences. Tiggemann and Williams measured flow via Szymanski and Henning's (2007) scale that was developed to identify the aspects of losing oneself in experience that were originally proposed by Csikszentmihalyi (1990). Lastly, they measured sexual functioning through Rosen et al.’s (2000) modified version of the Female Sexual Function Index (FSFI). This version of the index used 12 items to evaluate desire, arousal, orgasm, and satisfaction. They asked the participants to report their sexual functioning in a general sense, rather than reporting for the past 4 weeks. This alteration of the FSFI was also present in Steer and Tiggeman's (2008) study.

Tiggemann and Williams's (2011) final model, which was tested using structural equation modeling, identified multiple indirect paths that connected self-objectification to sexual functioning. Of the four proposed mediators between self-surveillance and sexual functioning (i.e., body shame, appearance anxiety, interoceptive awareness, and flow), only appearance anxiety was directly related to sexual functioning ($\beta = -.47$). All three of the other proposed mediators were indirectly related to sexual functioning via their
significant relationship with appearance anxiety. Tiggemann and Williams interpreted these results to indicate that appearance anxiety may be a stronger contributor to sexual functioning than any of the other proposed mediators. Perhaps, then, sexual dysfunction flows from a strong cognitive and appearance-evaluative mechanism that interferes with healthy functioning. Of the three mediating variables, perhaps body shame's lack of relationship with sexual functioning is most surprising. This lack of relationship may have occurred due to the complexity of the model.

Although it initially appears strange that Tiggemann and Williams (2011) found that appearance anxiety was more important than body shame when predicting sexual functioning, this finding is not unprecedented. Steer and Tiggemann (2008) found that body shame only related to sexual functioning via sexual self-consciousness (a more cognitive construct), and Sanchez and Kiefer (2007) also found an indirect relationship between body shame and measures of sexual functioning via self-consciousness. The uniqueness of body shame's relationship to sexual functioning, therefore, remains a bit uncertain, and merits further exploration.

Despite this uncertainty, the relationships of interoceptive awareness and flow with sexual functioning seem to be clearer. In Tiggeman and Williams's (2012) model, both of these variables related indirectly to sexual functioning via appearance anxiety, but neither approached significance in their direct relationships with sexual functioning (β = .06 and -.05, respectively). These nonsignificant relationships suggest that internal awareness and flow add little to the predicted variance in sexual functioning above and beyond their relationship with appearance anxiety, and, in the spirit of parsimony, could potentially be removed from an Objectification Theory (Fredrickson & Roberts, 1997).
model that focuses primarily on predicting sexual outcomes. Tiggemann and Williams supported this conclusion as well, indicating that they offered no predictive usefulness above and beyond their relationship to appearance anxiety.

Tiggemann and Williams's (2012) model accounted for 16% of the variance in sexual functioning, a latent construct created from four underlying indicators: desire, arousal, orgasm, and sexual satisfaction. Certain indicators loaded more strongly onto the latent construct than others. Sexual arousal loaded on sexual functioning strongly (λ=.89), sexual desire (λ=.57) and sexual satisfaction (λ=.52) loaded moderately, and orgasm (λ=.39) loaded more weakly than the other indicators. One potential weakness in the study is that these differentially related indicators may not adequately summarize the sexual functioning construct, and/or perhaps sexual functioning may be more appropriately examined via these individual outcomes rather than one general construct. The utility of examining sexual functioning outcomes individually (rather than in a composite variable) has been shown in previous studies (i.e., Sanchez & Kiefer, 2007).

Another way in which the study could be improved is by including a relationship status variable. Other research has suggested that women's relationship status may contribute significant variance to their experience of self-objectification, particularly in sexual settings (Sanchez & Kiefer; Steer & Tiggemann, 2008). An examination of objectification experiences without taking into account relationship status may be incomplete. As discussed previously, Steer and Tiggemann identified that relationship status emerged as a key covariate influencing the way that Objectification Theory variables related to sexual functioning.
Summary of Objectification Theory literature related to sexual functioning.

The aforementioned extant literature on sexual functioning viewed through the lens of Objectification Theory suggests that some changes may be warranted for the way that researchers examine women's sexuality within this theory. First of all, interoceptive awareness and flow seem to have a limited relationship to sexual functioning (Tiggemann & Williams, 2011). The inclusion of these variables may introduce unnecessary complexity to Objectification Theory in its application to sexual functioning.

Furthermore, the nature of the relationship between body shame and sexual functioning remains unclear, despite extensive inquiry. Some studies indicate that body shame relates to sexual functioning via a cognitive mediator, such as appearance anxiety (i.e. Sanchez & Kiefer, 2007; Tiggemann & Williams), but other studies such as Calogero and Thompson's (2009) show a direct relationship between body shame and sexual functioning.

Only a handful of studies have included both body shame and appearance anxiety in their model explaining sexual dysfunction. Tiggemann and Williams (2011) examined all three variables, and indicated that body shame was not directly related to sexual dysfunction; instead, it was indirectly related to sexual dysfunction via appearance anxiety. Their results should be interpreted with the understanding that the nonsignificant direct relationship was moderate in effect size (β=.20), and that the complexity of their model could have obscured the significance of more subtle relationships. In another study, Steer and Tiggemann (2008) found that both body shame and appearance anxiety related to sexual functioning via the mediating variable of sexual self-consciousness; however, neither one had a direct relationship with sexual
functioning. The inconsistency of findings with these two variables suggests that future research ought to include body shame, appearance anxiety, sexual self-consciousness, and sexual dysfunction as a way to continue to clarify the relationships among these constructs.

In addition to exploring the roles of body shame, appearance anxiety, and sexual self-consciousness in women's sexual functioning, future researchers also ought to explore other variables that could factor into women's sexual experiences. Literature suggests that relationship status may play a large role in women's sexual functioning (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Sanchez and Kiefer found that women in long-term, committed relationships experienced less sexual self-consciousness less sexual dysfunction than women who were engaged in short term dating. In addition to relationship status, researchers might consider examining the role of sexual assertiveness, which conceptually relates to many aspects of Objectification Theory, including appearance anxiety, body shame, sexual self-consciousness, and sexual functioning.

**Sexual Assertiveness and Sexual Functioning**

Although objectification research has indicated that appearance anxiety, and to some extent body shame, relate to decreased functioning in areas of sexuality, Objectification Theory does not provide much information about intervening variables that may explain or facilitate this connection. Some studies have indicated that sexual self-consciousness may mediate these relationships (i.e. Steer & Tiggemann, 2008); however, other potential variables remain relatively unexplored.
Research outside of Objectification Theory seems to indicate that sexual assertiveness may act as a vehicle by which body shame and appearance anxiety affect women's sexual functioning. Sexual assertiveness refers to the tendency to communicate one's sexual wishes to one's partners (Auslander, Baker, & Short, 2012). It reflects action tendencies, and, thereby differs from potentially related constructs such as sexual self-esteem (a tendency to view oneself positively in sexual situations and as sexual partners [Wiederman, 2000]). Conceptually, one might suspect that if a woman is more able to express her sexual wishes, then those wishes will be more likely to be acted upon and she may increase her pleasure and functioning in sexual settings.

**Body Image Self-Consciousness and Sexual Assertiveness**

Although sexual assertiveness has not been explored within the framework of Objectification Theory (Fredrickson & Roberts, 1997), research outside of this theory has shown that the way women view their bodies relates to the extent to which they are sexually assertive. Wiederman (2000) explored this link as part of the validation process for his Body Image Self-Consciousness Scale (BISC). Wiederman administered the BISC, along with a battery of other related measures, to 209 mostly (90.9%) White women at a Midwest university. The women were between the ages of 18 and 21 and identified as primarily heterosexual. In his study, Wiederman assessed women's body image self-consciousness during sexual acts (i.e., sexual self-consciousness) and examined how it related to their sexual assertiveness and their sexual experience. Wiederman evaluated sexual assertiveness via the Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1991), a 25-item measure that explores sexual assertiveness in sexual relationships on a 5-point scale. Lower HISA scores indicate less assertiveness and
higher scores indicate greater assertiveness. Wiederman assessed women's sexual avoidance via the Sexual Avoidance subscale of the Sexual Aversion Scale (Katz, Gipson, & Turner, 1992). Higher scores indicate greater avoidance of sexual situations and sexual interactions due to fear and anxiety. Wiederman found that women with higher levels of body image self-consciousness reported less sexual assertiveness ($r = -0.56$) with their partners and more avoidance of sexual activity ($r = .46$). Wiederman's research suggests that sexual assertiveness may play a substantial role in the body image self-consciousness that women may feel during sexual activities.

Wiederman's (2000) findings relate to sexual findings within Objectification Theory because his inventory of body image self-consciousness (BISC) is the same inventory that has been used to measure sexual self-consciousness in tests of Objectification Theory (i.e., Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Previous researchers have identified that higher scores on the BISC, i.e., higher sexual self-consciousness, relate to expressions of sexual dysfunction (Sanchez & Kiefer; Steer & Tiggemann). Given that sexual assertiveness relates to sexual self-consciousness (Wiederman), and sexual self-consciousness has been shown to mediate the relationships of body shame and/or appearance anxiety with sexual functioning, (Sanchez & Kiefer; Steer & Tiggemann), a next logical step in elucidating the mechanisms of sexual functioning might be to investigate if and how sexual assertiveness relates to women's experience of sexual functioning.

**Sexual Assertiveness and Sexual Functioning**

Previous studies have suggested a relationship between sexual assertiveness and sexual functioning, albeit not within the context of Objectification Theory. Hurlbert
(1991), for example, surveyed 100 married women in an Army community support center on their sexual behaviors during a four-week period. The sample of women was divided by a median split in terms of their assertiveness and stratified according to race and religion. They were also matched as closely as possible on age, education, length of marriage, number of children, household income, and employment status. Sexual assertiveness was evaluated via the HISA (1991). Women's sexual functioning was evaluated in five ways. At the start of the study, women were asked to complete the Index of Marital Satisfaction and the Index of Sexual Satisfaction. Although the authors did not identify the source of these instruments, they stated that lower scores indicated less satisfaction in the measured areas. For the remaining three measures, women recorded the frequency of sexual activity, number of orgasms, the amount of sexual desire they felt during sexual activity (via a 10-point scale) during the four-week duration of the study. Hurlbert found via t-tests that more highly assertive women experienced greater marital satisfaction, sexual satisfaction, more sexual activity, more orgasms, and greater subjective sexual desire than women who were less assertive.

Hurlbert's (1991) study indicated that greater sexual assertiveness in women related to higher sexual functioning; however, future studies could clarify and add to the findings in a variety of ways. For example, Hurlbert looked at a very specific subset of the population (i.e., military wives) that may or may not translate to the general population of women. It is uncertain how well military wives' experiences reflect the experiences of other women. Furthermore, Hurlbert's study offers insight into the experiences of women in long-term, married relationships; however, previous research has indicated that women in long-term relationships may experience sexual functioning
in a way that is different from women in short-term, or dating relationships (Sanchez & Kiefer, 2007). An interesting extension of Hurlbert's study would be to explore the relationship between sexual assertiveness and sexual functioning, while taking into account relationship status.

Another study supporting the purported relationship between sexual functioning and sexual assertiveness (as defined by communication of sexual needs) was conducted by Ferroni and Taffe (1997). Ferroni and Taffe recruited 656 women from 50 medical practices in Western Australia to participate in their study. The women's ages spanned from 30 to 50, \( M = 39.6, SD = 5.9 \). Race/ethnicity information was not collected. The participants rated their communication with partners about sexual needs on a four-point scale, from very good to very bad. Their responses were coded dichotomously as good or bad. Simple comparisons between women who identified sexual communication with their partners as good vs. bad revealed that women with good sexual communication engaged in intercourse more often, experienced orgasm more often and rated intercourse as more pleasant.

Despite the apparent clarity of this study, Ferroni and Taffe (1997) dichotomized all of the sex-related variables in their study except the frequency of sexual activity. Therefore, sexual communication, experience of orgasm, and enjoyment of intercourse were evaluated via a mostly good/mostly bad choice. This dichotomization simplified their research design; however, it may have also obscured some of the more subtle relationships between these variables. Allowing participants to rate their experiences on a continuous scale may permit a greater ability to evaluate the strength of these relationships. Lastly, Ferroni and Taffe did not gather information about the relationship
status of the women in their study. As previously indicated, relationship status may be a key ingredient in expression (or lack thereof) of sexual dysfunction.

Summary and Limitations of Objectification Theory

Objectification Theory (Fredrickson & Roberts, 1997) is a comprehensive framework used to investigate women's experiences of living in a culture that evaluates them largely based upon their appearance. Per Objectification Theory, the United States is steeped in sociocultural norms that treat women's bodies as one of the most important parts of their beings. This intense focus on women's bodies overshadows emphasis on women's capabilities, strengths, wishes, goals, etc. As women grow up in a world more focused on how they look than what they do, they begin to internalize a perpetual sense of being critically gazed upon and appraise their appearance based upon unattainable societal ideals (i.e., self-objectify). Their self-objectification directly relates to various intermediary psychological correlates (body shame, appearance anxiety, lack of flow experiences, decreased interoceptive awareness) and, via these correlates, indirectly relates to three larger mental health concerns (eating disorder symptomology, depressive symptoms, sexual dysfunction). Of these three major mental health outcomes, sexual dysfunction has been least studied.

Research in the area of sexual functioning via the framework of Objectification Theory has supported a variety of correlates related to sexual functioning. Multiple studies have supported the relationships of body shame and appearance anxiety to sexual dysfunction (Calogero & Thompson, 2009; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Although appearance anxiety consistently emerges as being strongly related to sexual functioning, body shame's relationship to sexual functioning is less clear. Some
studies have shown a direct relationship between body shame and sexual functioning (Calogero & Thompson, 2009), and other studies have identified mediators (sexual self-consciousness and appearance anxiety) that express more proximally body shame's relationship to sexual outcomes (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008; Tiggemann & Williams, 2011). Further research exploring a model that includes body shame, appearance anxiety, and sexual self-consciousness may help elucidate the interconnections between these variables, and their relationships to sexual functioning.

Variables Meriting Further Consideration in an Explanatory Model of Sexual Functioning

Sexual self-consciousness is a construct that merits further consideration in future models relating sexual functioning with objectification, due to its conceptual and empirical relationship to other Objectification Theory (Fredrickson & Roberts, 1997) variables. Conceptually, sexual self-consciousness fits with Objectification Theory, such that the body shame and appearance anxiety that women feel in a general way is likely be experienced by them in sexual contexts. In fact, they may experience appearance anxiety and body shame in a particularly intense way when they are in sexual contexts, because their bodies are highly exposed to another person. This conceptual connection is echoed in empirical studies which identify sexual self-consciousness as a mediator in the relationships of body shame and appearance anxiety to sexual functioning (Sanchez & Kiefer, 2007; Steer & Tigemann, 2008; Wiederman, 2000). Sexual self-consciousness, therefore, appears to be a manifestation of body shame and appearance anxiety, and may be more proximally related to sexual functioning than either of the other two variables. The clarity of these relationships, however, could be further elucidated via studies that
include body shame, appearance anxiety, and sexual self-consciousness in the same model. Steer and Tiggemann (2008) conducted a study of this nature and found that sexual self-consciousness fully mediated the relationships of body shame and appearance anxiety to sexual functioning; however, given that it was the only study to date which examined all three variables, the outcome bears repeating in future research.

Another construct that is emerging as an important factor in women's sexual functioning is the status of women's relationships with their sexual partners. Research suggests that women in short term relationships experience more sexual self-consciousness than women in long term relationships (Steer & Tiggemann, 2008; Wiederman, 2000). Presumably, this phenomenon occurs because women in relationships have greater opportunity to experience body image desensitization in the sexual realm with their partners (Wiederman). This differential experience between women in short vs. long term relationships, therefore, is likely to play a substantial role in women's sexual functioning and ought to be controlled for in future studies so that it does not obscure sexual self-consciousness's relationship to other variables.

