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Objectification, Femininity Ideology, and Sexual Assertiveness: A Model of Women's Sexual Functioning

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OBJECTIFICATION, FEMININITY IDEOLOGY, AND SEXUAL ASSERTIVENESS: A
MODEL OF WOMEN'S SEXUAL FUNCTIONING

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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ABSTRACT

Numerous research studies have investigated the relationship between sexual objectification and women's experience of their bodies, while fewer have focused on the possible role of endorsement of traditional femininity ideologies in helping to explain adult sexual functioning. The studies that do exist concentrate primarily on illuminating the differences between men and women versus exploring how endorsing particular attitudes or roles may affect women's experience of their bodies. This study investigated the relationships among traditional femininity ideology, sexual victimization, and self-objectification as well as how these variables related to body monitoring, sexual assertiveness for initiation and refusal, body shame, and appearance anxiety. All eight of these variables were investigated as they related to women's reports of sexual dysfunction.

The primary investigator visited a large general psychology lecture in order to inform potential participants of the research opportunity and provide them with a general understanding of the study. Only women were recruited, as evidence suggests a greater incidence of sexual victimization among women and greater controversy regarding female sexuality – two elements central to this particular study. Because of the focus on sexual experiences and sexual health, students must have reported having engaged at least once in voluntary sexual activity or intercourse to be included in the final sample. While minimal discomfort was anticipated by participating in the study, students were asked to provide personal information regarding their sexual functioning and any history of sexual abuse.

All informed consent and data collection were completed online via www.surveymonkey.com. No personally identifying information was collected, and students participated anonymously. Because no signatures were required for informed consent, there was no way to connect individual students to the private information they provided. The full survey consisted of approximately 130 items from the Childhood Sexual Abuse Scale, Adult Sexual Victimization Scale, Femininity Ideology Scale, Hyperfemininity Scale, Sexual Assertiveness

Scale, Objectified Body Consciousness Scale, Self-Objectification Questionnaire, Adolescent Femininity Ideology Scale, Appearance Anxiety Scale, Female Sexual Function Index, Psychosexual Functioning Scale, and the Balanced Inventory of Desirable Responding.

Latent Variable Modeling was performed to analyze the research data using EQS software to investigate 13 main hypotheses primarily concerning sexual victimization, femininity ideology, and sexual assertiveness. As expected, a history of sexual victimization was positively correlated with self-objectification and negatively correlated with sexual assertiveness. Endorsement of traditional femininity ideologies was negatively correlated with sexual assertiveness for initiation, but contrary to expectations, it was not correlated with self-objectification or sexual assertiveness for refusal. Surprisingly, sexual assertiveness for refusal was directly related to sexual dysfunction. While the majority of relationships posited by Objectification Theory were supported, neither body shame nor appearance anxiety was found to correlate with female sexual dysfunction. On the whole, this information supports the body of knowledge concerning sexual victimization and objectification but challenges the assertion that the objectification variables traditionally studied relate to female sexual functioning.

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Objectification, Femininity Ideology, and Sexual Assertiveness:

A Model of Women's Sexual Functioning

Statement of the Problem

Objectification Theory, originally proposed by Frederickson and Roberts (1997), is now supported by a growing body of research suggesting women are subjected to a myriad of negative psychological and behavioral consequences stemming from experiences of sexual objectification (Slater and Tiggemann, 2002; Calogero, 2004; Roberts and Gettman, 2004; Tylka and Hill, 2004; Greenleaf and McGreer, 2006; Grabe, Hyde, and Lindberg, 2007). The theory argues that experiences of sexual objectification lead women to self-objectify and that this internalization of objectification results in an increased incidence of such negative consequences as sexual dysfunction. Studies suggest as many as 44% of women meet criteria for sexual dysfunction as recognized by the American Psychiatric Association (Laumann, Paik, and Rosen, 1999, Bancroft, Loftus, and Long, 2003); thus, studies exploring contributors to sexual dysfunction are clearly needed. Fredrickson and Roberts argue the relationship between self-objectification and sexual dysfunction is typically mediated by women's experiences of body shame, appearance anxiety, fewer peak motivational states, and a reduced awareness of internal bodily cues. This study sought to expand this model by using latent variable modeling to explore the roles of femininity ideology and sexual assertiveness. Sexual victimization was conceptualized as the vehicle of objectification in order to explore its overall relationship to women's sexual functioning.

Justification of the Problem

An objectifying experience occurs when a woman's body is separated from her person and valued for its use to or by others; her body is taken as entirely representative of her being and is regarded as available for the use and pleasure of others. Fredrickson and Roberts (1997) argue objectification can occur in three primary ways: through actual interpersonal and social encounters, in visual media that depict these encounters, and through visual media's implicit sexualizing gaze. The objectification construct readily captures both personal and vicarious experiences of constant, unrelenting sexual observation and evaluation; however, Szymanski and Henning (2007) argue experiences such as sexual harassment and sexual violence should also be viewed through the lens of objectification. While these experiences are not discussed in great detail in the originally proposed theory, Fredrickson and Roberts do acknowledge that sexual objectification is a key component of sexual violence and thus a source of constant appearance-related anxiety for many women.

To date, no studies examining the effects of objectification have investigated sexual victimization as the underlying source of objectification. Most researchers have conceptualized objectification experiences as occurring as a result of exposure to objectifying media. For examples, Aubrey (2006) operationalized objectification as the frequency with which study participants watched television programs or read magazines that emphasized the body and appearance as primary components of sexual desirability. Studies such as the current survey that explored what is arguably the most severe form of objectification, sexual victimization, were clearly needed. In this study, sexual victimization and femininity ideology were hypothesized to indirectly predict women's sexual dysfunction as mediated by: self-objectification, sexual assertiveness for initiation and refusal, body monitoring, body shame, and appearance anxiety. Figure 1 depicts the variables included in the model as well as prediction arrows illustrating the hypotheses and exploratory analyses investigated.

Objectification and Self-Objectification

Amidst what they consider commonplace objectification, Fredrickson and Roberts (1997) argue the most profound effect of being regularly evaluated as sexual beings is that women learn to self-objectify at an early age. While objectification experiences remain the original source of negative consequences, self-objectification is the central feature of the authors' theory. Women are habituated to look at themselves as objects, objects to be judged and appreciated by others, by external observers. The authors define self-objectification as the process of internalizing an external sexual view of one's body, noting that the many social benefits conferred upon women who prioritize their appearance (e.g., popularity, upward mobility) serve to reinforce this model of behavior and self-perception, even when it is not considered equally necessary for men's advancement or social acceptance. Thus, in light of how physical appearance and sexuality influence the way women are valued, attending to these factors can be seen not as simple vanity, but as women's strategy for predicting social acceptance and treatment. By outlining the concept of self-objectification in addition to transient experiences of external objectification, Fredrickson and Roberts allow for both trait and state-dependent objectification. Self-objectification has long been considered the crux of the authors' theoretical model.

While Fredrickson and Roberts (1997) attribute self-objectification to the internalization of exposure to sexually objectifying images or experiences, little research examining Objectification Theory has tested this specific relationship or, even less commonly, the relationship between sexual victimization and self-objectification. Viewing self-objectification as the core component of the theory, most research has tested models that begin with self-objectification, ignoring how women come to adopt this perspective or whether certain objectifying images or experiences are more influential than others. There are, however, some exceptions. Moradi, Dirks, and Matteson (2005) surveyed 221 undergraduate women ($M = 20.42$ y/o), asking them to report the frequency with which they were subject to a list of seven objectifying experiences (e.g., sexist comments about clothing, whistling) and to rate their degree

of acceptance of various societal standards of beauty (e.g., “I wish I looked like a swimsuit model”), a key component of self-objectification. The authors found reports of experiencing objectification were positively correlated with reports of internalizing sociocultural standards of beauty, thus providing support for the relationship between objectifying experiences and self-objectification.

Subjective Consequences of Objectification

Body Monitoring

A natural consequence of being aware of the central role played by one’s physical self is an increased amount of attention being paid to one’s physical self, a habit referred to as “body monitoring.” While Fredrickson and Roberts’ (1997) original theory positions self-objectification as a precursor to body monitoring, other researchers have suggested body monitoring is itself a form of self-objectification (McKinley and Hyde, 1996). This confusion has received recent attention in the literature (Tiggemann and Lynch, 2001; Tiggemann and Slater, 2001), suggesting the two constructs constitute independent paradigms; nonetheless, when considered either synonymous with self-objectification or a behavior stemming from it, body monitoring refers to the habitual checking or imagery women engage in to monitor how their bodies appear to others. This behavior may take the form of checking one’s reflection when passing storefront windows or other reflective surfaces, visualizing one’s body in a particular position or posture, adjusting one’s clothing to best conceal less socially accepted physical features, etc. Considering both the ever-present media images of idealized female bodies and also the benefits women see distributed according to approximations of that ideal, it is no wonder women are plagued by a continuous habit of monitoring their own bodies and comparing them to the cultural ideal. Tylka and Hill (2004) explored the relationship between a specific type of objectification, pressure for thinness, and body monitoring, conceptualizing the latter as a form of self-objectification. They surveyed 460 undergraduate women ($M = 21$ y/o), and, as predicted, latent variable modeling revealed

pressure for thinness was a significant predictor of body monitoring, accounting for 26% of the variance in scores.

Body Shame

Since so few women are anywhere near capable of attaining society's idealized version of beauty despite diet, exercise, the latest fashion, beauty products, and developments in cosmetic surgery, the combination of knowing both what a male-dominated culture deems beautiful and also that that beauty is unattainable is a clear recipe for what Fredrickson and Roberts (1997) describe as body-based shame. In essence, women regularly evaluate themselves relative to an internalized cultural ideal based on physical appearance, and they lose every time. Given the value placed on women's physical appearance, and the inability to live in a social environment without exposing one's physical self, this discrepancy translates into feelings of shame and worthlessness. Conversely, it seems possible that women who judge themselves to closely approximate beauty ideals actually derive pleasure from viewing their bodies; they may experience a kind of body pride when aware that others would likely evaluate their bodies positively. To date, this hypothesis has not been studied in Objectification Theory research. Quinn, Kallen, and Cathey (2006) investigated the effect of self-objectification on body shame and lingering body-related thoughts among 150 men and women. Participants were asked to try on either a one-piece bathing suit or a v-neck sweater in a private dressing room. They then completed survey materials that included a self-objectification manipulation check that asked participants to think about how wearing the clothing item made them feel before filling in 20 self-statements regarding those feelings. Additionally, participants completed 19 items measuring experiences of body shame. As expected, results revealed only women reported increased body shame after the self-objectifying experience and that this shame mediated the extent to which self-objectification led to continued thoughts about the body during a subsequent free-response activity.

Appearance Anxiety

Fredrickson and Roberts (1997) propose appearance and safety anxieties result from women not being able to anticipate when their bodies will be looked at or how they will be evaluated. Firstly, when the message is internalized that women are represented by their physical bodies and that their physical beauty determines their overall value, it becomes clear how important women may find monitoring their bodies and how anxiety-producing it may be to constantly anticipate being looked at or evaluated. Secondly, given the relationship between physical attractiveness and perceived responsibility for sexual assault (Beneke, 1982; Jacobson and Popovich, 1983), women are not only preoccupied with their physical appearance for purposes of being accepted by others (appearance anxiety), but they are also plagued by concerns of how their physical appearance may attract unwanted attention from others (safety anxiety). Society encourages women to internalize an external view of themselves as sexual beings, but this internalization results in anxiety regarding both falling short of beauty standards and the possibility of being victimized because of approximations of those beauty standards. In a study of 160 undergraduate men and women, Roberts and Gettman (2004) investigated the relationship between a primed state of self-objectification and participants' reports of appearance anxiety. Students were instructed to complete a scrambled sentence task where 15 of 25 words were related to self-objectification, (e.g., slender, desirable) body competence, (e.g. fitness, energetic) or neutral control words (e.g., silly, honesty); participants then completed a scale assessing individuals' feelings of appearance anxiety. MANOVA results revealed a main effect for gender on the appearance anxiety measure, indicating women reported more appearance anxiety than men across the three conditions. Furthermore, women primed with self-objectification reported higher levels of appearance anxiety than those primed with body competence words. Both results are consistent with Objectification Theory's hypothesized relationship between self-objectification and appearance anxiety in that those women who internalized unrealistic cultural

standards of beauty reported greater anxiety concerning their physical appearance, a relationship not replicated among the men surveyed