One last variable that warrants exploration in its relationship to sexual functioning is sexual assertiveness. Although unstudied in its connection to other elements of Objectification Theory (Fredrickson & Roberts, 1997), sexual assertiveness appears to be related to both women's sexual self-consciousness (Wiederman, 2000) and sexual functioning (Hurlbert, 1991; Ferroni & Taffe, 1997), suggesting that it may also have a place in the theory. Conceptually, sexual assertiveness is unlikely to be the sole explanatory force for women's sexual dysfunction; however, it may be an additional and more proximal influence on sexual functioning than sexual self-consciousness. Sexual
assertiveness may be one manifestation of that self-consciousness, such that more sexually self-conscious women are less likely to assert their sexual needs and desires. This could occur because women who are sexually self-conscious allocate more of their cognitive resources to their self-image (i.e., spectatoring; Masters & Johnson, 1970), and are, therefore, less focused on asserting their needs. It may also occur because their increased self-consciousness leads them to feel less power and agency within a sexual setting. Either way, given its simultaneous distinction from and connection to variables within Objectification Theory, sexual assertiveness likely adds to the variance in sexual functioning in a way that differs from other objectification variables. It is likely to be a partial mediator in the relationship of sexual self-consciousness to sexual dysfunction.

**Operationalizing Sexual Functioning**

Given that sexual functioning is the proposed outcome of Objectification Theory that has been least well explained in the past (Calogero, Tantleff-Dunn, & Thompson, 2011), identifying additional variables that relate to this outcome is warranted. In addition to identifying other variables, however, another way to expand the theory is by operationalizing sexual functioning in a specific and comprehensive way. Researchers have defined sexual functioning in a variety of ways, including sexual arousal, sexual desire, sexual pleasure, sexual satisfaction and ability to experience orgasm (i.e., Tiggemann & Williams, 2011; Sanchez & Kiefer, 2007; Calogero & Thompson). Some researchers have examined only one or two of these areas of sexual functioning, and others have examined multiple areas, collapsing them into one construct. Tiggemann and Williams (2011), for example, chose to evaluate sexual functioning as one latent construct, but found great diversity in the extent to which certain aspects of sexual
functioning loaded onto their construct. Tiggemann and Williams's findings suggest that various measures of sexual functioning might be related, but more accurately evaluated in their own right, rather than combined into one construct. An examination of sexual functioning in this fashion may allow us to identify which facets of sexual functioning are best predicted through the Objectification Theory framework. Future studies, therefore, may benefit from including multiple distinct measures of sexual functioning without collapsing them into one construct.

Although sexual functioning has been evaluated in a variety of different ways, research has not yet identified the most effective way to summarize this construct. In an attempt to study this varied construct, some researchers have employed less than ideal ways to hone in on different facets of sexual functioning. Calogero and Thompson (2009), for example, employed a sexual satisfaction scale that only included three items. Similarly, Sanchez and Kiefer (2007) explored orgasm difficulty with two questions: "How often do you reach orgasm during sexual activity with your partner?", and "How often do you have difficulty reaching orgasm with your partner?" They also examined sexual pleasure via a three-question measure. Other studies have employed measures with multiple questions; however, they have collapsed different aspects of sexual functioning into one, broad construct and potentially missed nuanced relationships among different expressions of sexual functioning. One of the most commonly used multidimensional measures is the Female Sexual Functioning Index (FSFI; Rosen et al., 2000), which examines female sexual functioning via a comprehensive scale with six domains of sexual function: desire, arousal, lubrication, orgasm, satisfaction, and pain. The scale produces a total score, encompassing all domains; however, even total scores
from this scale may be less than ideal in their measurement of sexual functioning.

Tiggemann and Williams (2011) found great variability in each of these domains' relationship to their latent sexual functioning construct. The value of their factor loading for arousal was .89; however, the path coefficient for orgasm was only .39.

Another challenge to using the total scores from the FSFI (Rosen et al., 2000) as a summary of women's sexual functioning is that the domains of the FSFI emerged from a factor analysis of the experiences of women with Female Sexual Arousal Disorder (FSAD). Rosen et al.'s 19-item questionnaire was factor analyzed three times: once using data from 128 FSAD participants, once using data from 131 control (non-FSAD) participants, and once using the combined aforementioned samples, to total 259 women. They used a principal components analysis to identify the domains, and found a six-factor solution based upon the following statistical criteria: each item loaded highly/moderately on one factor, had low cross-factor loadings, high/moderate test-retest reliability, and good discrimination between the FSAD sample and the control sample. According to Rosen et al., the pattern of factor loadings was similar for the FSAD group and the combined group (half FSAD, half control), but not for the control group. The pattern of loadings for the control group included more cross-loadings, and potentially had a different factor structure. For example, Rosen et al. stated that lubrication and arousal items loaded onto one factor for this sample. Since Rosen et al. were more concerned with distinguishing between FSAD and non-FSAD individuals, this differing pattern of loadings was not problematic, and potentially even expected. For the purposes of surveying a sample of women who do not identify as FSAD, however, the FSFI's current factor structure may not be the best summary of sexual functioning. Provided they are
not studying FSAD, future researchers ought to consider re-examining the factor structure of the FSFI for a sample that is more representative of a non-clinical population.

**Purpose of This Dissertation**

Overall, the studies reviewed in this dissertation demonstrate that there is a growing need to explore the relationship between women's body objectification and their sexual functioning. There has been support for the use of Objectification Theory (Fredrickson & Roberts, 1997) as a framework to explain how body focus in the external environment filters down to the way that women view themselves, and ultimately affects their ability to experience a fully satisfying sexual life. Recent research on Objectification Theory has paved the way for a new understanding of women's sexual functioning. Studies have demonstrated that appearance anxiety plays a key role in women's sexual functioning, and have suggested that body shame may also relate strongly. Furthermore, previous research has explored many different manifestations of sexual functioning, including sexual satisfaction, orgasm, sexual pleasure, sexual arousal, etc. Despite the budding interest in this area of research, previous studies have not identified a standard way to model the objectification-sexual functioning link. The many disparate ways that researchers have operationalized sexual functioning leads one to wonder which areas of sexual functioning are most affected by objectification.

As researchers have moved toward a better understanding of how women's objectification can relate to their sexual functioning, they have identified that women's sexual self-consciousness may be a key driving force that both expresses women's body shame and appearance anxiety in a particular context, as well as ties these experiences to their sexual functioning. Empirically, sexual self-consciousness has been shown to
mediate the relationships of body shame and appearance anxiety with sexual functioning (i.e., Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008), and conceptually, it is sensible that women who experience body shame and appearance anxiety would also experience those phenomena when they are in an intimate and exposed setting. For these reasons, future sexual research in the objectification framework ought to include this variable.

A second variable that has emerged as important in women's sexual functioning is their relationship status. Relationship status has been included in a handful of studies that have examined sexual functioning through the lens of Objectification Theory (Fredrickson & Roberts, 1997), and early results suggest that women in committed relationships may experience better sexual functioning. Steer and Tiggemann (2008) identified that one way relationship status affects sexual functioning may be through sexual self-consciousness. They found that women in relationships experienced less sexual self-consciousness than women who were not in relationships. Sanchez and Kiefer (2007) corroborated these findings, such that relationship status emerged as a significant covariate, contributing variance to sexual self-consciousness. In order to fully understand the way that sexual self-consciousness relates to sexual functioning, then, researchers need to account for the role of relationship status.

In addition to relationship status, sexual assertiveness is another variable with the potential to explain women's functioning through Objectification Theory (Fredrickson & Roberts, 1997). Although it has not been explored via this framework, it has been explored within the realm of sexuality, and appears to be highly tied to women's sexual self-consciousness. Because sexual self-consciousness typically mediates the relationships of body shame and appearance anxiety with sexual dysfunction, sexual
assertiveness may also play a role in the expression of these constructs on women's sexuality. The addition of sexual assertiveness to a model of Objectification Theory may be particularly important because the amount of variance explained in sexual functioning is typically rather low. Sexual assertiveness could be an additional, unexplored variable that may allow researchers to better explain women's sexual functioning.

The purpose of this dissertation, then, is to investigate women's sexual functioning in a specific and comprehensive way via an expanded version of Objectification Theory that includes sexual self-consciousness, relationship status, and sexual assertiveness. The aims of the study are to answer the following research questions: (1) What factor structure in the FSFI (Rosen et al., 2000) best summarizes the sexual experiences in women of a non-clinical population? (2) To what extent does Objectification Theory predict individual aspects of women's sexual functioning? (3) How does relationship status influence the effect of body shame and appearance anxiety on women's sexual self-consciousness? and (4) To what extent does lack of sexual assertiveness explain the effects of body shame, appearance anxiety, and sexual self-consciousness on women's sexual functioning?

Hypotheses

The focus of this study involves exploring the relationship of sexual functioning to Objectification Theory (Fredrickson & Roberts, 1997) variables, and the extension of the Objectification Theory model. Please refer to Figure 2 for a visual representation of the proposed pathways. In particular, this study will: (1) factor analyze the FSFI (Rosen et al., 2000) to determine a factor structure that fits a nonclinical population, (2) explore the roles of self-objectification, body shame, appearance anxiety, sexual self-
consciousness, and sexual assertiveness in predicting sexual dysfunction (as defined by the factor structure of the FSFI), (3) explore the mediating role of sexual self-consciousness in the relationships of body shame and appearance anxiety to sexual functioning (4) explore the mediating role of sexual assertiveness in the relationships of sexual self-consciousness with sexual dysfunction.

Figure 2. An extension of Fredrickson and Roberts's (1997) Objectification Theory, as it relates to sexual functioning.

Factor Analysis

Hypothesis 1: When applied to a nonclinical sample of women, the FSFI (Rosen et al., 2000) has a different factor structure than that which emerged from a sample of
women with Female Sexual Arousal Disorder. In order to fully understand the way that the Objectification Theory model relates to sexual dysfunction, one must first identify the dimensions of sexual functioning that are most applicable to the lives of the average woman. Although the FSFI (Rosen et al.) is a measure used for exploring women's sexual functioning in multiple domains, its factor structure has been identified via the experiences of women with Female Sexual Arousal Disorder (FSAD). Rosen et al. found that the sexual experiences of women without FSAD did not seem to hold to the same structure. Rather than assuming that the factor structure for a nonclinical sample mimics that of Rosen et al.'s sample, researchers must confirm or disconfirm this structure via a Confirmatory Factor Analysis (CFA).

**Direct Relationships in Objectification Theory**

Fredrickson and Roberts suggest that self-objectification leads to body shame and appearance anxiety, and that these two psychological variables subsequently relate to sexual dysfunction. Sexual dysfunction in this study was operationalized using a factor analyzed version of the Female Sexual Functioning Index (FSFI; Rosen et al., 2000). In addition to these relationships posited by Fredrickson and Roberts, there were additional posited direct relationships that emerged from proposed variables which extend Objectification Theory. Hypotheses 2-7 describe these direct relationships.

_Hypothesis 2: Hypothesized positive relationship between self-objectification and body shame (Path A)._ Women who view themselves and their bodies from an outsider's perspective (self-objectify) experience greater shame toward their bodies.

_Hypothesis 3: Hypothesized positive relationship between self-objectification and appearance anxiety (Path B)._ Women who view themselves and their bodies from an
outsider’s perspective (self-objectify) experience greater anxiety toward the appearance of their bodies.

*Hypothesis 4: Hypothesized relationship between body shame and appearance anxiety (Path C).* Given that both body shame and appearance anxiety tap into a negative view toward one’s physical self, they are expected to be related to each other. Previous research has placed body shame as an antecedent to appearance anxiety (Tiggemann & Williams, 2011)

*Hypothesis 4: Hypothesized positive relationships of body shame and appearance anxiety with sexual self-consciousness (Paths D and E).* Women who experience increased body shame and increased appearance anxiety in general experience increased self-consciousness about their bodies when they are in a sexual setting. Various researchers (i.e., Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008) have identified sexual self-consciousness as a manifestation of generalized body shame/appearance anxiety that emerges within a sexual context.

4A: *Body shame relates positively to sexual self-consciousness (Path D).*

4B: *Appearance anxiety relates positively to sexual self-consciousness (Path E).*

*Hypothesis 5: Hypothesized negative relationships between sexual self-consciousness and measures of sexual function (Paths G1-G6).* Sexual self-consciousness directly and negatively relates to domains of sexual function. Women who experience increased sexual self-consciousness experience poorer sexual functioning in multiple areas.

Hypothesis 7: Hypothesized positive relationships between sexual assertiveness and measures of sexual function (Paths I1-I6). Hurlbert (1991), and Ferroni and Taffe (1997) identify that women who are more sexually assertive engage in intercourse more often, experience orgasm more often, experience more desire, and experience more pleasure than women who are less sexually assertive. For this reason, one could assume that women who are more sexually assertive experience increased sexual function in the dimensions of the FSFI (Rosen et al., 2000).

Mediated Relationships and Extensions to Objectification Theory

In addition to exploring direct effects of the proposed model, there are hypotheses related to indirect pathways between predictor and outcome variables. It is hypothesized that part of the total relationship between predictor variables and sexual functioning outcomes is mediated through intervening variables. Hypotheses 8 and 9 describe these mediating relationships.

Hypothesis 8: The relationships of body shame and appearance anxiety to sexual dysfunction are fully mediated by sexual self-consciousness. As reported by Sanchez and Kiefer (2007), as well as Steer and Tiggemann (2008), sexual self-consciousness is posed to fully mediate the relationships of body shame and appearance anxiety with measures of sexual functioning.

Hypothesis 8A: The relationships between body shame and domains of sexual functioning are fully mediated by sexual self-consciousness (Paths DxG1-6).
**Hypothesis 8B**: The relationships between appearance anxiety and domains of sexual functioning are fully mediated by sexual self-consciousness (Paths ExG1-G6).

**Hypothesis 9**: The relationships between sexual self-consciousness and measures of sexual functioning are partially mediated by sexual assertiveness (Paths HxI1-6). It is proposed that sexual self-consciousness may be the driving force toward sexual dysfunction, and one way (of many) that sexual self-consciousness is transmitted to women's sexual functioning is through decreased assertiveness during sexual activities.

**Covariate Relationship**

**Hypothesis 10**: Relationship status is significantly related to sexual self-consciousness (Path F). Steer and Tiggemann (2008) identified that women in committed relationships experienced less sexual self-consciousness than women who were in short term relationships. Furthermore, Sanchez and Kiefer (1997) similarly found that relationship status was significantly related to sexual self-consciousness. For that reason, relationship status is proposed to explain some of the variance in sexual self-consciousness. In order to fully understand the relationship between sexual self-consciousness and sexual functioning, then, relationship status is included as a covariate to sexual self-consciousness.
CHAPTER III

METHODS

The purpose of this chapter is to describe the participants, procedures, and instruments that were used for this study. Participants completed an online battery of surveys that evaluated their experiences with self-objectification, body shame, appearance anxiety, sexual functioning, and sexual assertiveness. The participants were also surveyed about their relationship status and satisfaction. The battery of surveys included a demographic questionnaire, as well as the Objectified Body Consciousness Scale (OBC; McKinley & Hyde, 1996) body shame and self-surveillance subscales, the Appearance Anxiety Questionnaire (AAQ; Dion, Dion, & Keelan, 1990), the Body Image Self-Consciousness Scale (BISC; Wiederman, 2000), the Sexual Assertiveness Scale for Women (SAS; Morokoff, Quina, Harlow, et al., 1997), and the Female Sexual Function Index (FSFI; Rosen et al., 2000).

Participants and Procedure

Participants were 471 women, ranging in age from 18 to 84 ($M = 37.00$, $SD = 11.64$). 414 participants (87.9%) identified as Caucasian, 10 (2.1%) identified as African American, 9 (1.9%) Latina, 3 (.6%) Asian, 6 (1.3%) Middle Eastern, 1 (.2%) Native American, 13 (2.8%) as More than one race, and 15 (3.2%) as Other. Research suggests that lesbian women experience a pattern of relationships in objectification theory that
differs from that which is experienced by heterosexual women (Kozee & Tylka, 2006); therefore, only women who identified as heterosexual or primarily heterosexual were invited to participate in this study. Of the 471 participants, 317 (67.3%) identified themselves as “in a committed relationship,” and 154 (32.7%) identified themselves as “not in a committed relationship/casually dating.” Women who identified themselves as currently being in a relationship were asked to report how long they had been in a relationship with their current partner. Of the 317 women who identified as being in a relationship, five (1.5%) had been with their partners for three months or less, one (.3%) had been with her partner between four and six months, and 311 (98.1%) had been with their partners for more than six months. Given that 98.1% of the women in relationships had been with their partners for more than six months, the researcher used a dichotomous relationship variable and was not able to explore variations within length of relationship. Participants were excluded from the study if they did not identify as female, over the age of 18, primarily heterosexual, and/or had not experienced sexual activity within their lifetime.