Health Consequences of Objectification

Sexual Dysfunction

Objectification Theory culminates in an evaluation of the way experiences of objectification influence depression, eating disorders, and sexual dysfunction, problems that occur most often among American women. In discussing sexual dysfunction, Fredrickson and Roberts (1997) argue that the shame and anxiety many women feel in regard to their physical selves may carry over into their sexual experiences, experiences which make women undeniably physically vulnerable. Objectification Theory's framework allows for two equally viable paths in predicting health consequences: an indirect path where an accumulation of the subjective consequences of objectification contributes to physical or psychological distress and a direct path where the overt use of a women's body as a tool for another's pleasure (e.g., sexual victimization), leads to poor mental health. Most of the research to date focuses on the indirect paths to depression and eating disorders but neglects objectification's relationship to sexual dysfunction. Likewise, research examining objectification via sexual victimization specifically is lacking. The current study looked to bridge the gap by examining indirect paths between sexual victimization and participants' reports of sexual dysfunction.

Aubrey (2007) investigated the relationships among exposure to sexually objectifying media, body self-consciousness, negative body emotions (body shame, appearance anxiety), and sexual self-perceptions in a sample of 384 undergraduate men and women ($M = 19.6$ y/o). Defining body self-consciousness as the combination of self-objectification and body monitoring, her study integrates the Fredrickson and Roberts (1997) and McKinley and Hyde (1996) frameworks. The author hypothesized exposure to sexually objectifying media images would be related to poor sexual self-perceptions as mediated by body self-consciousness. Regression equations revealed objectifying media exposure predicted body monitoring but not self-

objectification, meaning the predicted effect on body self-consciousness was only partially supported. Body monitoring, but not self-objectification, was found to fully mediate the relationship to body shame and appearance anxiety; however, both self-objectification and body monitoring were found to predict body-related self-consciousness during physical intimacy, indicating participants who reported greater self-objectification and body monitoring were more likely to also report concerns about feeling unattractive or fat during physical intimacy.

Sanchez and Kiefer (2007) found a similar result in a survey of 320 men and women recruited online. Both men's and women's reports of body shame were significantly related to increased body-related self-consciousness during physical intimacy. Structural equation modeling revealed a negative relationship between body shame and sexual arousability that was fully mediated by body-related self-consciousness, while sexual pleasure was predicted by body-related self-consciousness only. Orgasm difficulty was assessed; however, no relationship was revealed between either body shame or body-related self-consciousness and difficulty achieving orgasm. See Appendix A for a detailed synthesis of recent research investigating the traditionally studied objectification variables.

Considerations for Theory Expansion

Since Fredrickson and Roberts (1997) introduced Objectification Theory, most investigations into its major tenets have varied little from the originally proposed model. A limited amount of research has begun to address means of modifying or expanding the theory to incorporate supplementary constructs (see Appendix B). Two particular fields still offer enticing untapped information: femininity ideology and sexual assertiveness.

Femininity Ideology

The focus of much gender-related research is shifting from studying women's personal behaviors (enactment of feminine gender roles) to their endorsement of more global attitudes regarding women and gender (gender ideology). While gender roles refer to the performance of a particular pattern of difference based on distinctions between men and women (Acker, 1992),

gender ideology references attitudes toward widespread norms or rules regarding a particular gender (Sinn, 1997). Gender role research most typically investigates heterosexual interactions and involves heterosexual samples; however, Kozee and Tylka (2006) explored the appropriateness of Fredrickson and Roberts' (1997) model for the experiences of lesbian women (see Appendix C). Their results suggest the model best captures the correlates of objectification for lesbian women when slightly modified, but the basic structure was nonetheless supported (see Figure 2).

Objectification Theory is centered on women's internalization of the message that the physical appearance of one's body determines her value and society decides what bodies are beautiful. While messages of this sort are pervasive, so are messages regarding how women should behave with those bodies. Longstanding gender roles promote the claim that a woman's responsibility is to respond to her partner's sexual initiations and only use sex to confirm relationship commitment or promote relationship intimacy (Amaro, Raj, and Reed, 2001). A compelling area for expansion of Objectification Theory is the examination of how women's internalization of messages regarding appropriate gendered behavior for women (femininity ideology) influences their experience of their bodies as sexual beings. Research already suggests women who endorse traditional gender roles may be more likely to experience adult sexual victimization and less likely to assert themselves in initiating wanted sex or refusing unwanted sex (Williams, 2009), but whether gender ideology fits into a broader model incorporating the traditional objectification variables remains unknown.

Sexual Violence

Fredrickson and Roberts (1997) describe multiple forms of objectification, one of which is sexual violence, but research has focused on media images and interpersonal encounters like male gaze to the exclusion of more severely objectifying experiences such as sexual victimization. An extensive body of literature exists highlighting the negative effects of both childhood and adult sexual victimization, suggesting childhood sexual abuse is related to poor

sexual self-esteem (Van Bruggen, Runtz, and Kadlec, 2006), less sexual assertiveness for refusing unwanted sex (Morokoff, et al., 1997; Williams, 2009), adult sexual victimization, and an increased risk for HIV and other STDs (Polusny and Follette, 1995). Furthermore, Parillo and colleagues (2001) argue adult sexual victimization amplifies the effects of childhood abuse (e.g., victims of childhood abuse face increased risk for STDs if also victimized as adults). While sexual victimization is considered an extreme form of objectification, data does not yet exist to support a direct relationship between victimization and the traditionally studied Objectification Theory variables. If Fredrickson and Roberts' claim that objectification is a key component of sexual violence is to be upheld, studies should show that experiences of sexual violence relate to self-objectification in the same way more common, frequently studied examples of external objectification do.

Sexual Assertiveness

Recent studies have begun connecting experiences of victimization to women's sexual assertiveness, showing adult sexual victimization is negatively related to women's tendency to refuse unwanted sex (Testa, VanZile-Tamsen, and Livingston, 2007; Williams, 2009). Given the research supporting Objectification Theory, and the notion that sexual victimization is an extreme form of objectification, an interesting area for new research is to investigate whether any of the originally proposed variables are similarly associated with women's reports of sexual assertiveness. It seems reasonable to hypothesize that women who have internalized a view of themselves as sexual objects would be less likely to assert themselves when presented with unwanted sexual advances. Similarly, those who believe a woman's value comes from providing pleasure to her partner may be less likely to assert their own sexual interests since this behavior deviates from the notion that women's bodies are tools to be used by and for others.

Method

Overview of Model and Major Hypotheses

This study investigated the predictors that discriminate among women's reports of sexual dysfunction. Both indirect and direct paths were investigated as well as some hypothesized correlations among the independent variables. Sexual victimization and femininity ideology were evaluated as independent variables. Mediating variables included self-objectification, body monitoring, sexual assertiveness for initiation, sexual assertiveness for refusal, body shame, and appearance anxiety. Subscales or item parcels served as multiple indicators for independent as well as mediating variables. No specific hypotheses were established for the relationship between sexual victimization and femininity ideology or between sexual assertiveness and body shame or appearance anxiety, but these relationships were investigated as potential expansions to Fredrickson and Roberts (1997) original model. The following hypotheses were tested:

1. Sexual victimization will be a positive predictor of self-objectification.
2. Sexual victimization will be a negative predictor of sexual assertiveness for initiation.
3. Sexual victimization will be a negative predictor of sexual assertiveness for refusal.
4. Femininity ideology will be a positive predictor of self-objectification.
5. Femininity ideology will be a negative predictor of sexual assertiveness for initiation.
6. Femininity ideology will be a negative predictor of sexual assertiveness for refusal.
7. Self-objectification will be a mediating positive predictor of body monitoring.
8. Self-objectification will be a mediating negative predictor of sexual assertiveness for initiation.
9. Self-objectification will be a mediating negative predictor of sexual assertiveness for refusal.
10. Body monitoring will be a mediating positive predictor of body shame.
11. Body monitoring will be a mediating positive predictor of appearance anxiety.
12. Body shame will be a mediating positive predictor of female sexual dysfunction.

13. Appearance anxiety will be a mediating positive predictor of female sexual dysfunction.

Participants

Because Latent Variable Modeling is one form of Structural Equation Modeling (SEM), a minimum of 300 participants was needed to complete the process in order to argue statistical reliability and accuracy. The present research sample was composed of volunteer participants from a general psychology course at the University of Rhode Island. Individuals received course credit for volunteering in the study and were recruited by the researcher with a short description of the study during their class. While the investigation of femininity ideology could involve both men and women, because of the higher prevalence of sexual victimization among girls (Zierler et al., 1991) and the more socially controversial idea of female sexuality (Muehlenhard and McCoy, 1991), this study only recruited female participants. Additionally, while the study was expected to draw a primarily heterosexual sample, Kozee and Tylka's (2006) work recaps the importance of recruiting women identifying with diverse sexual orientations. Criteria for inclusion of participant data in the research analyses included female status, being 18 years of age or older, and having engaged at least once in sexual activity or intercourse. All female psychology students 18 or older were recruited to participate regardless of age, ethnicity, sexual orientation, or stage of education; however, those students who reported they had never been sexually active were not included in the final sample. See Appendix D for a description of the racial diversity that was expected based on the demographics of the University student body at the time of recruitment. See Appendix E for a discussion of factors that influence sample size requirements.

Materials

See Appendix F for a copy of the complete survey.

Demographics. Participants were asked a number of questions regarding age, ethnicity, year in school, religion and history of sexual experience.

Sexual Victimization. Five items adapted from Wyatt (1985) and used in Whitmire et al. (1999) were used to assess participants' history of childhood sexual abuse (e.g., "Before you were

14, did anyone older ever try to make you touch his or her genitals?"). Abuse experience items were scored on a 4-point scale from 1 = "no" to 4 = "many times." Cronbach's alpha reported for the full scale was .95. Twelve items adapted from the Sexual Victimization Scale (Koss and Oros, 1982) and used in Whitmire et al. (1999) were used to assess adult sexual victimization (e.g., "Since the age of 14, have you ever had a partner mistake how far you wanted to go with sex?"). Items were scored on a 4-point scale from 1 = "definitely no" to 4 = "definitely yes." Cronbach's alpha reported was .91. These 17 items provided 4 composite scores evaluating touch and penetrative childhood sexual abuse as well as adult sexual coercion and use of force.

Femininity Ideology. Ten items from two subscales of the Femininity Ideology Scale (FIS: Lehman, 2000) and five items adapted from the Hyperfemininity Scale (Murnen and Byrne, 1991) were used to assess traditional feminine gender ideology. Selected items evaluated participants' attitudes concerning women's appropriate sexual behaviors as well as behaviors appropriate for heterosexual interactions (e.g., "Women should not initiate sex" and "Women should act sexy to get what they want from men"). Items were scored on a 5-point scale from 1 = "strongly disagree" to 5 = "strongly agree." Cronbach's alphas reported for complete Dependence/Deference and Purity FIS subscales were .76 and .85 respectively. Cronbach's alpha reported for the full Hyperfemininity Scale was .89. See Appendix G for a discussion of the item selection process for the femininity ideology construct.

Self-Objectification. The Self-Objectification Questionnaire (Noll and Fredrickson, 1998) was used to assess participants' physical self-concept. Participants were asked to rank ten body attributes in order of importance to their physical self-concept. Five attributes were appearance-based (e.g., weight) and five were competence-based (e.g., muscular strength). Higher scores, as determined by the difference between appearance- and competence-based subscale scores, reflected participants' attention to observable attributes over non-observable attributes. Additionally, five items from the Objectified Relationship with Body (ORB) subscale of the Adolescent Femininity Ideology Scale (AFIS: Tolman and Porsche, 2000) were used to

assess participants' internalization of an objectified view of their bodies (e.g., "I think that a girl has to be thin to feel beautiful"). Items were scored on a 6-point scale from 1 = "strongly disagree" to 6 = "strongly agree." Cronbach's alpha reported for the complete ORB subscale was .81.