Participants were recruited to participate in this study in two ways. Some were recruited from Introduction to Psychology classes at a large, metropolitan, Midwestern university and were be offered extra credit for their participation in this optional study. Other participants were recruited online through women-oriented social media sites. The social media sites used to recruit participants were titled Woman2Woman, My Recipe Magic, and Women Hold Up Half The Sky. All participants completed an informed consent form and a demographics form before completing the surveys described below.
Data were collected online via a secure and encrypted computerized data collection website. Following their completion of the surveys, participants were debriefed.

**Measures**

**Objectified Body Consciousness Scale: Self-Surveillance Subscale**

The Self-Surveillance subscale of the Objectified Body Consciousness scale (OBC; McKinley & Hyde, 1996; see Appendix A) was used to measure the extent to which women monitor their bodies visually rather than considering how they feel or how their bodies operate. Self-surveillance was used as the measure of self-objectification because it is considered the outward manifestation of self-objectification (Moradi & Huang, 2008). The OBC-Self-Surveillance subscale is an 8-item subscale which measures items on a 7-point Likert Scale from *strongly disagree* (1) to *strongly agree* (7). Higher scores indicate greater body surveillance. Questions include, “I rarely compare how I look with how other people look,” (reverse coded) and “During the day, I think about how I look many times.”

There has been some discussion regarding the applicability of the OBC-Self-Surveillance scale to represent self-objectification in women, despite the fact that it has been described as the outward manifestation of self-objectification (Calogero, 2011). Tiggemann and Kuring (2004) have suggested that self-surveillance, as measured by the OBC, is not the same as self-objectification, and that the Self Objectification Questionnaire (SOQ; Noll & Fredrickson, 1998) might better represent the construct. Indeed, in some studies of women's objectification, self-objectification as measured by the SOQ has only shown weak to moderate correlations with self-surveillance measured by the OBC-Self-Surveillance subscale (Steer & Tiggemann, 2008; Tiggemann &
Kuring, 2004; Tiggemann & Slater, 2001). The SOQ (Noll & Fredrickson, 1998), which asks women to rank order a list of appearance-based and competence-based characteristics, does, in fact, differ from the OBC-Self-Surveillance subscale, which asks them to assess the extent to which they view their bodies from an observer's perspective. Despite these differences, however, the SOQ's short, rank-order format introduces more measurement error than the OBC Self-Surveillance scale, and therefore makes it difficult to adequately assess internal consistency (Calogero, 2011). This increased measurement error not only makes it difficult to gain an accurate representation of a woman's self-objectification; it also challenges the ability to make an informed hypothesis about how closely the SOQ is related to the OBC-Self-Surveillance scale. For these reasons, the OBC-Self-Surveillance subscale was used to measure women's self-objectification.

The Self-Surveillance subscale of the OBC has been employed to evaluate self-objectification and self-surveillance among many different populations. It has specifically been used to evaluate college women on multiple occasions (i.e., Basow, Foran, & Bookwala, 2007; Calogero, 2009; Tiggemann & Kuring, 2004). McKinley and Hyde's (1996) initial validation of the scale demonstrated Cronbach’s alphas ranging from .79 to .89 amongst a group of 429 college aged and middle aged women who identified as heterosexual and were primarily Caucasian. Its developers have reported that it demonstrates construct and convergent validity through its .64 correlation with the Appearance Orientation Scale of the Multidimensional Body-Self Relations Questionnaire (MBSRQ; Brown, Cash & Mikulka, 1990; see McKinley & Hyde, 1996) and its .46 correlation with the Public Body Consciousness Scale of the Body
Consciousness Questionnaire (BCQ; Miller, Murphy, & Buss, 1981; see McKinley & Hyde, 1996).

**Objectified Body Consciousness Scale: Body Shame Subscale**

The Body Shame subscale of the OBC (McKinley & Hyde, 1996) was used to measure the extent to which women feel embarrassment and humiliation toward their bodies and themselves because their bodies do not match cultural standards of body ideals and beauty. The OBC-Body Shame subscale is an 8-item subscale which follows the same format as the OBC-Surveillance subscale. It measures items on a 7-point Likert Scale from strongly disagree (1) to strongly agree (7). Higher scores indicate greater body shame. Questions include, “I feel like I must be a bad person when I don’t look as good as I could,” and “I would be ashamed for people to know what I really weigh.” Cronbach’s alpha for a group of 429 college aged and middle aged women who identified as heterosexual and were primarily Caucasian has ranged from .70 to .84 (McKinley, 1999; McKinley & Hyde, 1996). Scores on the Body Shame subscale of the OBC have been purported to reflect women’s humiliation when they do not match up to cultural standards of beauty. Correspondingly, OBC-Body Shame scores have been shown to correlate positively with women’s agreement with cultural body standards (McKinley & Hyde, 1996).

**Appearance Anxiety Questionnaire**

The Appearance Anxiety Questionnaire (AAQ; Dion, Dion, & Keelan, 1990) was used to measure the extent to which women experience apprehension about their bodies and the way that others evaluate them. Although appearance anxiety is similar to body shame in the way it relates to a critical assessment of one's appearance, it differs
from body shame because it taps into a cognitive (rather than affective) evaluation, and it explores participants' view of their appearance in a variety of different areas, including, but not limited to, their bodies. In this scale, participants rate the extent to which they identify with 30 statements of appearance nervousness on a Likert scale ranging from never (0) to almost always (4). Higher scores indicate greater appearance anxiety. Questions include, “I get nervous when others comment on my appearance,” and “I would be uncomfortable without products to enhance my appearance.”

Cronbach's alpha for a group of nearly 300 college student participants was .886, and has been evaluated at .86 in two follow-up studies (Dion et al., 1990). Furthermore, two-week test-retest reliability has been shown at .89 for a small group of participants (n=27). The high test-retest reliability suggests some stability for the construct of appearance anxiety. In support of validity, appearance anxiety scores, as measured by the AAQ, have been shown to correlate significantly with measures of self-esteem (r=-.46), shyness (r=.37), public self-consciousness (r=.32), interaction anxiety (r=.34), audience anxiety (r=.23), and social avoidance and distress (r=.27).

**Body Image Self-Consciousness Scale**

The Body Image Self-Consciousness Scale (BISC; Wiederman, 2000) was used to measure the extent to which women feel self-conscious during times of sexual intimacy. In this scale, participants rate the extent to which they identify with 15 items tapping into sexual self-consciousness. Items are rated on a 7-point Likert scale that allows women to identify how well each item typifies their intimate experience. The scaling ranges from never (1) to always (6). Higher scores indicate greater sexual self-consciousness. Questions include, "During sexual activity it is (would be) difficult not to think about
how unattractive my body is," and "I (could) only feel comfortable enough to have sex if it were dark so that my partner could not clearly see my body."

Cronbach's alpha for the BISC has been evaluated at .94 and .93 among groups of heterosexual, primarily White college women (Wiederman, 2000). Furthermore, 21-day test-retest reliability was .92 in a sample of heterosexual, primarily White college women. Wiederman identified that scores on the BISC show convergent validity with actual body size, general body dissatisfaction, and self-rated bodily attractiveness. The BISC showed evidence of discriminant validity via nonsignificant correlations with self-monitoring and control/impulsivity. These findings suggest that BISC relates to body dissatisfaction in general; however, it may differ from measures of self-surveillance, such as the OBC Self-Surveillance.

**Female Sexual Functioning Index**

The Female Sexual Functioning Index (FSFI; Rosen et al., 2000) was used to measure women's sexual functioning in six domains of sexual experiences. The FSFI is a 19-item, self-report measure that was designed to assess women's experiences over the course of the past four weeks. Previous researchers have successfully adjusted the scale so it can assess women's sexual experiences in a more general way that is not bound by the temporal limits of the past four weeks (i.e., Steer & Tiggemann, 2008). Steer and Tiggemann adjusted the FSFI scale by changing the words, "over the past 4 weeks" to "in general." The scale was adjusted in this way for the purposes of the current study. Adjusting the measure permitted sexually active women to participate even when they had not engaged in sexual activity during the last four weeks. The FSFI provides individual scores in each of six domains, as well as a total score. The six domains
assessed are: desire, arousal, lubrication, orgasm, satisfaction, and pain. Higher scores indicate healthier sexual functioning. Questions include "In general, how often do you feel sexually aroused ('turned on') during sexual activity or intercourse?" (Arousal Subscale), and "In general, how satisfied are you with your ability to reach orgasm (climax) during sexual activity or intercourse?" (Orgasm Subscale).

The FSFI (Rosenberg et al., 2000) has shown strong evidence of reliability and validity. Rosen et al. (2000) reported Cronbach's alphas for each of the subscales and the complete FSFI of .82 and higher. The FSFI has also shown test-retest reliability (over the course of 2-4 weeks) at $r = .79 - .86$ for all of the individual domains and $r = .88$ for the entire scale. The overall FSFI showed evidence of validity via its statistically significant, yet modest, correlation with the Locke-Wallace Marital Adjustment Test, which is a test of marital satisfaction. This correlation suggests that the FSFI has some overlap with marital satisfaction; however, it measures a different construct, as might be expected.

**Sexual Assertiveness Scale for women**

The Sexual Assertiveness Scale for women (SAS; Morokoff et al., 1997) is an 18-item scale that measures sexual assertiveness via three subscales: initiation, refusal, and pregnancy/sexually transmitted disease prevention. The scale is scored for each of the three subscales and an overall score for general sexual assertiveness. All items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate increased assertiveness. Questions from the three subscales include: "I begin sex with my partner if I want to" (initiation), "I refuse to have sex if I don't want to, even if my partner insists" (refusal), and "I make sure my partner and I use a condom or latex barrier when we have sex" (pregnancy/sexually transmitted disease prevention).
In a sample of 256 women in introduction to psychology classes, the SAS showed good reliability and validity (Morokoff et al., 1997). Coefficient alpha for Initiation, Refusal, Pregnancy-STD Prevention and total scores were .77, .71, .83, and .75, respectively. The SAS showed construct validity through its ability to predict a statement of sexual assertiveness, "I believe that I am assertive in sexual matters" $F (3, 256) = 33.63, p < .001$, as well as its correlation with other related measures. The Initiation and Refusal factors of the SAS also showed modest yet significant associations with relationship satisfaction, $r = .14$ and .19, respectively. All three factors also correlated significantly with women's indication that they had more say in their relationship (Initiation, $r = .11$; Refusal, $r = .13$; Pregnancy-STD prevention, $r = .16$).

**Demographic questionnaire**

The demographic questionnaire addressed participant age, gender, racial/ethnic background, sexual orientation, and relationship status. In addition, it included a question asking participants if they had experienced sexual intercourse in their lifetime. Individuals who identified as lesbian or bisexual, and/or individuals who had never engaged in sexual intercourse were excluded from this study.
CHAPTER IV

RESULTS

The purpose of this chapter is to describe the results of the study. The information presented reflects the data screening and cleaning procedures including the way that missing data were handled. Furthermore, it includes descriptive statistics, internal reliability estimates, correlations among the major variables, and the results of the confirmatory factor analysis and the path analysis.

Data Screening

Missing Data

The data were first screened according to best practices for managing missing data (Schlomer, Bauman, & Card, 2010). Schlomer et al. (2010) suggest reporting the amount, source, and patterns of missing data. The study resulted in 538 participants who took the survey. Of these 538, 23 individuals did not complete adequate amounts of the survey, in that they did not respond to any questions beyond the informed consent, demographics questions, or the first two questions in the first survey. In addition to them, four individuals did not identify as woman, 25 individuals did not identify as primarily heterosexual, and 15 individuals had not experienced any form of sexual activity in their
lives. This resulted in 67 cases, or 12.45% of individuals who did not meet the inclusion criteria and therefore were dropped from the total usable sample.

According to Bennett (2001), if no more than 10% of data are missing from a given scale, then the data are likely to be unbiased. When examining the total number of questions unanswered on each survey, the OBC-Self-Surveillance scale was missing .37% of its data, the OBC-Body Shame scale was missing 1.11%, the AAQ was missing 2.29%, the BISC was missing 3.54%, the SA was missing 6.90%, and the FSFI was missing 7.54%. Therefore, none of the individual scales violated Bennett's (2001) 10% rule. Presumably, the increasing amounts of missing data were due to participant fatigue, given that participants answered the OBC-Self-Surveillance scale first, and answered the FSFI last.

Schlomer et al. (2010) encourage researchers to examine the pattern of their missing data in order to identify whether the missingness represents data that are missing completely at random (MCAR), missing at random (MAR), or not missing at random (NMAR). Per their suggestion, the missing items were dummy coded and examined to identify whether or not there were discernible patterns in the way the data were missing. If the unanswered items are completely unrelated to other observed or missing items, then they are considered to be MCAR, and still highly representative of the population (assuming that the percentage of missing data is not too great). If the unanswered items seem to be related to another variable in the study, but not the variable of interest, then the missing data can be considered MAR. In this case, both the variable that has a high level of missingness, and the variable with which it is related ought to be included in the analyses, so as to appropriately handle the missing data. Lastly, if the variable for which
data are missing seems to be related to the score on that variable, the missing data are considered NMAR. NMAR data are problematic, but essentially difficult to determine, given that a researcher generally will not be able to determine whether a variable with missing data is related to the variable score, because the researcher does not have access to the data the participant would have provided. According to Schlomer et al., MCAR and MAR data are generally assumed, unless there appears to be evidence to the contrary.

In this study, there was a pattern to the missing data, such that participants were more likely to have missing data on scales that were presented later in the survey rather than scales that were presented early in the survey. This pattern of missingness seems to indicate participant fatigue. Little’s (1988) MCAR test was used to identify whether there were any other patterns in the missing data. Given that the FSFI was the inventory with the greatest missing data, individuals with missing data on the FSFI were compared to individuals without missing data. T-tests were used to identify whether or not there were significant differences between these two groups on the other survey measures. No significant differences emerged, and the data, therefore, were assumed to be MCAR.

Schlomer et al. (2010) suggest using Full Information Maximum Likelihood (FIML) or Multiple Imputation (MI) as ways to manage missing data while introducing the least amount of bias to the analysis. In this study, FIML was used to manage the missing data. FIML is preferred over traditional imputation methods because it does not create a new data set for the imputation of missing values. Instead, it borrows information from other data points to create an estimate for the missing value while simultaneously conducting the analysis of interest (confirmatory factor analysis and path
analysis, in this case). Furthermore, it retains the original sample size and, therefore, creates more accurate estimates of error (Schlomer et al., 2010).

**Normality**

Data were screened for normality using guidelines presented by Tabachnick and Fidell (2001). Tabachnick and Fidell suggest that researchers ought to explore outliers, skewness, kurtosis, and scatter plots in order to identify the normality of their samples. Per these recommendations, data were examined first for univariate outliers. Scale scores were converted into $z$-scores as a way to identify items with extreme standardized scores. There were two cases that exceeded an absolute value of 3.29, which was the cutoff recommended by Tabachnick and Fidell. Those scores were -3.64 and -4.02. Both of these $z$-scores came from participant scores on the FSFI, and the responses were examined for abnormalities. The responses from these two cases fell within the range of possible answers. Tabachnick and Fidell report that in large samples, it is expected that a couple of scores may exceed the 3.29 cutoff. With that in mind, no action was taken to remove or transform the scores from these two cases. All other scores fell within the absolute value of 3.29. The range of $z$-scores was from -4.02 to 2.87.

Per recommended guidelines, data were examined for multivariate outliers by calculating Mahalanobis distances for the predictor variables (Tabachnick & Fidell, 2001). Mahalanobis distances were generated, and were then compared to their value on a chi-square distribution. There were six predictors in this study, which resulted in degrees of freedom of 5 (i.e., $n - 1$). The dependent variable was a combined FSFI score. At a .001 probability for outliers with 5 degrees of freedom, the critical value is 20.515. Upon
examination of the Mahalanobis distances, one case exceeded this critical value and was identified as a multivariate outlier. According to Tabachnick and Fidell, Mahalanobis distance values can be too stringent in identifying multivariate outliers. Cook’s distance is another measure that can be used in conjunction with Mahalanobis distance to evaluate whether or not a case qualifies as a multivariate outlier. The Cook’s distance for the case that had been identified as having a large Mahalanobis distance was quite small (.003) compared to Tabachnick and Fidell’s recommended cutoff of 1.0, thereby negating its outlier status. The researcher allowed the case to remain in the data set.