Body Monitoring. The Body Surveillance subscale of the Objectified Body Consciousness Scale (McKinley and Hyde, 2006) was used to assess participants' degree of body monitoring (e.g., "During the day, I think about how I look many times"). Items were scored on a 7-point scale from 1 = "strongly disagree" to 7 = "strongly agree." Cronbach's alpha reported was .89.

Sexual Assertiveness. Twelve items from the Sexual Assertiveness Scale (Morokoff et al., 1997) were used to assess initiation and refusal assertiveness (e.g., "I let my partner know if I want my partner to touch my genitals" and "I refuse to have sex if I don't want to, even if my partner insists"). Items were scored on a 5-point scale from 1 = "never" to 5 = "always." Cronbach's alphas reported were .82 and .79 respectively.

Body Shame. The Body Shame subscale of the Objectified Body Consciousness Scale (McKinley and Hyde, 2006) was used to assess participants' degree of body shame (e.g., "I would be ashamed for people to know what I really weigh"). Items were scored on a 7-point scale from 1 = "strongly disagree" to 7 = "strongly agree." Cronbach's alpha reported was .75.

Appearance Anxiety. The Appearance Anxiety scale (Dion, Dion, and Keelan, 1990) was used to assess participants' experience of anxiety regarding their physical appearance (e.g., "I feel nervous about aspects of my physical appearance"). Items were scored on a 4-point scale from 1 = "sometimes" to 4 = "almost always." Cronbach's alpha reported was .86.

Female Sexual Dysfunction. Three subscales of the Female Sexual Function Index (Rosen, et al., 2000) were used to assess participants' overall sexual dysfunction according to phases of the sexual response cycle (e.g., "Over the past four weeks, how often did you feel sexual desire or interest?"). Items were scored on 5-point scales assessing frequency, intensity,

confidence, difficulty, and satisfaction regarding sexual desire, arousal, and orgasm. Cronbach's alphas reported were .89, .90, and .91 respectively. Three items from the Psychosexual Functioning Scale (Harlow et al., 1993) were also used to assess participants' overall sexual satisfaction and attitudes about their personal sex lives (e.g., "I do not like some parts of my sex life"). Items were scored on a 5-point frequency scale from 0 = "never" to 4 = "always." Cronbach's alpha reported for the full scale was .85. Lastly, two items were included to assess participants' feelings of sexual distress and shame (e.g., "Over the past four weeks, how discouraged have you felt by your sexual response?"). These items were scored on a 5-point scale from 1 = "not at all" to 5 = "extremely."

Response Bias. Ten items from the Impression Management subscale of the Balanced Inventory of Desirable Responding (Paulhus, 1991) were included to measure participants' tendency to respond with socially desirable answers (e.g., "I sometimes tell lies if I have to"). Items were scored on a 7-point scale from 1 = "not true" to 7 = "very true." Cronbach's alpha for the full subscale has been reported between .75 and .86.

Procedure

After receiving Institutional Review Board approval, the researcher visited a large general psychology lecture in order to provide students with a brief description of the study and what was being asked of study participants. Students received the incentive of class credit for participating. In order to minimize discomfort related to disclosing personal information about one's sexual functioning and victimization experiences, participant anonymity was provided through the use of online surveys; participants completed all survey tools online through www.surveymonkey.com. Confidentiality, participation information, and an informed consent document were provided at the beginning of the survey. Participants indicated they understand this information, and no signatures were required, thus preserving participant anonymity. Participants accessed the online survey at their leisure and had the duration of one semester to participate. In the unlikely event the survey material caused personal distress, referrals to the

Psychological Consultation Center and URI Counseling Center were provided to each participant. Contact information for the researcher was also provided if questions or concerns arose regarding participation in the study.

Results

Women's experience of their bodies is complex and multifaceted, hardly explained by isolated relationships between individual independent and dependant variables. Using a model that allowed for an understanding of complex, multifaceted relationships was thus ideal. Due to its sanction of mediating variables, Latent Variable Modeling produced a robust understanding of the relationships among established Objectification Theory variables, femininity ideology, and sexual assertiveness. As recommended, a small global significance statistic (χ^2), a large Comparative Fit Index (CFI>.90), a small Root Mean Squared Error of Approximation (RMSEA<.06), and significant individual regression parameters with residuals less than .20 were used as criteria when evaluating the fit of the investigated model and whether relationships among variables were adequately explained (Schumacker and Lomax, 2004). Lagrange multiplier (LM) and Wald tests were used to improve the fit of the model when adjustments to the originally proposed parameters were both statistically and theoretically supported.

Demographics and Descriptives

Of the 377 participants included in the final data set, the highest percentage identified as White (80.11%), Catholic (59.42%), and somewhat religious (29.71%). Table 1 lists the percentage groups for all surveyed demographic questions. Table 2 lists descriptive statistics for all variables included in major analyses. Table 3 provides a complete correlation matrix including both factor indicators and also full scale latent variables.

Preliminary Analyses

Confirmatory factor analysis (CFA) was used to explore the goodness-of-fit between the data and the proposed measurement model. Eight independent and one dependent variable were included as assessed by eighteen indicators. A significant χ^2 test of fit revealed the originally proposed model deviated significantly from the data ($\chi^2 (314) = 900.683$, $n = 337$, $p < .001$). The Confirmatory Fit Index (CFI) and Root Mean Square Error of Approximation (RMSEA), two

additional model-fit statistics, also indicated the model was a poor fit with values of .84 and .08 respectively.