Per recommendations by Tabachnick and Fidell (2001), upon completion of outlier screening, data were examined for skewness and kurtosis. Skewness and kurtosis were evaluated using z-scores generated from skewness and kurtosis values divided by their standard errors. These values are provided in Table 1. Skewness and kurtosis were also visually evaluated via a histogram plotted against a normal curve. Skewness and kurtosis values and histograms suggested that multiple scales were not normally distributed. Due to this non-normality, the maximum likelihood estimator with robust standard errors (MLR) was used to account for the non-normality of the scale scores. Muthén and Muthén (2010) identify that the MLR can be used with data sets that are missing data, and that it accounts and corrects for non-normality of data.
Table 1. Skewness and Kurtosis Values for Scale Scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>Skewness</th>
<th>SE of Skewness</th>
<th>Z of Skewness</th>
<th>Kurtosis</th>
<th>SE of Kurtosis</th>
<th>Z of Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBC-SS</td>
<td>-0.31</td>
<td>0.11</td>
<td>-2.82</td>
<td>-0.36</td>
<td>0.23</td>
<td>-1.57</td>
</tr>
<tr>
<td>OBC-BS</td>
<td>0.28</td>
<td>0.11</td>
<td>2.55</td>
<td>-0.55</td>
<td>0.23</td>
<td>-2.39</td>
</tr>
<tr>
<td>AAQ</td>
<td>0.29</td>
<td>0.11</td>
<td>2.64</td>
<td>-0.38</td>
<td>0.23</td>
<td>-1.65</td>
</tr>
<tr>
<td>BISC</td>
<td>1.02</td>
<td>0.12</td>
<td>8.20</td>
<td>0.16</td>
<td>0.23</td>
<td>0.70</td>
</tr>
<tr>
<td>SA</td>
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<td>0.12</td>
<td>-4.08</td>
<td>-0.15</td>
<td>0.23</td>
<td>-0.65</td>
</tr>
<tr>
<td>FSFI</td>
<td>-0.95</td>
<td>0.12</td>
<td>-7.92</td>
<td>0.77</td>
<td>0.23</td>
<td>3.35</td>
</tr>
</tbody>
</table>

Note: Objectified Body Consciousness, Self-Surveillance subscale (OBC-SS), Objectified Body Consciousness, Body Shame subscale (OBC-BS), Appearance Anxiety Questionnaire (AAQ), Body Image Self- Consciousness scale (BISC), Sexual Assertiveness scale (SA), Female Sexual Functioning Scale (FSFI)

**Descriptives, Correlations, and Internal Consistency Reliabilities**

Descriptive statistics, including means, standard deviations, and Cronbach’s alphas, as well as zero-order correlations were provided for all of the variables of interest. These statistics are reported in Table 2. The coefficient alphas ranged from .87 to .93, suggesting good internal reliabilities for all of the scales. The intercorrelations between individual scales range from -.40 to .76. All variables from Objectification Theory (Fredrickson & Roberts, 1997; i.e. self-objectification, body shame, and appearance anxiety) were positively correlated with each other, such that there was a moderate correlation between self-objectification and body shame ($r = .56$), a strong correlation
between self-objectification and appearance anxiety \((r = .71)\), and a strong correlation between body shame and appearance anxiety \((r = .76)\). In addition, appearance anxiety and body image self-consciousness in sexual settings were highly positively correlated \((r = .72)\).

Table 2. Correlations, Means, Standard Deviations, and Coefficient Alphas for Primary Variables of Interest

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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</thead>
<tbody>
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<td>.71*</td>
<td>.49*</td>
<td>-.23*</td>
<td>-.21*</td>
</tr>
<tr>
<td>OBC-BS</td>
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<td>.76*</td>
<td>.61*</td>
<td>-.19*</td>
<td>-.24*</td>
<td></td>
</tr>
<tr>
<td>AAQ</td>
<td>1.00</td>
<td>.72*</td>
<td>-.28*</td>
<td>-.30*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BISC</td>
<td>1.00</td>
<td>-.30*</td>
<td>-.40*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>1.00</td>
<td>.33*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSFI</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[ M \]

\[
\begin{array}{ccccccc}
M & 3.88 & 3.04 & 2.79 & 2.42 & 3.86 & 4.00 \\
SD & 0.90 & 1.04 & 0.69 & 1.23 & 0.61 & 0.69 \\
A & 0.87 & 0.88 & 0.94 & 0.97 & 0.83 & 0.93 \\
\end{array}
\]
Note. *p < 0.01, two-tailed. Objectified Body Consciousness Scale, Self-Objectification subscale (OBCSS; N = 469), Objectified Body Consciousness Scale, Body Dissatisfaction subscale (OBCBS; N=465), Appearance Anxiety Questionnaire (AAQ; N=461), Body Image Self-Consciousness scale (BISC; N= 454), Sexual Assertiveness scale (SA; N=433), Female Sexual Functioning Index (FSFI; N=434).

Tabachnick and Fidell (2001) note that inclusion of variables in an analysis that have a bivariate correlation of .70 and above can weaken the analyses by increasing the size of error terms. Three intercorrelations exceeded this cutoff (OBCSS with AAQ, .71; OBCBS with AAQ, .76; BISC with AAQ, .72). All three correlations involved the Appearance Anxiety Questionnaire, suggesting that appearance anxiety may overlap substantially and therefore be multicollinear with some of the other scales. Despite this potential redundancy, Tabachick and Fidell identify that the greatest problems occur when scales correlate at .90 and higher. This researcher decided to allow all scales to remain in the primary analyses, due to theoretical support for their presence; however, future studies may consider exploring a more parsimonious model.

Confirmatory Factor Analysis

Confirmatory factor analysis (CFA) is an analytic procedure that is often used to confirm a hypothesized factor structure within a particular population (Wang & Wang, 2012). CFAs are typically used when theory and/or empirical findings have already indicated that a particular factor structure is likely to exist. In the case of this study, Rosen et al.'s (2000) study indicated that the FSFI resulted in a six factor solution for their sample. In order to generalize that factor structure to the participants involved in
this study, the researcher chose to conduct a CFA so as to confirm (or disconfirm) that the six factor solution would also be applicable to the current sample.

Hypothesis 1 indicated that the FSFI factor structure in the current sample was expected to significantly differ from the factor structure solution that emerged from Rosen et al. (2000). Rosen et al. reported that the FSFI resulted in a six-factor oblique solution, including desire, arousal, lubrication, orgasm, satisfaction, and pain factors; however, their structure emerged from a sample of women who had been diagnosed with Female Sexual Arousal Disorder (FSAD). Due to the highly specific sample of women that had been included in the Rosen et al. study, it was proposed that a CFA for the current sample of FSFI responses might result in a different structure.

In order to test for the factor structure of the sexual functioning data, a CFA was conducted with the current sample, testing the fit of the data to Rosen et al.’s six factor oblique solution. The CFA was conducted using Mplus 5.2 (Muthén & Muthén, 1998-2010). In the analysis, a maximum likelihood estimator was used, identifying 72 free parameters. The model included six intercorrelated factors that were derived from 19 indicators. The first factor, defined by two indicators, was Desire. It included items measuring the extent to which women feel an emotional sense of wanting sexual activity. The second factor, defined by four items was Arousal. It included items measuring the extent to which women feel a physical sense of being “turned on.” The third factor, defined by four items was lubrication. It included items related to vaginal changes that women may experience in response to sexual situations. The fourth factor, defined by three indicators, was orgasm. It included items related to climax experiences related to sexual situations. The fifth factor, defined by three items, was satisfaction. It included
items that related to subjective evaluation of sexual activity. Lastly, the sixth factor, defined by three times, was pain. It included items related to feelings of vaginal pain that women may experience during sexual activity. Pain was reverse coded, so that a high score on the pain subscale indicated lack of pain and positive sexual functioning.

**Goodness of Fit Indices for the CFA**

According to Byrn (2012), researchers ought to report multiple indices of goodness of fit and examine the patterns of fit that emerge from the set, thereby obtaining a more comprehensive estimation of how well the observed data fit the proposed model. In this study, the researcher explored the chi-square test of model fit, Comparative Fit Index (CFI), Standard Root Mean Square Residual (SRMR), and Root Mean Square Error of Approximation (RMSEA) to evaluate the fit of the data to the proposed model. A non-significant $\chi^2$ value, CFI exceeding .95 (Hu & Bentler, 1999), SRMR less than .05 (Byrne, 2012), and an RMSEA that does not exceed .06 (Hu & Bentler) indicate good model fit. The chi-square statistic ($\chi^2 = 361.97, p < .001$) was significant, suggesting that the proposed CFA structure might not be an adequate fit for the data. However, Byrne suggests that the chi-square test is particularly sensitive to sample size, and often misrepresents model fit. The CFI value was .97, SRMR was .04 and RMSEA was .06, all of which suggested a well-fitting model. Considered collectively, CFA results indicated that the six-factor structure identified by Rosen et al. (2000) is an adequate representation of the structure of the FSFI in the current sample.

**Path Analysis**

Path analyses were conducted via Mplus 5.21 (Muthén & Muthén, 1998-2010) in order to examine simultaneous relationships between the variables of interest. Path
analysis is particularly useful when examining variables that have purported causal relationships, although it can only provide support for correlational, rather than causal, connections. The observed variables were self-objectification (as measured by the OBC self-surveillance subscale; McKinley & Hyde, 1996), body shame (as measured by the OBC body shame subscale; McKinley & Hyde), appearance anxiety (as measured by the AAQ; Dion, Dion, & Keelan, 1990), sexual self-consciousness (as measured by the BISC; Weiderman, 2000), sexual assertiveness (as measured by the SAS; Morokoff et al., 1997), and six sexual functioning outcomes, as measured by the six FSFI (Rosen et al., 2000) subscales: desire, arousal, lubrication, orgasm, satisfaction, and pain. Maximum likelihood estimation with robust standard errors was used to conduct the path analysis. The model was tested in two ways, in order to assess for partial and full mediators. See Figure 3 for the hypothesized model and Figure 4 for a version of the model with additional direct paths that provides support for the hypothesized fully mediated relationships of body shame and appearance anxiety to sexual functioning.

In the proposed version of the model, self-objectification was hypothesized to be directly and positively related to both body shame and appearance anxiety. Body shame was hypothesized to predict appearance anxiety. Appearance anxiety and body shame were hypothesized to directly and positively relate to sexual self-consciousness. Relationship status was also hypothesized to relate with sexual self-consciousness as a covariate, given that research suggests that it may account for some of the variance in women’s level of comfort in sexual situations (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Sexual self-consciousness was expected to directly and inversely relate to the six identified factors involved in sexual functioning via the FSFI, and
directly and inversely relate to sexual assertiveness. It was also expected to indirectly relate to the sexual functioning factors via sexual assertiveness. Sexual assertiveness was also hypothesized to relate directly and positively to those factors.

**Goodness of Fit Indices for the Path Model**

The following indices were examined to summarize how well the data fit the proposed model: chi-square test of model fit, CFI, SRMR, and RMSEA. Recall that data which fit the model well should have a non-significant \( \chi^2 \) value, CFI exceeding .95 (Hu & Bentler, 1999), SRMR less than .05 (Byrne, 2012), and an RMSEA that does not exceed .06 (Hu & Bentler). The chi-square statistic was significant, \( \chi^2(31, N=466) = 129.02, \ p < .001 \), suggesting that the proposed path analysis model might not be an adequate fit for the data. As previously stated, however, the chi-square test can misrepresent model fit due to its sensitivity to sample size. Examination of the other fit indices revealed that the CFI value was .95, SRMR was .05 and RMSEA was .08. The CFI and SRMR both met cutoffs for the indication of a good model fit; however, the RMSEA exceeded Hu and Bentler’s (1999) suggested cutoff of .06. According to Brown and Cudeck (1993), .08 still lies within the realm of acceptable fit. MacCallum et al. (1996) report that .08 to .10 suggests mediocre fit. Considering Hu and Bentler, Brown and Cudeck, and MacCallum et al., one might infer that .08 lies just on the border of an acceptable fit. Therefore, the array of fit index values indicated that the hypothesized model provided an acceptable fit to the data.

**Prediction of Sexual Functioning as Measured by the Hypothesized Model**

**Direct effects.** Given that the proposed model fit the data well, the researcher examined the path coefficients to explore the strength and significance of the predictors
for sexual functioning. Direct effects were explored first. In the hypothesized model, self-objectification related significantly and positively to both body shame ($\beta=.57, p < .001$) and appearance anxiety ($\beta=.42, p < .001$), as hypothesized. Furthermore, body shame related significantly to appearance anxiety ($\beta=.52, p < .001$). Both body shame ($\beta=.13, p < .05$) and appearance anxiety ($\beta=.62, p < .001$) related significantly to sexual self-consciousness. Additionally, sexual self-consciousness related significantly and inversely to sexual assertiveness, or lack thereof ($\beta=-.31, p < .001$). Contrary to predictions, relationship status did not explain a significant amount of variance in sexual self-consciousness ($\beta=-.05, p = .10$). Sexual self-consciousness was significantly and inversely related to each sexual outcome, including desire ($\beta=-.19, p < .001$), arousal ($\beta=-.26, p < .001$), lubrication ($\beta=-.18, p < .05$), orgasm ($\beta=-.28, p < .001$), satisfaction ($\beta=-.35, p < .001$), and pain ($\beta=-.13, p < .05$). Sexual assertiveness was significantly and positively related to five of the six sexual outcomes, including desire ($\beta=.15, p < .05$), arousal ($\beta=.28, p < .001$), lubrication ($\beta=.22, p < .001$), satisfaction ($\beta=.15, p < .05$), and pain ($\beta=.20, p < .001$). Contrary to hypothesis, sexual assertiveness was not significantly related to orgasm ($\beta=.06, p = .20$). In sum, results indicated support for 17 of 19 hypothesized direct effects. The amount of variance accounted for in the outcome variables was as follows: body shame ($R^2=.32$), appearance anxiety ($R^2=.70$), sexual self-consciousness ($R^2=.53$), sexual assertiveness ($R^2=.10$), desire ($R^2=.08$), arousal ($R^2=.19$), lubrication ($R^2=.10$), orgasm ($R^2=.09$), satisfaction ($R^2=.18$), and pain ($R^2=.07$).
Indirect and mediating effects. In addition to the direct effects, women’s sexual self-consciousness was predicted to relate indirectly to their sexual outcomes via the influence of sexual assertiveness. Because all sexual outcomes were significantly and directly related to all of the sexual outcomes, any significant indirect effects provide evidence for the role of sexual assertiveness as a partial mediator between sexual self-consciousness and sexual outcomes. Indirect effects were estimated using the bootstrapping technique, set at 1000 bootstrap draws of the original data (Kline, 2005). 95%, two-tailed confidence intervals were generated to identify whether the standardized estimate for an indirect path was likely to be different from 0 at a $p < .05$ significance.
level. Confidence intervals not including zero indicate statistically significant indirect effects (Kline). Results indicated that five out of the six indirect pathways were significant. Sexual Self-Consciousness significantly contributed to the variance in Desire ($\beta = -.04, p < .05$), Arousal ($\beta = -.06, p < .05$), Lubrication ($\beta = -.04, p < .05$), Satisfaction ($\beta = -.04, p < .05$), and Pain ($\beta = -.05, p < .05$) via its connection to Sexual Assertiveness. It did not relate to Orgasm via this connection ($\beta = -.02, ns$).

In addition to the indirect effects examined from sexual self-consciousness to domains of sexual functioning (via sexual assertiveness), indirect effects were also estimated from both body shame and appearance anxiety to sexual functioning domains, through the mediating factor of sexual self-consciousness. It was predicted that the relationships that body shame and appearance anxiety might have with areas of sexual functioning would occur via a variable that captures the self-consciousness that women feel specifically in sexual contexts. Indirect effects were estimated using the bootstrapping technique previously described, set at 1000 bootstrap draws of the original data, using $p$-values and confidence intervals to assess for significant paths (Kline, 2005). Results indicated that five out of the six indirect paths were significant for body shame and six out of six indirect paths were significant for appearance anxiety. The only path that was not significant was body shame’s indirect relationship with pain. Indirect path results are summarized in Table 3.

Given that body shame and appearance anxiety were shown to have significant indirect effects on domains of sexual functioning by means of their connection to sexual self-consciousness, a mediation model was explored that included direct paths connecting body shame and appearance anxiety with all domains of sexual functioning. This model
is shown in Figure 4. If these direct paths were found to be non-significant, then one could assume that the full impact of both body shame and appearance anxiety on sexual functioning occurs via the driving force of sexual self-consciousness (and possibly sexual assertiveness).