In an attempt to improve model fit, CFAs were run to explore the effects of dichotomizing and combining the poorly loading childhood sexual abuse items; however, the fit was still poor (χ^2 (314) = 898.14, n = 337, p < .001, CFI = .85, RMSEA = .07; χ^2 (288) = 698.87, n = 337, p < .001, CFI = .89, RMSEA = .07). Given this negligible improvement, a series of CFAs was next run to assess how eliminating other variable indicators with poor loadings (<.30) improved the model's fit. The childhood sexual abuse items were deleted from the variables indicating Sexual Victimization; items from the Hyperfemininity Scale were deleted from those indicating Femininity Ideology; Desire and Orgasm subscales were deleted from those indicating Female Sexual Dysfunction, and Physical Self-Concept (PSC) was dropped as an indicator of Self-Objectification. Because the removal of PSC left Self-Objectification with only one indicator, the five items from this remaining indicator were serially divided into two item parcels. Additionally, participants who had been previously deleted due to missing responses on the measures listed above were reinstated once those measures were removed from the model, increasing the final data set from 337 to 377 participants. Ultimately, the best goodness-of-fit was found once all of the poorly loaded indicators listed above had been removed (χ^2 (195) = 427.53, n = 377, p < .001, CFI = .94, RMSEA = .06). While the χ^2 test of fit was still found to be significant, this was likely due to the large sample size. Overall, results of the final CFA suggested the proposed model, with minor adjustments in indicators, was a good fit for the data. Abbreviations for all retained variables and indicators can be found in Table 4.

Latent Variable Modeling

Once the measurement model was successfully adjusted for fit, the data was subjected to Latent Variable Modeling (LVM). The original LVM analysis (Figure 3) revealed adequate goodness-of-fit (χ^2 (209) = 535.12, n = 377, p < .001, CFI = .91, RMSEA = .06). Lagrange

multiplier test results suggested two theoretically justified additional parameters: SO predicting BS and SAS-R predicting FSD. A modified model (Figure 4) was thus analyzed with a second LVM. Eight latent variables were hypothesized to predict one outcome measure through both direct and mediated paths. Each latent variable was indicated by at least two manifest variables, and most indicators were item parcels devised from large measurement tools. Once again, the χ^2 test of fit was significant ($\chi^2 (207) = 468.04$, $n = 377$, $p < .001$); however, additional fit statistics suggested the modified model was a good fit for the data ($CFI = .93$, $RMSEA = .06$).

Of the 19 parameters investigated in the modified model, 7 involved only variables traditionally studied in Objectification research. Of those seven parameters, five were found to be significant. SV (.31) was found to be significantly associated with SO ($R^2 = .10$), indicating women who experienced sexual victimization were more likely to report greater self-objectification than those without victimization histories. SO was also found to be significantly related to BM ($R^2 = .46$) and BS ($R^2 = .43$) with correlation coefficients of .68 and .46 respectively, indicating greater experience of self-objectification was related to more body monitoring and body shame. BM was also found to be significantly associated with AA ($R^2 = .40$) and BS with correlation coefficients of .60 and .23 respectively, indicating body monitoring was associated with greater experience of appearance anxiety and body shame. While these results all support the established Objectification Theory model, neither BS nor AA was found to be significantly associated with FSD, meaning participants who reported body shame or appearance anxiety were no more likely to report sexual dysfunction than those who did not. BS and AA were, however, significantly related to each other.

FGI, SAS-I, and SAS-R were investigated as potential additions to the well-established Objectification Theory model. They contributed twelve parameters to the analyzed model, and results revealed five of these parameters were significant. SAS-I ($R^2 = .08$) was found to have a significant negative relationship with SV (-.18) and FGI (-.18) but not SO. The relationship

between SAS-I and FGI was the only relationship involving FGI found to be significant. Results revealed women who reported traditional femininity ideologies were not likely to report more self-objectification or less sexual assertiveness for refusal as originally hypothesized. Furthermore, SAS-I was not significantly related to BS or AA as originally expected. These results suggest women who reported experience of sexual victimization or who endorsed traditional femininity ideologies were less likely to report sexual assertiveness for initiation. Less sexual assertiveness for initiation did not, however, relate to participants reports of body shame or appearance anxiety.

While only two of the parameters involving SAS-I were significant, three of the relationships involving SAS-R found support in the data. A significant negative relationship was found between SV (-.33) and SAS-R ($R^2 = .14$), indicating women who reported experiences of sexual victimization were less likely to report sexual assertiveness for refusal. The hypothesized relationship between SO and SAS-R was not found to be significant. A significant negative relationship was also found between SAS-R (-.12) and AA, meaning women who reported greater sexual assertiveness for refusal were less likely to report feelings of appearance anxiety. The relationships in the modified LVM mimicked those in the original LVM with one exception related to SAS-R. In the original model, the direct relationship between SO and BS was not included, and results revealed a small but significant negative association between SAS-R (-.17) and BS ($R^2 = .35$). With the addition of the parameter from SO to BS in the modified model, the relationship between SAS-R and BS lost significance, but the variance explained among body shame scores increased to 43%.

Of the three variables ultimately investigated as predictors of FSD, only the parameter added in the modified model was found to be significant. Results revealed FSD ($R^2 = .19$) was significantly associated with SAS-R (-.34) but not the two variables originally hypothesized to predict it, BS and AA. These results suggest women who experienced sexual dysfunction were

less likely to be sexually assertive in refusing unwanted sex. Contrary to study hypotheses, however, women with sexual dysfunction were not more likely to report body shame or appearance anxiety. FSD exhibited a medium effect size indicating approximately 19% of the variance in reports of female sexual dysfunction was explained by model variables.

A series of LVMs was next conducted to explore how minimizing or eliminating the contributions of FGI, SAS-I, and SAS-R would affect the overall model fit. SAS-R was found to be significantly related to SV and AA, and it also had a strong relationship to the model's only outcome variable, FSD. While SAS-I was significantly related to SV and FGI, its contribution to the model beyond that was negligible. Neither FGI nor SAS-I was found to be significantly related to the variables traditionally studied in Objectification research, thus reducing or eliminating their contributions to the model was expected to improve parsimony as well as goodness-of-fit.