This model fit the data very well, as evidenced by the goodness of fit. The chi-square statistic was non-significant, \( \chi^2(10, N=466) = 12.32, \ p = .26 \), suggesting that the proposed path analysis model was an adequate fit for the data. Examination of the other fit indices revealed that the CFI value was .99, SRMR was .01 and RMSEA was .02 (90% C.I = .00-.06) All indices indicated very good fit. Although this model fit the data very well, it was not the most parsimonious model. When additional direct effects were included from body shame to sexual functioning domains and appearance anxiety to sexual functioning domains, 11 of the 12 direct effects were non-significant, the exception being the relation of appearance anxiety to sexual desire (\( \beta = .17, \ p < .05 \)) (see Table 3.) The amount of variance explained in the outcome variables in this model was as follows: body shame (\( R^2 = .32 \)), appearance anxiety (\( R^2 = .70 \)), sexual self-consciousness (\( R^2 = .53 \)), sexual assertiveness (\( R^2 = .10 \)), desire (\( R^2 = .09 \)), arousal (\( R^2 = .20 \)), lubrication (\( R^2 = .10 \)), orgasm (\( R^2 = .09 \)), satisfaction (\( R^2 = .18 \)), and pain (\( R^2 = .08 \)).
Figure 4. Path Model With All Tested Direct and Indirect Paths.  *Note:* One asterisk (*) indicates a significant value at $p < .05$ and two asterisks (**) indicate a significant value at $p < .001$. 
<table>
<thead>
<tr>
<th>Indirect Paths</th>
<th>Standardized Estimate</th>
<th>Lower 2.5% C.I.</th>
<th>Upper 2.5% C.I.</th>
<th>Upper C.I.</th>
</tr>
</thead>
<tbody>
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</tr>
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<tr>
<td>OBC-BS → SSC → Lubrication</td>
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<td>-0.05</td>
<td>-0.00</td>
<td></td>
</tr>
<tr>
<td>OBC-BS → SSC → Orgasm</td>
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<td>-0.07</td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>OBC-BS → SSC → Satisfaction</td>
<td>-0.05*</td>
<td>-0.09</td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>OBC-BS → SSC → Pain</td>
<td>-0.02</td>
<td>-0.04</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AAQ → SSC → Desire</td>
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<td>-0.06</td>
<td></td>
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<tr>
<td>AAQ → SSC → Arousal</td>
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<td>-0.23</td>
<td>-0.09</td>
<td></td>
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<tr>
<td>AAQ → SSC → Lubrication</td>
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<td>-0.18</td>
<td>-0.04</td>
<td></td>
</tr>
<tr>
<td>AAQ → SSC → Orgasm</td>
<td>-0.18*</td>
<td>-0.25</td>
<td>-0.10</td>
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</tr>
</tbody>
</table>
Post-hoc Modified Model

**Fit indices.** The results of the tests of the initially hypothesized model and the second model with direct effects connecting body same and appearance anxiety with sexual functioning dimensions suggest that some alterations might result in a stronger, better fitting model. Therefore, the researcher explored the fit and paths of the data when all non-significant paths were set to zero. In this final model, informed by the fit and paths of the two previous versions, the fit was particularly strong, and all paths were significant. The model matches the initially hypothesized model; however, the paths from relationship status to sexual self-consciousness and from sexual assertiveness to orgasm are set to zero (given that they were non-significant in the previous models).
Furthermore, there is an additional path estimated from appearance anxiety to desire, as it was significant in the second model tested. This final model shows itself to be the strongest of the three tested, due to its parsimonious summarizing of the data and its goodness of fit. The chi-square statistic is significant, $\chi^2(33, N= 466)= 126.37$, $p = .00$, CFI = .96, RMSEA = .08 (90% C.I. = .06-.09), and SRMR = .05.

**Direct effects.** In the post-hoc model, self-objectification related significantly and positively to both body shame ($\beta$=.57, $p < .001$) and appearance anxiety ($\beta$=.42, $p < .001$), as hypothesized. Furthermore, body shame related significantly to appearance anxiety ($\beta$=.52, $p < .001$). Both body shame ($\beta$=.14, $p < .05$) and appearance anxiety ($\beta$=.62, $p < .001$) related significantly to sexual self-consciousness. Additionally, sexual self-consciousness related significantly and inversely to sexual assertiveness, or lack thereof ($\beta$=-.31, $p < .001$). All of these relationships were identical in size and direction to the relationships in the hypothesized model, with the exception that body shame related to sexual self-consciousness in a slightly stronger way in this current model ($\beta$=.14 as opposed to $\beta$=.13).

When examining the relationship between predictors and outcome variables in this final model, sexual self-consciousness was significantly and inversely related to each sexual outcome, including desire ($\beta$ = -.30, $p < .001$), arousal ($\beta$=-.27, $p < .001$), lubrication ($\beta$=-.18, $p < .001$), orgasm ($\beta$=-.30, $p < .001$), satisfaction ($\beta$=-.36, $p < .001$), and pain ($\beta$=-.13, $p < .05$). Sexual assertiveness was also significantly and positively related to the hypothesized paths, including desire ($\beta$=.15, $p < .05$), arousal ($\beta$=.25, $p < .001$), lubrication ($\beta$=.20, $p < .001$), satisfaction ($\beta$=.13, $p < .05$), and pain ($\beta$=.19, $p < .001$). Recall that sexual assertiveness did not have an estimated pathway with orgasm,
given that this relationship was non-significant in the previous model. In addition to these pathways, appearance anxiety was significantly related to desire, as had been indicated in the previous model ($\beta=.15, p < .05$). The amount of variance explained in each of the outcome variables was as follows: body shame ($R^2 = .31$), appearance anxiety ($R^2 = .70$), sexual self-consciousness ($R^2 = .53$), sexual assertiveness ($R^2 = .10$), desire ($R^2 = .09$), arousal ($R^2 = .18$), lubrication ($R^2 = .10$), orgasm ($R^2 = .09$), satisfaction ($R^2 = .17$), and pain ($R^2 = .07$). See Figure 5. for the post-hoc model and associated pathways.

**Indirect effects.** Indirect effects for the post-hoc model were estimated using the bootstrapping technique, set at 1000 bootstrap draws of the original data (Kline, 2005). 95%, two-tailed confidence intervals were generated to identify whether the standardized estimate for an indirect path was likely to be different from 0 at a $p < .05$ significance level. Confidence intervals not including zero indicate statistically significant indirect effects (Kline). When exploring the indirect effects from sexual self-consciousness to the sexual functioning domains via sexual assertiveness, all five of the hypothesized paths in the post-hoc model were significant. Sexual self-consciousness contributed significantly to the variance in Desire ($\beta = -.05, p < .05$), Arousal ($\beta = -.08, p < .05$), Lubrication ($\beta = -.06, p < .05$), Satisfaction ($\beta = -.04, p < .05$), and Pain ($\beta = -.06, p < .05$) via its connection to Sexual Assertiveness. In this post-hoc model, its connection to Orgasm was set to zero, as informed by previous models.

Indirect effects for the post-hoc model were also estimated from both body shame and appearance anxiety to sexual functioning domains, through the mediating factor of sexual self-consciousness. Results indicated that, similar to findings in the hypothesized model, five out of the six indirect paths were significant for body shame and six out of six
indirect paths were significant for appearance anxiety. The only path that was not significant was body shame’s indirect relationship with pain. Indirect path results are summarized in Table 4.

In general, the indirect effects in the post-hoc model mimicked those in the hypothesized model. All paths that were significant in the hypothesized model were also significant in the post-hoc model. The strength of those relationships, however, was greater in the post-hoc model. Recall that the post-hoc model differed from the hypothesized model because it included an extra path from appearance anxiety to desire, and it set to zero the connection between relationship status and sexual self-consciousness, as well as the path from sexual assertiveness to orgasm. In sum, the post-hoc model had a better fit than the hypothesized model, and its paths showed slightly stronger relationships.
Figure 5. Post-Hoc Model. Note: One asterisk * indicates a significant value at $p < .05$ and two asterisks ** indicate a significant value at $p < .001$.

Table 4. Indirect Paths for the Post-hoc Modified Model.

<table>
<thead>
<tr>
<th>Indirect Paths</th>
<th>Standardized Estimate</th>
<th>Lower 2.5% C.I.</th>
<th>Upper 2.5% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSC → SA → Desire</td>
<td>-.05*</td>
<td>-.08</td>
<td>-.01</td>
</tr>
<tr>
<td>SSC → SA → Arousal</td>
<td>-.08*</td>
<td>-.12</td>
<td>-.04</td>
</tr>
<tr>
<td>SSC → SA → Lubrication</td>
<td>-.06*</td>
<td>-.10</td>
<td>-.02</td>
</tr>
<tr>
<td>SSC → SA → Satisfaction</td>
<td>-.04*</td>
<td>-.07</td>
<td>-.01</td>
</tr>
</tbody>
</table>
Table 4. Indirect Paths for the Post-hoc Modified Model (Continued).

<table>
<thead>
<tr>
<th>Path</th>
<th>Indirect Effect</th>
<th>Unstandardized Beta</th>
<th>Standardized Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSC (\rightarrow) SA (\rightarrow) Pain</td>
<td>-0.06*</td>
<td>-0.09</td>
<td>-0.02</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Desire</td>
<td>-0.04*</td>
<td>-0.08</td>
<td>-0.01</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Arousal</td>
<td>-0.04*</td>
<td>-0.07</td>
<td>-0.01</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Lubrication</td>
<td>-0.03*</td>
<td>-0.05</td>
<td>-0.00</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Orgasm</td>
<td>-0.04*</td>
<td>-0.07</td>
<td>-0.01</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Satisfaction</td>
<td>-0.05*</td>
<td>-0.09</td>
<td>-0.01</td>
</tr>
<tr>
<td>OBC-BS (\rightarrow) SSC (\rightarrow) Pain</td>
<td>-0.02</td>
<td>-0.04</td>
<td>0.00</td>
</tr>
<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Desire</td>
<td>-0.19*</td>
<td>-0.27</td>
<td>-0.11</td>
</tr>
<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Arousal</td>
<td>-0.17*</td>
<td>-0.24</td>
<td>-0.10</td>
</tr>
<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Lubrication</td>
<td>-0.11*</td>
<td>-0.18</td>
<td>-0.05</td>
</tr>
<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Orgasm</td>
<td>-0.19*</td>
<td>-0.26</td>
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<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Satisfaction</td>
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<td>-0.29</td>
<td>-0.15</td>
</tr>
<tr>
<td>AAQ (\rightarrow) SSC (\rightarrow) Pain</td>
<td>-0.08*</td>
<td>-0.15</td>
<td>-0.02</td>
</tr>
</tbody>
</table>

*Note. *\(p < .05\), two-tailed. (\(N=466\)). Sexual Self-Consciousness (SSC) as measured by the Body Image Self-Consciousness Scale, Sexual Assertiveness Scale (SA), Body Shame (OBC-BS) as measured by the Objectified Body Consciousness Scale, Body Image subscale, Appearance Anxiety Questionnaire (AAQ) Female Sexual Functioning Scale, Desire subscale (Desire), Female Sexual Functioning Scale, Arousal subscale (Arousal), Female Sexual Functioning Scale, Lubrication subscale (Lubrication), Female Sexual Functioning Scale, Orgasm subscale (Orgasm), Female Sexual Functioning Scale,
Satisfaction subscale (Satisfaction), Female Sexual Functioning Scale, Pain subscale (Pain).

**Summary of the Results**

In conclusion, the hypothesized model fit the data well and provided insight into the ways that self-objectification and its correlates related to many of women’s sexual experiences. Unexpectedly, the factor structure of the FSFI for Rosen et al.’s (2000) sample fit the current sample well, despite the fact that Rosen et al.’s sample consisted of many women who had been diagnosed with Female Sexual Arousal Disorder. The goodness of fit indices therefore suggested that the six components of sexual functioning experienced by the women in the current sample were desire, arousal, lubrication, orgasm, satisfaction, and pain. Sexual self-consciousness and sexual assertiveness emerged as important mediators in the relationships of body shame and appearance anxiety with these domains of sexual functioning. Path analyses revealed that sexual assertiveness partially mediated the relationships between sexual self-consciousness and all domains of sexual functioning except orgasm. In each of these relationships there were significant direct and indirect (via sexual assertiveness) connections between sexual self-consciousness and sexual functioning. In the case of orgasm, however, there was a significant direct effect between sexual self-consciousness and orgasm, but there was not a significant indirect effect occurring via sexual assertiveness.

In addition to the hypothesized model, a second model was examined that included additional direct pathways connecting body shame and appearance anxiety with the sexual outcomes. In all cases except one, these direct pathways were insignificant, suggesting that the relationships of body shame and appearance anxiety to sexual...
outcomes were fully mediated by sexual self-consciousness and sexual assertiveness. The one pathway that did not fit this pattern was the direct pathway between appearance anxiety and desire. Appearance anxiety’s connection to desire was only partially mediated by the combination of sexual self-consciousness and sexual assertiveness; it maintained a significant relationship with desire above and beyond what was explained by these mediators. Indirect pathways were explored that connected body shame and appearance anxiety to domains of sexual functioning via the mediating factor of sexual self-consciousness. Eleven out of twelve of these indirect paths emerged as significant, the one exception being body shame’s connection to women’s experience of pain during sexual experiences.

One unexpected relationship that did not emerge as significant in any of the models was relationship status’ connection with sexual self-consciousness. Relationship status was predicted to contribute significantly to the variance in sexual self-consciousness and was included as a covariate to this factor. Its failure to emerge as a significant covariate suggests that sexual self-consciousness may vary in ways that do not relate to one’s relationship status.

Using the two previous models as guides, a post-hoc model was created which included only the relationships that emerged as significant. This model diverged from the originally hypothesized model because it included a direct path from appearance anxiety to desire, and it removed the non-significant paths connecting relationship status to sexual self-consciousness and connecting sexual assertiveness to orgasm. This model showed the best fit and the strongest paths of all the tested models. When indirect paths were explored in this model, sexual self-consciousness had significant indirect effects on
all the hypothesized sexual functioning domains. Furthermore, both body shame and appearance anxiety showed significant indirect effects on domains of sexual functioning, via sexual self-consciousness. The one exception was body shame’s connection to the experience of pain during sexual activity. This indirect effect did not emerge as significant.
CHAPTER V

DISCUSSION

The purpose of this chapter is to review the objectives and hypotheses of this study, and to compare its findings with previous research. In particular, the study will be examined in the ways that it relates to and extends research in the realm of Objectification Theory (Fredrickson & Roberts, 1997). Furthermore, the researcher will explore implications of the study, limitations of the study, and suggestions for areas of future research.

Review of Objectives and Hypotheses

This purpose of this study was to revisit some of the main tenets of Objectification Theory (Fredrickson & Roberts, 1997) as they relate to sexual functioning. In implementing this study, two of the correlates of self-objectification – body shame and appearance anxiety – were examined in their relationship to desire, arousal, lubrication, orgasm, satisfaction, and pain. A CFA confirmed that these domains of sexual functioning represented a meaningful factor structure for the sexual experiences of the women included in this study. In addition to exploring how Objectification Theory constructs related to these domains, this study was intended to extend Objectification Theory by including other potentially influential variables. The other variables included were relationship status, sexual self-consciousness, and sexual assertiveness.
Although Objectification Theory (Fredrickson & Roberts, 1997) has drawn a fair amount of interest in psychological literature as of late (e.g., it was featured as a Major Section in *The Counseling Psychologist* in 2011), only certain outcomes of the theory have been heavily researched. Two of the three purported outcomes, eating disorder symptomology and depressive symptoms, have received great empirical emphasis (e.g., McKinley & Hyde, 1996; Prichard & Tiggemann, 2005; Tolman, Impett, Tracy & Michael, 2006); however, the third purported outcome – sexual functioning – has only been represented in a handful of studies (Moradi & Huang, 2008).