When all prediction parameters from FGI, SAS-I, and SAS-R to other model variables were eliminated (Figure 5), BS (.20) was found to be significantly related to FSD, but only 5% of the variance in sexual dysfunction was explained, a drop from 19%. Likewise, goodness-of-fit was found to be significantly worse ($\chi^2(216) = 507.242$, $n = 377$, $p < .001$, CFI = .92, RMSEA = .06), indicating the statistically significant paths from SAS-R to AA and FSD did play an important role in the fit of the investigated model. When the stronger of these parameters (SAS-R to FSD) was reinstated, LVM results revealed a χ^2 test of fit still worse than that of the modified model ($\chi^2(215) = 477.66$, $n = 377$, $p < .001$); however, additional fit statistics suggested equal fit (CFI = .93, RMSEA = .06). This change was statistically no different than reinstating both parameters ($\chi^2(214) = 474.79$, $n = 377$, $p < .001$, CFI = .93, RMSEA = .06), thus the relationship between SAS-R and FSD was shown to be a particularly important addition to the model. When SAS-R was included as a predictor of AA, FSD, and BS as originally proposed, LVM results revealed a χ^2 goodness-of-fit statistically no different than the modified model (χ^2

(213) = 471.28, $n = 377$, $p < .001$, CFI = .93, RMSEA = .06). Because the variance in sexual dysfunction scores improved slightly to 20% and fewer parameters were included than in the modified version, it could arguably be considered the more parsimonious of the two. The correlation coefficients and effect sizes for each statistically significant parameter in this last reduced-path model can be found in Figure 6.

The LVM results described above illustrate mixed support for the investigated hypotheses. Hypotheses 1, 2, and 3 proposed SV would be positively correlated with SO and negatively correlated with SAS-I and SAS-R. In support of these hypotheses, women's reports of sexual victimization were found to be associated with greater self-objectification, less sexual assertiveness for initiation, and less sexual assertiveness for refusal. Hypothesis 5 proposed FGI would be negatively associated with SAS-I. In support of this hypothesis, results revealed women who endorsed more traditional femininity ideologies were less likely to report sexual assertiveness for initiation. Conversely, results did not support Hypothesis 4 or 6 which argued FGI would be positively correlated with SO and negatively correlated with SAS-R. Women who reported traditional femininity ideologies were not more likely to report self-objectification or less likely to report sexual assertiveness for refusal. Hypothesis 7 proposed SO would be positively associated with BM, and results supported this claim. Women who reported greater self-objectification were more likely to also report body monitoring. Conversely, results did not support Hypothesis 8 or 9 which proposed SO would be negatively correlated with SAS-I and SAS-R. Women who reported engaging in more self-objectification were not found to report less sexual assertiveness for either initiation or refusal. Hypotheses 10 and 11 proposed BM would be positively correlated with BS and AA. Results supported both hypotheses as women who reported frequent body monitoring were more likely to also report feelings of body shame and appearance anxiety. Hypothesis 12 proposed BS would be positively related to FSD. Results revealed support for this claim, but only when SAS-R was not included in model analyses. The significant statistical relationship between women's reports of body shame and sexual

dysfunction disappeared when sexual assertiveness for refusal was investigated simultaneously. Contrary to Hypothesis 13, results did not support a relationship between AA and FSD. Women who reported appearance anxiety were not more likely to report sexual dysfunction.

In addition to the hypothesized relationships investigated, four exploratory parameters were also analyzed to evaluate whether a relationship existed among sexual assertiveness, body shame, and appearance anxiety. No significant relationship was found between SAS-I and either BS or AA; and relationships involving SAS-R were inconsistent. Results from the original LVM revealed SAS-R was negatively correlated with BS and AA, suggesting women who reported more sexual assertiveness for refusal were less likely to experience either body shame or appearance anxiety. When the relationship between SO and BS was added to the model, however, the relationship between SAS-R and BS lost significance. Furthermore, the relationship between SAS-R and AA was only found to be significant when parameters connecting SAS-R to BS, AA, and FSD were all analyzed simultaneously. Clearly the relationship between women's sexual assertiveness for refusal and feelings of body shame or appearance anxiety needs further exploration.

Standardized residuals, LM and Wald tests revealed no meaningful way to improve the model, but a final LVM was run to compare the fit of the reduced-path models to a model in which FGI and SAS-I, two poorly performing variables, had been removed completely (Figure 7). This condensed model had a better χ^2 goodness-of-fit than any of the reduced-path models ($\chi^2(122) = 299.37$, $n = 377$, $p < .001$, CFI = .95, RMSEA = .06); however, it is not a nested model and cannot be directly compared. Overall, it could arguably be considered the most parsimonious given it was revealed to be a good fit to the data with fewer variables than the modified or reduced-path models; however, the explained variance in sexual dysfunction was slightly lower at 18%. The correlation coefficients and effect sizes for each parameter in the condensed model can be found in Figure 7. Table 5 provides a list of all factor indicators included in final analyses and

their individual loadings as revealed in the last reduced-path model. Table 6 lists Cronbach's alpha reliability statistics for each factor measure included in LVM analyses.

Discussion

The principal aim of this study was to explore whether Objectification Theory could be meaningfully expanded to include femininity ideology and sexual assertiveness. Secondly, unlike most Objectification research, this study incorporated both external and internal experiences of objectification, operationalizing external objectification as the experience of sexual victimization instead of exposure to sexualized media or whistling, etc. as commonly captured. Lastly, sexual dysfunction has long been hypothesized to be a consequence of objectification and the related experiences of body shame and appearance anxiety; however, most research in the field has targeted disordered eating or depression as the outcome of interest. It became clear while evaluating the LVM results that sexual assertiveness for refusal adds to the understanding captured by the Objectification model. Furthermore, sexual victimization in particular was found to relate to women's experience of self-objectification just as past research has shown this relationship when investigating less severe forms of objectification. While femininity ideology and sexual assertiveness for initiation were not found to contribute to expanding the Objectification model, the lack of relationship between female sexual dysfunction and either body shame or appearance anxiety challenges past assertions that objectification ultimately leads to problems with sexual functioning.