Given the scarcity of research exploring how women’s sexual experiences relate to the objectification of their bodies, it is unsurprising that researchers are still in the early stages of identifying and operationalizing some of the key factors in this phenomenon. Variables from Objectification Theory (Fredrickson & Roberts, 1997), including self-objectification, body shame, and appearance anxiety, have appeared in psychological research frequently, and are generally measured in similar ways across these studies. Other variables, however, such as sexual functioning, have been operationalized in a variety of ways in disparate areas of research, and it is less clear how to measure these variables in specific, comprehensive, and applicable ways. Furthermore, the small research base relating objectification variables with sexual functioning has not allowed for much exploration into new factors that may play a role in women’s body image and sexual experiences. Surely, the complexity of sexual experiences would suggest that there are other factors that are involved in these processes, even though they have not yet appeared in Objectification Theory research. One piece of research supporting this claim is a study conducted by Tiggemann and Williams (2011), in which they tested the full
model of Objectification Theory with all of its intermediary correlates and mental health outcomes. In their model, sexual functioning was the outcome with the least variance explained. This finding suggests that the theory, although a useful tool for explaining women’s experiences as a whole, may lack specificity when used strictly as a predictor of their sexual experiences. Researchers may, therefore, need to include new variables into Objectification Theory when it is applied to women’s sexual functioning.

As an attempt to address some of the limitations and questions that have emerged from previous research involving Objectification Theory (Fredrickson & Roberts, 1997) and sexual functioning, this study involved a re-evaluation of the factor structure of women’s sexual experiences, and included additional variables that appeared to be theoretically relevant in explaining the complexity of women’s sexual experiences. The current test of an expanded version of Objectification Theory was conducted with a diverse sample of women who were drawn from both a college setting and social media websites. All participant responses were anonymous, which was particularly important, given the sensitivity of the topics surveyed. The social media component of participant recruitment allowed the researcher to gather a broad swath of women’s experiences, so as to provide a more representative sample.

Although a diversity of women was recruited for this study, there were some entry-level criteria that all women had to meet in order to participate in the study. In order to be eligible, women had to identify as primarily heterosexual and they had to report that they had experienced some form of sexual experience in their life. The experience of objectification is explained as an internalization of the (societal) male gaze aimed at women (Fredrickson & Roberts, 1997; Tiggemann & Williams, 2011), and
research suggests that women who identify as lesbian or bisexual may experience this “internalized male gaze” in ways unique to their sexual orientation (Kozee & Tylka, 2006). Therefore, women who did not identify as primarily heterosexual were excluded. In addition, women who had not experienced sexual activity would not have been able to answer the majority of the questions, and they were also excluded.

Due to the multiplicity of ways that sexual functioning had previously been defined in Objectification Theory (Fredrickson & Roberts, 1997) literature, this study aimed to identify a measure that would specifically and comprehensively assess for women’s sexual experiences. The Female Sexual Functioning Index (FSFI; Rosen et al., 2000) had been used as an outcome measure in previous studies; however, researchers had often either used the cumulative score which collapsed women’s functioning across multiple domains, or they had chosen to only evaluate one or two of the sexual functioning factors in their research. Both of these ways of operationalizing female sexual function incompletely capture women’s experiences. As a result, this researcher chose to use each of the six domains as individual outcomes in the present study.

Prior to employing the six domains of sexual functioning as outcome variables, this researcher chose to conduct a CFA on the FSFI item responses (Rosen et al., 2000), so as to confirm that the domains which emerged in the initial validation study represented the experiences of the women in the present sample. This was particularly necessary because Rosen et al. validated their study on a group of women who had been diagnosed with Female Sexual Arousal Disorder (FSAD). It was uncertain if the factor structure that they had identified would also represent the experiences of the women who participated in the current study. The CFA revealed that the original six-factor structure
did, indeed, fit for the women who participated in the current study. The six identified factors were arousal, desire, lubrication, orgasm, satisfaction, and pain.

Following the CFA of the outcome measures, a path analysis was used to estimate relationships among a set of variables that had been identified as predictors of the sexual functioning outcomes. The path analysis included three of the original Objectification Theory (Fredrickson & Roberts, 1997) variables – self-objectification, body shame, and appearance anxiety –, the six domains of sexual functioning (as outcome variables), as well as two new intermediary variables and one covariate. The additional variables that were added were sexual self-consciousness and sexual assertiveness, and the covariate was relationship status.

Sexual self-consciousness is a variable that had been included in some Objectification Theory research to measure the expression of body shame and appearance anxiety that women experience when they are engaged in sexual activities (i.e., Sanchez & Kiefer, 2007). Research suggests that sexual self-consciousness often coincides with experiences of sexual dysfunction (Sanchez & Kiefer; Steer & Tiggemann, 2008). One might interpret these findings to mean that women who experience discomfort and anxiety related to their bodies and appearance during sexual activities experience less enjoyable sexual outcomes.

The relationship between sexual self-consciousness and the six domains of sexual functioning, however, was hypothesized to be partially mediated by sexual assertiveness. Weiderman (2000) identified that women who are more sexually self-conscious also tend to be less assertive with their sexual needs and desires. Research in the area of sexual functioning has also identified that women who are less sexually assertive tend to have
poorer sexual outcomes (Hurlbert, 1991). Given these two findings, it seemed reasonable to hypothesize that some of the negative sexual outcomes associated with sexual self-consciousness occur via a lack of sexual assertiveness. For that reason, sexual assertiveness was included as a partial mediator in the relationship between sexual self-consciousness and sexual functioning.

The last new variable included in this study was relationship status. Research has suggested that women in short-term relationships may experience more sexual self-consciousness than women in long-term relationships. It was important, therefore, to include relationship status as a covariate in this study so as to ensure that measures of sexual self-consciousness were not merely reflecting women’s relationship status in long-term or short-term relationships. Relationship status was the third new variable that was included in this study as a way to extend current Objectification Theory (Fredrickson & Roberts, 1997) research.

The hypothesized model, which included these additional variables, was arranged in a theoretically grounded sequence, such that self-objectification predicted body shame and appearance anxiety. Body shame predicted appearance anxiety, and both variables were hypothesized to be positively related to the experience of sexual-self-consciousness (with some variance also accounted for by the relationship status covariate). Sexual self-consciousness was then hypothesized to be directly and positively related to women’s sexual functioning on the six identified sexual domains of desire, arousal, lubrication, orgasm, satisfaction, and pain. These relationships were also hypothesized to be partially mediated by sexual assertiveness. The model as a whole was expected to lend support to the placement of sexual (dys)functioning as a mental health outcome in Objectification
Theory (Fredrickson & Roberts, 1997), and also identify the specific sexual outcomes that could be expected to suffer when a woman experiences high levels of self-objectification. This study was groundbreaking in its extension of Objectification Theory to include the variables of sexual self-consciousness, sexual assertiveness, and relationship status. It was expected that the addition of these variables might help to explain additional variance in women’s sexual experiences as they relate to self-objectification.

**Discussion of Research Findings**

**Operationalization of Sexual Functioning**

The current study provides support for the use of the FSFI (Rosen et al., 2000) as an explanatory framework for women's sexual functioning. Although the FSFI has been used in various forms to define women's sexual functioning, it had not been confirmed through a CFA to be used with a non-clinical population. Given that it was initially normed on women who experienced FSAD, it was not clear that the instrument would be applicable for women who did not experience arousal problems. Ethical use of the FSFI required scientific inquiry into its generalization to other populations. The CFA in the present study showed very good fit for the use of the FSFI with the women in the current sample, suggesting that their sexual functioning was well expressed via the constructs of sexual arousal, desire, orgasm, lubrication, satisfaction, and pain.

**Role of Self-Objectification, Body Shame, and Appearance Anxiety Variables**

The path analyses in the current study revealed that, as predicted in Objectification Theory (Fredrickson & Roberts, 1997), self-objectification was moderately and significantly related to body shame and appearance anxiety. The effect
sizes in the current study for self-objectification’s relationships to body shame ($\beta = .57$) and appearance anxiety ($\beta = .42$) were similar in size to those identified by Tiggemann and Williams’s (2011) test of the entire Objectification Theory ($\beta$s = .42 and .37, respectively). These results lend support to Fredrickson and Roberts’s theory that when women internalize the objectifying gaze that others direct at them, they start to evaluate their self-worth based upon the way that the look. This internalized self-criticism and self-objectification often contribute to feelings of shame when women realize that their bodies do not match societal ideals, and anxiety when they try to manage their appearance as a result of this discrepancy.

**Role of Sexual Self-Consciousness**

Sexual self-consciousness is a relatively new variable that was included in the current study. It has been emerging as an important mediator variable involved in the application of Objectification Theory (Fredrickson & Roberts, 1997) to sexual functioning (i.e., Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008), and appears to function as an expression of the generalized body shame and appearance anxiety women feel when they are operating in the specific context of a sexual situation. In the current study, both body shame and appearance anxiety were positively and significantly related to sexual self-consciousness; however, sexual self-consciousness’s relationship to appearance anxiety was stronger than its relationship to body shame. Sexual self-consciousness’s comparatively stronger relationship with appearance anxiety is not unsurprising, given that anxiety and self-consciousness are both cognitive in nature, whereas shame is more of an emotional experience.
The unequal contributions of appearance anxiety and body shame to sexual self-consciousness reflect a pattern that has been emerging in sexuality research within the context of Objectification Theory (Fredrickson & Roberts, 1997), such that appearance anxiety seems to play a stronger role than body shame in negative sexual experiences. Steer and Tiggemann (2008) found that body shame related modestly to sexual self-consciousness ($\beta = .21$), whereas appearance anxiety had a stronger relationship ($\beta = .47$). Tiggemann and Williams (2011) found a similar pattern; body shame’s relationship to sexual functioning was non-significant and small in size ($\beta = .20$) and appearance anxiety’s relationship was significant and moderate ($\beta = -.47$). In the current study, an examination of direct pathways connecting both body shame and appearance anxiety with the domains of sexual functioning revealed that only appearance anxiety had a significant direct pathway to an area of sexual functioning (desire) above and beyond what was expressed through the mediating variables of sexual self-consciousness and sexual assertiveness. Body shame had no significant direct paths to areas of sexual functioning. These results suggest that the cognitive aspect of focusing on one’s appearance may be a bigger obstacle to some areas of sexual functioning (specifically desire) than the emotional feelings of shame. Surely, though, as predicted in this model, the two phenomena are related.

It is unclear why appearance anxiety would maintain a direct relationship with sexual desire above and beyond what is explained by sexual self-consciousness and sexual assertiveness, although a connection of this nature seems to indicate that a general sense of anxiety could affect women’s sexual functioning before they even find themselves very involved sexual situations. Women who experience strong anxiety about
how they look could experience more global feelings of anxiety that would dull the desire that they have to engage in a variety of activities, including sexual ones. This anxiety might affect sexual desire more than other sexual outcomes because desire tends to occur before experiences of arousal, lubrication, orgasm, satisfaction, or pain. If a woman feels too great of a sense of appearance anxiety and, consequently, decreased feelings of sexual desire, any initiations of sexual acts might end prematurely.

**Role of Sexual Assertiveness**

As predicted, sexual assertiveness served as a partial mediator in most of the relationships between sexual self-consciousness and domains of sexual functioning. It was a significant partial mediator in five of the six relationships, and only failed to mediate the relationship between sexual self-consciousness and orgasm. This finding suggests that one of the reasons why sexual self-consciousness relates to poorer sexual outcomes is because increased sexual self-consciousness coincides with decreased sexual assertiveness, and that decreased sexual assertiveness tends to relate to negative sexual outcomes. It appears that women who feel more self-conscious in sexual situations tend to assert themselves less about their sexual needs, and end up experiencing less desire, arousal, lubrication, and satisfaction, as well as increased pain. One might assume that women who are feeling uncomfortable in these settings might experience a decreased sense of sexual agency which could influence their likelihood to tell their partners which sexual activities feel good and/or which ones do not. If women do not feel empowered to speak up about their feelings in sexual situations, then their sexual experiences are likely compromised.
Decreased sexual assertiveness, however, is only one of the ways that sexual self-consciousness relates to sexual outcomes. The significant direct relationship that remained between sexual self-consciousness and all domains of sexual functioning after accounting for sexual assertiveness indicates that there are other reasons why increased sexual self-consciousness might result in decreased sexual functioning that do not involve sexual assertiveness. One way that self-consciousness might impact women in the bedroom above and beyond sexual assertiveness is by decreasing their ability to fully immerse themselves in the sensory stimulation of sexual experience. Masters and Johnson (1970) suggest that “spectatoring,” i.e., observing one’s appearance from a bystander standpoint when engaging in sexual activities, can create negative self-appraisal that prevents individuals from attending to pleasure during sexual acts. Furthermore, they report that the negative emotional state associated with spectatoring conflicts with the positive emotional states connected to sexual arousal and pleasure. Considering Masters and Johnson’s theory of spectatoring, the experience of observing oneself from afar would not have to connect with sexual assertiveness in order to influence one’s sexual experience, but rather, would relate to sexual outcomes in a more direct way.

Although sexual assertiveness had a significant positive relationship with five of the six sexual functioning domains, it did not have a significant relationship with orgasm. One might assume that a woman’s ability to assert her desires during sexual contact might influence the likelihood that she would experience orgasm during sexual activities. Women in the current study did not report that their ability to assert their needs in sexual situations was related to their frequency of experiencing orgasm during sexual activities.
Given that orgasm has been identified as a complex experience that is influenced by many different factors (Meston, Hull, Levin, & Sipski, 2004), it could be that any influence of sexual assertiveness on this variable is diluted by other variables. It seems likely, therefore, that the experience of orgasm for women may be one of the more difficult sexual outcomes to predict, as evidenced by the current study.

**Indirect Effects of Body Shame and Appearance Anxiety**

In addition to all of the direct paths and mediated relationships mentioned previously, the path model was examined to identify if body shame and appearance anxiety were significantly and indirectly related to women’s domains of sexual functioning, via sexual self-consciousness and sexual assertiveness. These individual indirect relationships might be expected, given that the original Objectification Theory model (Fredrickson & Roberts, 1997) predicted that body shame and appearance anxiety would directly predict sexual functioning, as a unified construct. The current findings identified that, indeed, both body shame and appearance anxiety were significant indirect predictors of each of the domains of sexual functioning, with the exception of body shame’s connection with pain during sexual activity. Pain appeared to be better predicted by appearance anxiety. Anxiety often takes a physiological expression of tensing the body, which might relate to its significant connection with sexual pain. Body shame does not appear to affect women’s physiological experience of pain in the same way.

**Role of Relationship Status**

One variable that did not fit the model in the hypothesized way was relationship status. Previous studies had suggested that women in long-term, committed relationships were less likely to experience sexual self-consciousness (e.g., Sanchez & Kiefer, 2007).
In the current study, however, that relationship was non-significant. Although relationship status did not emerge as a significant covariate, its direction was consistent with predictions; women who were in long term relationships experienced slightly less self-consciousness in sexual settings. Even so, the small effect size and non-significance of the relationship make it difficult to infer information about the role of relationship status in sexual self-consciousness.

One reason why relationship status may not have emerged as a significant covariate is because, as a variable, it is subjective, difficult to operationalize and difficult to map onto a continuous scale that allows for variability. This researcher attempted to resolve these problems by including a question that asked all individuals who identified as “in a relationship” to report how long they had been seeing their current partner. Ideally, individuals would then have been placed in one of multiple categories based upon the number of months/years that they were seeing their partners. Unfortunately, however, there was very little variability, considering that 97.9% of the individuals who identified themselves as being in a committed relationship had been dating their partners for 6 months or more. As a result, the relationship status variable was coded as dichotomous and collapsed into two categories: “not currently in a relationship/casual dating,” and “in a committed relationship.” About two thirds of the participants identified themselves as “in a committed relationship,” and the lack of variability in this category may have affected the predictive power of this construct.

Although the relationship status variable was dichotomized, it is still surprising that it did not emerge as a significant covariate, given that previous studies have found it to be significant. Sanchez and Kiefer (2007), for example, found that relationship status
emerged as a significant (albeit small in size) predictor of sexual self-consciousness ($\beta=.14$), even though it was measured as a dichotomous variable similarly to the way it was measured in the current study. Similarly, Steer and Tiggemann (2008), found significantly different levels of sexual self-consciousness in a $t$-test examining women who were in a relationship vs. women who were not in an exclusive relationship. These studies differed from the current study in that the age of their participants was somewhat lower. The current study had a mean age of 37.9 ($SD = 11.91$) which might suggest that the women in this study had more relationship experience than younger women, and may have achieved a greater level of comfort with their bodies. Sanchez and Kiefer’s participants had a mean age of 31.01 ($SD = 12.96$), and Steer and Tiggemann’s participants had a mean age of 22.74 ($SD = 8.44$). It is uncertain how age or lack of variability may have affected the strength and significance of the relationship status covariate; however, future research may explore operationalizing relationship status in a way that allows for greater variance within the construct and collecting an age- and relationship-stratified sample of women that would allow for a more detailed analysis of sexual activity within varied levels of these constructs.

**Summary of the Path Model**

Taken together, the significant paths identified in the current model suggest that the extent to which women experience self-objectification (i.e., comparison of self to societal body models) relates significantly to the amount of shame they feel about their bodies and the amount of anxiety they experience regarding their appearance. Furthermore, the emotions of body shame and appearance anxiety they feel relate to the cognitive experience of being preoccupied about how they look. Both of these
experiences (but especially the appearance anxiety) connect to the self-consciousness that they feel about their body’s appearance in sexual settings. Their sexual self-consciousness coincides with the (lack of) assertiveness they show in the bedroom. That sexual self-consciousness results in more negative sexual outcomes in its own right, and it also results in more negative sexual consequences via the operating factor of decreased sexual assertiveness. Some negative sexual outcomes connect with both sexual self-consciousness and sexual assertiveness; the experience of decreased orgasm, however, appears to only relate to the experience of sexual self-consciousness and is unrelated to sexual assertiveness. When examined for indirect effects, the current model also revealed that both body shame and appearance anxiety are indirectly (via sexual self-consciousness) and significantly related to women’s experiences of sexual functioning, with the exception of body shame’s relationship to women’s experience of pain during sexual activity.

**Limitations of the Study**

As with any study, the findings that have emerged from the current study ought to be considered within the context of limitations that may have affected the results. One area of consideration is the collection and composition of the sample. The sample in the current study was collected via both recruitment of college students involved in psychology classes and via social media. Multiple forms of recruitment were used in order to diversify the sample and increase the generalizability of the results. The inclusion of social media data collection likely increased the age diversity in the sample ($M=37.00, SD=11.64$); however, the sample was still largely homogenous, particularly in reference to racial and ethnic background (i.e., 90% Caucasian). This homogeneity
affects the extent to which the current findings can be applied to individuals who are of
diverse racial and ethnic backgrounds.

The use of social media to collect participant data likely influenced the type of
women who were exposed to the study and given the opportunity to participate. The
researcher used snowball sampling by spreading the study widely via a variety of
individuals who also spread the study to people they knew; however, she also posted the
study on women-focused social media sites which may have honed in on women with
shared interests/backgrounds. There is no way to know whether this type of sampling
affected the responses received; however, it is important to note that this could have been
an influential factor for some of the participants gathered.

Another significant limitation in the current study is the racial homogeneity of the
sample. Due to this homogeneity, it is uncertain to what extent one can generalize the
results beyond white women. With that said, however, there is some research suggesting
that women of color may experience some similarities with white women in the ways
they are affected by self-objectification and its correlates. For example, in Hebl, King,
and Lin (2004)’s exploration of cross-racial experiences of objectification, Hebl et al.
found that Hispanic, Asian, African American, and Caucasian women experienced
similar patterns of negative effects that emerged from putting on a swimsuit (i.e. priming
a self-objectification state). Despite this similarity in pattern, they found that African
American women experienced less state self-objectification than white women. Other
studies, however, have suggested that Objectification, Theory, as applied to African
American women, is incomplete, and ought to include culture specific variables, such as
skin tone, if it is to fully capture the experiences of women of color (Buchanan, Fischer,
Tokar, & Yoder, 2008; Mitchell & Mazzeo, 2009). These examples highlight a movement toward extending Objectification Theory’s application to women of diverse racial and ethnic backgrounds; however, this movement is slowly evolving, and it has not yet expanded to include sexual experiences.

Another potential limitation is the age of the women that were represented in this study. Given that the mean age in this study was 37.0 ($SD = 11.64$), the women who participated were of an older age than many of the female college students who have participated in the vast majority of Objectification Theory research. Since Objectification Theory has primarily been used as a framework for understanding young (i.e., 18-24 years) women’s experiences (Augustus-Horvath & Tylka, 2009), the elevated mean age in this study presents a question as to whether or not the current findings could be used to describe the experiences of women in early adulthood. Although there is merit to exploring a wide age range of women, similar to those found in the current study, there is also value in honing in on the young adult age range. Research suggests that the societal model of beauty to which many women compare themselves includes an age component, in addition to the body shape and size components (Augustus-Horvath & Tylka). Women in their early adulthood years are often considered to be at the peak of their beauty (per societal standards), and they might, therefore, be more keenly influenced by forces of objectification than women of other ages. On the other hand, some research suggests that objectification affects women of all ages (Augustus-Horvath & Tylka; Fredrickson & Roberts, 1997). The higher mean age in the current study, combined with the variability of ages included, may enable the findings to generalize to a greater population of women.
Implications for Research and Practice

Research

The results of the current study could have a profound impact on the ways in which we conceptualize research within Objectification Theory and identify influential factors in women’s sexual functioning. The strong fit of the model in the current study suggests that researchers exploring women’s sexual experiences can benefit from using an objectification lens to better understand the multitude of influences on women’s sexual experiences. Clearly the variables in the current study do not explain all of the function/dysfunction women experience in sexual domains; however, the significance of the variables highlights that an important component of sexuality for women is the way that they see themselves and the extent to which they have internalized societal ideals as the “perfect” body.

In particular, the current study calls for an extension of Objectification Theory to include new intermediary variables. The inclusion of sexual self-consciousness and sexual assertiveness when modeling objectification theory (as applied to sexual experiences) may allow researchers to better understand how objectification constructs connect with each other. Sexual self-consciousness and sexual assertiveness fully mediated the relationships of body shame and appearance anxiety with domains of sexual functioning in 11 out of 12 instances. The inclusion of these mediators allows us to better represent the ways that self-objectification, body shame and appearance anxiety relate to women’s sexual functioning. Considering that the original Objectification Theory (Fredrickson & Roberts, 1997) model did not include mediators in the relationships of body shame and appearance anxiety with sexual functioning, the current
findings suggest that such mediators could be important to include, at least when Objectification Theory is being used to predict sexual functioning, instead of other outcomes of the model.

The current study also supports the use of the FSFI as a specific and comprehensive framework for understanding women's sexual experiences in the Objectification Theory model. Although most of the sexual outcomes statistically related to the predictors in similar ways, the specificity of the FSFI allowed this researcher to detect the exceptions to these similarities. For example, body shame was related to the experience of pain in a direct way, and was not mediated by sexual self-consciousness and sexual assertiveness (as was the case for body shame’s relation to the other sexual functioning variables). Similarly, orgasm was predicted by sexual self-consciousness, but, unlike the other areas of sexual functioning, it had no relationship to sexual assertiveness. These fine grained differentiations suggest that women’s sexual functioning is not just one composite experience, but rather, is a compilation of many individual factors.

Given that relationship status did not emerge as a significant covariate in the current study, but was identified as being significant in previous studies, future researchers ought to consider exploring different ways of measuring this variable, and identifying whether age plays a role in the extent to which relationship status is related to sexual experiences. Relationship status likely is not best measured as a categorical variable, considering that two elements of relationship status – time spent together and amount of commitment felt – are likely to be more continuous in nature. If relationship status is studied in a categorical way in future studies, it ought to include more than two
response options (i.e., *in a committed relationship* vs. *not in a committed relationship*), and researchers might consider using a stratified sample of women who are intentionally chosen for greater variance in relationship statuses. Furthermore, researchers ought to consider sampling specifically for women in different lengths of relationships, as well as measuring relationship status in new ways, such as exploring how relationship quality or satisfaction might be a better predictor of sexual self-consciousness than relationship commitment or length.

**Practice**

The results of the current study have profound implications for the ways that the field of Counseling Psychology might address women's struggles with body image and sexual functioning. In particular, these results suggest that counseling psychologists ought to receive increased education in areas of sexual functioning and its connection to body image and general well-being. With increased education in these areas, counseling psychologists may be better advocates for women and for women's healthy sexual lives. This role of healthy sex advocate can be expressed both in the counseling arena, and also in the greater environment via prevention and education of others.

Within the realm of counseling, this study suggests that women's experiences of sexual dysfunction are connected to a larger societal problem of the sexual objectification of women. Although women may be aware of sexual objectification in the media, they may not connect it to their own internalization of that objectification (i.e. self-objectification), or the ways that objectification may filter into their sexual lives. The pervasiveness of unhealthy cultural portrayals of women makes it insidious, and difficult to detect. Female clients presenting with sexual concerns may not automatically see
connections between their individual experiences and the health of the greater societal environment. For this reason, it is the job of counseling psychologists and other individuals in the mental health care arena to draw these connections for clients. Furthermore, female clients who may harbor shame related to their body image and sexual functioning concerns ought to be informed that these experiences can be interrelated. The use of psychoeducation can both help women see connections between body image and sexual functioning, as well as elucidate the ways that these concerns emerge from an unhealthy societal portrayal of women. By normalizing women's experiences with sexual dysfunction and connecting it to larger societal forces, counseling psychologists can participate in destigmatizing women's experiences of sexual dysfunction. Furthermore, this normalization provides clients with a sense of power over their ability to refute the media representation of women as being a healthy or accurate one. The decreasing of shame around negative body image or sexual dysfunction may promote women’s empowerment around these issues, they may assist women in gaining some resiliency against the internalization of sexual objectification in the first place. This type of a feminist informed intervention fits with Counseling Psychology's commitment to promoting socially just interventions for clients.

Another way that the current results could inform practice is through an increased emphasis on sexual assertiveness when working with clients who experience sexual dysfunction. Mental health professionals ought to be able to explain to their clients that individuals who use more sexual assertiveness tend to have improved sexual functioning. This information could promote feelings of agency and power in their clients, as women become more aware of their ability to take greater control over their sexual experiences
The role of exposing how societal objectification filters into women's sexual lives extends beyond the counseling room and into policy and program promotion. As social justice advocates, counseling psychologists have the responsibility of generating conversation about these topics in order to inform best practices in the arena of women's sexual health. Mental health professionals that who are armed with the knowledge of how sexual objectification relates to women's sexual experiences are in the unique position of advocating for resilience-focused prevention programs that may affect the way sexual objectification is internalized by young women. If schools were able to incorporate more education around healthy body-image, they might be able to help to sow the seeds of resilience in girls before they find themselves in sexual situations. This building of resilience has implications for women's sexual safety, as well as their sexual health and enjoyment. Since sexual assertiveness is related to self-objectification (via intermediary variables), decreasing the amount of self-objectification women feel may increase women's empowerment to define their sexual boundaries, and assert themselves when they wish to say no to sexual acts. One might assume that the male power and privilege that creates the objectification of women's bodies also builds an environment that is predisposed toward men's feelings of ownership over women's bodies. Increased education in health body-image might influence women's experiences of sexual coercion and assault.

In addition to benefitting young women, increased education around how sexual objectification affects women could benefit young men as well. Young men are negatively affected by the sexual objectification of women, as it likely prevents them from being able to connect with women on more human levels. The education of young
men around power and privilege, as well as how power and privilege relate to men’s objectification of women’s bodies may help young men identify how societal messages affect their expectations for women, women’s bodies, and their sexual experiences. The sexual objectification of women robs men of their ability to connect with women based upon shared values, passions, activities, and interests. Early education of young men in these topics might buffer the effects of sexual objectification on men's later relationships with women.

Summary

The findings of the current study suggest that Objectification Theory (Fredrickson & Roberts, 1997) ought to be modified from its original, basic form when applied to sexual functioning. In order to more fully capture the ways that self-objectification relates to sexual functioning, a model of Objectification Theory ought to include sexual self-consciousness and sexual assertiveness as mediators, and ought to operationalize sexual functioning into its specific functioning domains (e.g., desire, orgasm). When researchers model Objectification Theory’s application to sexual functioning in this way, it more fully captures and explains the experiences of white, heterosexual women of various ages. It is important to note that the current model ought to be tested with women of different races and ethnicities before it can be assumed to capture their experiences as well. Furthermore, one large population of women that was excluded from the current study was women who identify as lesbian, bisexual, or any orientation other than primarily heterosexual. Although their exclusion was intentional, due to indications that non-heterosexual women experience objectification differently (Haines et al., 2008),
future research ought to focus on exploring the ways that women who do not identify as primarily heterosexual are affected by objectification.

The findings of the current study illuminate the multitude of ways that women’s sexual experiences might relate to their internalization of sexual objectification that occurs within the environment. If mental health professionals could share this information with more women, then they might experience less shame and/or stigma surrounding their experiences, and they might be able to develop an increased sense of control and resiliency against the effects of sexual and self-objectification. In addition, the emergence of sexual assertiveness as an important factor in connecting self-objectification and sexual outcomes can empower women to take behavioral action (by asserting their sexual needs) to improve their sexual experiences and buffer the effects of self-objectification.
REFERENCES


Byrne, B. M. (2012). Structural equation modeling with Mplus: Basic concepts, applications, and programming. Taylor & Francis Group, LLC, NY.


APPENDICES
SCREENING QUESTIONS AND DEMOGRAPHIC QUESTIONNAIRE

Screening Questions

*Participants will be presented with these questions following the informed consent. If they do not answer "yes" to all questions, they will be presented with the statement below.*

*If they do answer "yes" to all questions, they will be taken to the beginning of the survey.*

1.) Do you identify as a woman?
   a. Yes
   b. No

2.) Are you over the age of 18?
   a. Yes
   b. No

3.) Do you identify as heterosexual, or primarily heterosexual?
   a. Yes
   b. No

4.) Have you had sexual intercourse during your adult life?
   a. Yes
   b. No
If No to any of the questions:

Thank you for your interest in this study. Unfortunately, you are not eligible to participate at this time. You may close your web browser now. If you have any questions, please contact the principal investigator, Betsy Lehman, at eal18@zips.uakron.edu.

Demographic Questionnaire

1.) Age: _________

2.) Sex:
   a. Male
   b. Female
   c. Intersex

3.) Sexual orientation:
   a. Exclusively Heterosexual
   b. Primarily Heterosexual
   c. Bisexual
   d. Lesbian
   e. Other (please describe)

4.) Racial/ethnic identity (choose all that apply):
   a. African American/Black
   b. Asian American
   c. European American/Caucasian/White
d. Hispanic/Latino/a
e. Native American
f. Middle Eastern
g. More than one race
h. Other (please specify)

5.) What is your current country of residence?
   a. United States of America
   b. Other (please specify)

6.) Which option best describes your relationship status?
   a. Not currently in a committed relationship or casual dating
   b. In a committed relationship
      (if the participant identifies as being in a committed relationship, they will be presented with the following 3 questions)
      i. How long have you currently been in a relationship with this partner?
         1. Less than a month
         2. One month to three months
         3. Three months to six months
         4. Greater than six months
      ii. On a scale of 1 to 5, with 1 indicating unsatisfied and 5 indicating completely satisfied, how satisfied are you with your relationship?
iii. Have you been sexually active with this partner?

1. No
2. Yes, via fondling
3. Yes, via oral sex
4. Yes, via sexual intercourse
5. Yes, via any combination of fondling, oral sex, or intercourse
6. Other (please specify)

7.) How long was your most recent romantic relationship?

a. I have not had any previous romantic relationships
b. Less than a month
c. One month to three months
d. Three months to six months
e. Greater than six months

(if the participant identifies has having previous romantic relationships, she will be presented with the following questions)

i. Were you sexually active with this partner?

1. No
2. Yes, via fondling
3. Yes, via oral sex
4. Yes, via sexual intercourse
5. Yes, via any combination of fondling, oral sex, or intercourse

6. Other (please specify)

8.) How long was the longest romantic relationship that you experienced?

   a. I have not had any previous romantic relationships
   b. Less than a month
   c. One month to three months
   d. Three months to six months
   e. Greater than six months

*(if the participant identifies having previous romantic relationships, she will be presented with the following questions)*

   i. Were you sexually active with this partner?

      1. No
      2. Yes, via fondling
      3. Yes, via oral sex
      4. Yes, via sexual intercourse
      5. Yes, via any combination of fondling, oral sex, or intercourse
      6. Other (please specify)

9.) Student status (Are you CURRENTLY):

   a. Not currently a student
b. Working on GED

c. Trade school or apprenticeship

d. Undergraduate student

e. Graduate or professional student

10.) Are you currently employed?

   a. Yes

   b. No

   c. Retired

   If yes, what is your employment status?

   i. Full-time (35 hours or more per week)

   ii. Part-time (less than 35 hours per week)
APPENDIX B

OBJECTIFIED BODY CONSCIOUSNESS SCALE: SELF-SURVEILLANCE

SUBSCALE

Objectified Body Consciousness Scale: Self-Surveillance subscale
For each of the statements below, indicate to what extent you agree or disagree with the statement, using the following scale, where 0=strongly disagree, 1=disagree, 2=somewhat disagree, 3=somewhat agree, 4=agree, and 5=strongly agree.

Strongly Disagree  Disagree  Somewhat Disagree  Somewhat Agree  Agree  Strongly Agree

Agree

0  1  2  3  4  5

1. I rarely think about how I look*

2. I think it is 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 often 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.*
Note: *Reverse scored item.
APPENDIX C

OBJECTIFIED BODY CONSCIOUSNESS SCALE: BODY SHAME SUBSCALE

Objectified Body Consciousness Scale: Body Shame subscale
For each of the statements below, indicate to what extent you agree or disagree with the statement, using the following scale, where 0=strongly disagree, 1=disagree, 2=somewhat disagree, 3=somewhat agree, 4=agree, and 5=strongly agree.

Strongly Disagree  Disagree  Somewhat Disagree  Somewhat Agree  Agree  Strongly Agree

Agree

0  1  2  3  4  5

1. When I can’t control my weight, I feel like something must be wrong with me.

2. I feel ashamed of myself when I haven’t made the effort to look my best.

3. I feel like I must be a bad person when I don’t look as good as I could.

4. I would be ashamed for people to know what I really weigh.

5. I never worry that something is wrong with me when I am not exercising as much as I should.*

6. When I’m not exercising enough, I question whether I am a good enough person.
7. Even when I can’t control my weight, I think I’m an okay person.*

8. When I’m not the size I think I should be, I feel ashamed.

Note: *Reverse scored item.
APPENDIX D

APPEARANCE ANXIETY QUESTIONNAIRE

Appearance Anxiety Questionnaire
For each of the statements below, indicate to what extent the statement is true or characteristic of you using the following scale, where 0=never, 1=sometimes, 2=often, 3=very often, and 4=almost always.

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. I feel nervous about aspects of my physical appearance.
2. Concern about my appearance has prompted me to diet.
3. I enjoy looking at myself in the mirror.*
4. I am self-conscious about the way that I look.
5. I am aware of my appearance.
6. I am unconcerned about how aging will affect my appearance.*
7. I worry about how others are evaluating how I look.
8. I am comfortable with my appearance.*
9. I like how I look.*

10. I feel ill at ease if I do not have enough time to make myself look good in the morning.

11. I am unconcerned with how others feel about my appearance.*

12. Because much of my physical appearance is beyond my control, I do not dwell on it.*

13. I get nervous when others comment on my appearance.

14. My appearance bothers me enough that I have thought about having cosmetic surgery.

15. Negative remarks about how I look do not bother me.*

16. I feel helpless to change my appearance.

17. If I wear a hat on very cold days, I worry it might make me look less attractive.

18. I worry about how I'll look as I grow older.

19. I feel comfortable with my facial attractiveness.*

20. I am satisfied with my body weight.*

21. I would like to change the way I look.

22. I am satisfied with my body's build or shape.*

23. I would be uncomfortable without products to enhance my appearance.

24. I feel uncomfortable with certain aspects of my physical appearance.

25. I feel ashamed of my physique or figure.

26. I feel that most of my friends are more physically attractive than myself.

27. I wish that I was better looking.

____________________________________

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28. I am concerned or worried about my ability to attract members of the opposite sex.

29. I am confident that others see me as physically appealing.*

30. I am satisfied with my height.*

Note: *Reverse scored item.
APPENDIX E

BODY IMAGE SELF-CONSCIOUSNESS SCALE

Body Image Self-Consciousness Scale
(measure of sexual self-consciousness)

Please use the following scale to indicate how often you agree with each statement or how often you think it would be true for you. The term "partner" refers to someone with whom you are romantically or sexually intimate.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I would feel very nervous if a partner were to explore my body before or after having sex.

2. The idea of having sex without any covers over my body causes me anxiety.

3. While having sex I am (would be) concerned that my hips and thighs would flatten out and appear larger than they actually are.

4. During sexual activity, I am (would be) concerned about how my body looks to my partner.
5. The worst part of having sex is being nude in front of another person.

6. If a partner were to put a hand on my buttocks I would think, "My partner can feel my fat."

7. During sexual activity it is (would be) difficult not to think about how unattractive my body is.

8. During sex, I (would) prefer to be on the bottom so that my stomach appears flat.

9. I (would) feel very uncomfortable walking around the bedroom, in front of my partner, completely nude.

10. The first time I have sex with a new partner, I (would) worry that my partner will get turned off by seeing my body without clothes.

11. If a partner were to put an arm around my waist, I would think, "My partner can tell how fat I am."

12. I (could) only feel comfortable enough to have sex if it were dark so that my partner could not clearly see my body.

13. I (would) prefer having sex with my partner on top so that my partner is less likely to see my body.

14. I (would) have a difficult time taking a shower or bath with a partner.

15. I (would) feel anxious receiving a full-body massage from a partner.
APPENDIX F

SEXUAL ASSERTIVENESS SCALE

Sexual Assertiveness Scale

*Think about a sexual partner you have now, or typical experiences you have had with sexual partners in the past. For each of the statements below, indicate to what extent you agree or disagree with the statement. Use the following scale: 0=disagree strongly, 1=disagree somewhat, 2=mixed, 3=agree somewhat, and 4=agree strongly.*

<table>
<thead>
<tr>
<th>Disagree Strongly</th>
<th>Disagree Somewhat</th>
<th>Mixed</th>
<th>Agree Somewhat</th>
<th>Agree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. I begin sex with my partner if I want to.
2. I let my partner know if I want my partner to touch my genitals.
3. I wait for my partner to touch my genitals instead of letting my partner know that's what I want.*
4. I wait for my partner to touch my breasts instead of letting my partner know that's what I want.
5. I let my partner know if I want to have my genitals kissed.

6. Women should wait for men to start things like breast touching.*

7. I give in and kiss if my partner pressures me, even if I already said no.*

8. I put my mouth on my partner's genitals if my partner wants me to, even if I don't want to.*

9. I refuse to let my partner touch my breasts if I don't want that, even if my partner insists.

10. I have sex if my partner wants me to, even if I don't want to.*

11. If I said no, I won't let my partner touch my genitals even if my partner pressures me.

12. I refuse to have sex if I don't want to, even if my partner insists.

13. I have sex without a condom or latex barrier if my partner doesn't like them, even if I want to use one.*

14. I have sex without using a condom or latex barrier if my partner insists, even if I don't want to.*

15. I make sure my partner and I use a condom or latex barrier when we have sex.

16. I have sex without using a condom or latex barrier if my partner wants.*

17. I insist on using a condom or latex barrier if I want to, even if my partner doesn't like them.

18. I refuse to have sex if my partner refuses to use a condom or latex barrier.

*Reverse scored item.

Note: *Reverse scored item.
APPENDIX G

FEMALE SEXUAL FUNCTIONING INDEX

Female Sexual Functioning Index

These questions ask about your sexual feelings and responses during your typical sexual experiences. Please answer the following questions as honestly and clearly as possible.

Your responses will be kept completely confidential. In answering these questions the following definitions apply:

**Sexual activity** can include caressing, foreplay, masturbation and vaginal intercourse.

**Sexual intercourse** is defined as penile penetration (entry) of the vagina.

**Sexual stimulation** includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

**Sexual desire or interest** is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. In general, how **often** do you feel sexual desire or interest?

   (1) Almost never or never
2. In general, how would you rate your level (degree) of sexual desire or interest?
   (1) Very low or none at all
   (2) Low
   (3) Moderate
   (4) High
   (5) Very high

3. In general, how often did you feel sexually aroused ("turned on") during sexual activity or intercourse?
   (1) Almost never or never
   (2) A few times (less than half the time)
   (3) Sometimes (about half the time)
   (4) Most times (more than half the time)
   (5) Almost always or always

4. In general, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?
   (1) Very low or none at all
(2) Low
(3) Moderate
(4) High
(5) Very high

5. In general, how confident have you been about becoming sexually aroused during sexual activity or intercourse?
   (1) Very low or now confidence
   (2) Low confidence
   (3) Moderate confidence
   (4) High confidence
   (5) Very high confidence

6. In general, how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   (1) Almost never or never
   (2) A few times (less than half the time)
   (3) Sometimes (about half the time)
   (4) Most times (more than half the time)
   (5) Almost always or always

7. In general, how often have you become lubricated ("wet") during sexual activity or intercourse?
(1) Almost never or never
(2) A few times (less than half the time)
(3) Sometimes (about half the time)
(4) Most times (more than half the time)
(5) Almost always or always

8. In general, how difficult has it been to become lubricated ("wet") during sexual activity or intercourse?*
   (1) Extremely difficult or impossible
   (2) Very difficult
   (3) Difficult
   (4) Slightly difficult
   (5) Not difficult

9. In general, How often have you maintained your lubrication ("wetness") until completion of sexual activity or intercourse?
   (1) Almost never or never
   (2) A few times (less than half the time)
   (3) Sometimes (about half the time)
   (4) Most times (more than half the time)
   (5) Almost always or always
10. In general, how **difficult** has it been to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

   (1) Extremely difficult or impossible
   (2) Very difficult
   (3) Difficult
   (4) Slightly difficult
   (5) Not difficult

11. In general, when you have sexual stimulation or intercourse, how **often** do you reach orgasm (climax)?

   (1) Almost never or never
   (2) A few times (less than half the time)
   (3) Sometimes (about half the time)
   (4) Most times (more than half the time)
   (5) Almost always or always

12. In general, when you have had sexual stimulation or intercourse, how **difficult** has it been for you to reach orgasm (climax)?*

   (1) Extremely difficult or impossible
   (2) Very difficult
   (3) Difficult
   (4) Slightly difficult
   (5) Not difficult
13. In general, how satisfied have you been with your ability to reach orgasm (climax) during sexual activity or intercourse?

(1) Very dissatisfied
(2) Moderately dissatisfied
(3) About equally satisfied and dissatisfied
(4) Moderately satisfied
(5) Very satisfied

14. In general, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?

(1) Very dissatisfied
(2) Moderately dissatisfied
(3) About equally satisfied and dissatisfied
(4) Moderately satisfied
(5) Very satisfied

15. In general, how satisfied have you been with your sexual relationship with your partner?

(1) Very dissatisfied
(2) Moderately dissatisfied
(3) About equally satisfied and dissatisfied
(4) Moderately satisfied
(5) Very satisfied

16. In general, how satisfied have you been with your overall sexual life?

   (1) Very dissatisfied
   (2) Moderately dissatisfied
   (3) About equally satisfied and dissatisfied
   (4) Moderately satisfied
   (5) Very satisfied

17. In general, how often do you experience discomfort or pain during vaginal penetration?*

   (1) Almost always or always
   (2) Most times (more than half the time)
   (3) Sometimes (about half the time)
   (4) A few times (less than half the time)
   (5) Almost never or never

18. In general, how often do you experience discomfort or pain following vaginal penetration?

   (1) Almost always or always
   (2) Most times (more than half the time)
   (3) Sometimes (about half the time)
   (4) A few times (less than half the time)
(5) Almost never or never

19. In general, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?*

(1) Very high
(2) High
(3) Moderate
(4) Low
(5) Very low or none at all

Note: *Reverse scored item.
Informed Consent

You are about to participate in a survey being conducted by Elizabeth A. Lehman, M.A., a graduate student in the Department of Psychology at The University of Akron, who is under the advisement of Dr. David Tokar, a faculty member in the Department of Psychology at The University of Akron. It is your decision to either take part in this study or not, so please read the description below before deciding to continue participation in this study.

The purpose of this study is to better understand the way that women view themselves, their bodies, and their sexual experiences. This study involves responding to several questionnaires about yourself and how you view your body, as well as your actions, thoughts, and emotions during sexual situations. In order to participate in this survey you must identify as a woman who is primarily heterosexual, be 18 years or older, and currently reside in the United States. Approximately 450 participants will complete the survey and survey completion is estimated to take 30-45 minutes in a single session.

Risk from participating in this study is minimal; however, some of the questions ask about sensitive and private sexual experiences and could make you feel uncomfortable, particularly if you have been exposed to negative sexual experiences. You may also feel psychological discomfort in revealing information about your attitudes toward your body and yourself. Further, there may be risks in taking part in this study that we do not know about. You have the right to withdraw from the study at any time if you find the questions too distressing or personal. You may also skip any particular question you find too uncomfortable. If you become uncomfortable or distressed and need assistance you may contact one of the following agencies: (1) if you are a student at The University of Akron you can contact the University Counseling Center at 330-972-7802 or the Summa Outpatient Psychiatric Clinic at 330-379-5167; (2) if you reside in
the United States you can speak with someone at the National Suicide Prevention Lifeline at 1-800-273-8255 and/or utilize the SAMSHA Behavioral Health Treatment Locator via http://findtreatment.samhsa.gov to locate local mental health treatment agencies.

If you agree to take part in this study, there may or may not be direct benefit to you. This research may help you to understand your own attitudes and experiences. Participation in this research will also contribute to the research on women’s body image and sexual experiences.

Participation in this study is completely voluntary. As a participant, you have the right to withdraw at any time. You will not be penalized in any activities, courses, or employment at the University of Akron for not completing this study. If you are a student at The University of Akron then you may receive extra credit for participating in this study if your instructor has deemed that this study fulfills extra credit requirements. You may also choose to enter yourself into a drawing to win one of four $25 Visa giftcards.

Your answers to the questionnaires will be kept confidential. Each survey is assigned a numerical code, and the data will be analyzed by this code number only. All data will be kept on password-protected computers in locked offices in the Department of Psychology at The University of Akron where only the principle investigator (Elizabeth Lehman, M.A.) will have access. The results of this research may be presented at academic conferences or published in professional journals. These reports will not contain any specific or individual responses, only aggregate findings.

If you have any questions about this study, you may contact Elizabeth Lehman via email at eal18@zips.uakron.edu. If you would like to speak with someone who is unaffiliated and uninformed about this project, you are welcome to contact the The University of Akron’s counseling services at 330.972.7082, the Summa Outpatient Psychiatric Clinic located in Akron, Ohio at 330.379.5167, or via a mental health service provider in your area (http://findtreatment.samhsa.gov). This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about your rights as a research participant, you may call the IRB at (330) 972-7666.

By clicking “Accept” below, you are consenting to participate in this online survey.
APPENDIX I

DEBRIEFING

Debriefing Information

Thank you for participating in my research. The purpose of this study is to better understand women's experiences with objectification of their bodies, and how those bodily views relate to their sexual experiences. The surveys you completed included a measure of self-objectification, body shame, appearance anxiety, sexual self-consciousness, sexual assertiveness, and sexual functioning. Studying women’s experiences with body objectification and sexual functioning is important because it will help us better understand the varied influences on women's sexual experiences, and may help women to feel more empowered in their sexuality.

Your willingness to participate in this study is greatly appreciated. Your input will help to advance the field of body image and sexuality research. Sometimes people find that the subject matter of the questionnaires can lead them to feel uncomfortable. If answering any of the questions led you to feel distressed and you would like to speak to someone, please contact one of the following agencies:

The University of Akron Counseling Center 330-972-7082

Summa Outpatient Psychiatric Clinic (Akron, Oh) 330-379-5167

National Suicide Prevention Lifeline 1-800-273-8255

We would ask you to maintain confidentiality about the purpose of the study since any pre-knowledge of the purpose will bias the data for that person and thus cannot be used.
If you have any complaints, concerns, or questions about this research, please feel free to contact Elizabeth Lehman (330-872-7280), Dr. David Tokar (330-972-6845) or University of Akron IRB Administrator (Ms. Sharon McWhorter, 330-972-8311).

Thank you very much for participating!
APPENDIX J

INSTITUTIONAL REVIEW BOARD APPROVAL

[Image of approval stamp]

Date: 5/17/2015

Elizabeth L. Lingen

[Signature]

From:_ethnics chair, IRB administrator

Re: 2012-0029 "Testing on Genomic Plateau/Human Aging and Age-Related Disease"

This is to confirm that the project described above was reviewed and found to be exempt from further IRB review. The protocol procedures involve no more than minimal risk or no more than minimal risk to human subjects, and are conducted in accordance with the IRB standards for those procedures.

[Signature]

Date: 5/12/2015

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Date: 5/12/2015

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Date: 5/12/2015

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