Strong support was found for the Objectification model as traditionally studied. With the exception of the lack of relationship between female sexual dysfunction and either body shame or appearance anxiety, there were no surprises in how the Objectification Theory variables performed. While not included as a direct relationship in the model as originally proposed, the revelation that women who reported more self-objectification also reported more body shame does have support in prior research (e.g., Quinn, Kallen, and Cathey, 2006). This finding conflicts with results of Aubrey (2007) which also revealed a fully mediated relationship and served as the basis for how these variables were incorporated into the original model. Aubrey's study may also help clarify the lack of association with female sexual dysfunction. As discussed

previously, in Aubrey's research, reports of body self-consciousness during physical intimacy functioned as indicators of sexual dysfunction. In the current study, female sexual dysfunction was operationalized as difficulty with physiological arousal as well as feelings of distress or dissatisfaction with one's sex life. It could be argued that the discrepancy in results is due to the discrepancy in operationalization of dysfunction. Additional research may find that Objectification Theory explains female sexual dysfunction as relates to women's perceptions of their bodies during sex but not as relates to physiological measures or general satisfaction with sexual experiences. Alternatively, because a relationship between body shame and female sexual dysfunction was revealed when a condensed version of the model was analyzed, the role of sexual assertiveness for refusal also be responsible. As discussed previously, Sanchez and Kiefer (2007) found body-related self-consciousness to be a mediator of the relationship between body shame and sexual dysfunction as measured by difficulty with arousal. This particular variable was not included in the present study, but the results argue for the same type of relationship to female sexual dysfunction as presented in the current study, a mediated one. While additional research may reveal sexual assertiveness for refusal to be a reliable correlate of female sexual dysfunction, its role in the current model remains somewhat unclear.

As discussed, the primary objective of the current study was to explore possible expansions of Objectification Theory. Results did not reveal support for broadening the Objectification model to include femininity ideology or sexual assertiveness for initiation; however, sexual assertiveness for refusal was exposed as an important, if somewhat inconsistent, additional factor. The relationship revealed between sexual victimization and sexual assertiveness for refusal was in line with previous research, showing that women who experience sexual coercion or victimization by force are less likely to assert themselves in refusing unwanted sex. The unique contribution of sexual assertiveness for refusal, however, is in its relationship to the traditionally studied Objectification Theory variables. Negative relationships were found between sexual assertiveness for refusal and both body shame and appearance anxiety as well as

between sexual assertiveness for refusal and female sexual dysfunction. This finding suggests women who are less likely to assert themselves in unwanted sexual situations are more likely to experience shame, anxiety, and dysfunction as relates to their bodies and sexual experiences. As mentioned, the role of sexual assertiveness for refusal is somewhat unclear, as it was no longer revealed as a significant correlate to body shame when the relationship between self-objectification and body shame was added to the model. What never changed, however, was the strong association to female sexual dysfunction.

In reviewing these relationships, a pattern emerges whereby one may hypothesize objectification leads to body monitoring which leads to appearance anxiety. This anxiety relates to less assertiveness for refusing unwanted sex which then results in problems with sexual functioning and satisfaction. It must be kept in mind, however, that the nature of cross-sectional data precludes drawing causal conclusions. Thus, hypothesizing that female sexual dysfunction leads to appearance anxiety, reduced sexual assertiveness for refusal and more frequent body monitoring is equally likely based on this data. Nevertheless, given the longitudinal evidence that supports Objectification Theory (Aubrey, 2006; Grabe, Hyde, and Lindberg (2007), justification exists for further researching directional paths that result in female sexual dysfunction.

While the variables traditionally studied in Objectification research performed as expected, the weaknesses in the model were the exploratory relationships investigated in an attempt to link Objectification Theory to femininity ideology and sexual assertiveness for initiation. Prior research has not focused on the relationship between femininity ideology and self-objectification nor tried to evaluate how sexual assertiveness is associated with body shame or appearance anxiety within the context of Objectification Theory. One may hypothesize that an association between sexual assertiveness for initiation and body shame or appearance anxiety was masked in the present study by the significant relationship found between sexual assertiveness for initiation and femininity ideology: women who do not assert themselves in initiating sex may not feel shame or anxiety about their bodies because they believe it is unfeminine for women to assert

themselves. Likewise, women who are more likely to assert themselves in initiating sex may not experience body shame or appearance anxiety because they hold less traditional views regarding women's roles and capabilities in sexual situations. As for the lack of relationship between femininity ideology and self-objectification, given the relative newness of the femininity ideology construct, it may be additional efforts are needed to develop its measurement before ruling out a relationship to self-objectification. Similarly, a relationship between self-objectification and sexual assertiveness for initiation may have shown itself had a direct approach been taken to trigger participants' self-objectification, such as previous researchers' method of having participants try on swimsuits and view themselves in a mirror before answering survey questions about self-objectification. Clearly additional research is needed to test any of these explanations.

In previous research, Williams, et al. (2009) found women's identification with traditional feminine gender roles to be associated with both experience of adult sexual victimization and also sexual assertiveness for refusing unwanted sex. Neither relationship was significantly replicated in the current study; however, FGI did show small correlations with SV and SAS-R (.07 and -.10 respectively). One explanation for the discrepancy in results may be that the previous study explored women's personal endorsement of traditional feminine role behaviors while the present study aimed to capture participants' reports of femininity ideology. It may be that traditionally feminine characteristics and behaviors are associated with victimization and less sexual assertiveness for refusal while global attitudes regarding what is feminine are not. Additionally, toward this aim of measuring a slightly different construct, different measures were used in the current study than those that resulted in the significant relationships found by Williams, et al. No conclusions can be drawn regarding the way feminine traits and femininity ideologies relate differently until research is conducted to compare them directly.

Aside from the nonsignificant relationships discussed above, results from the current study support the relationships revealed by previous research. Most of the study's significant relationships involve the variables traditionally studied in Objectification research and sexual

assertiveness. As reported by Moradi, Dirks, and Matteson (2005), experience of objectification was found to be significantly associated with self-objectification. Like Quinn, Kallen, and Cathey (2006), results revealed a significant relationship between self-objectification and body shame, a direct relationship not originally included in the model. The mediational relationship through body monitoring, however, supports results by Aubrey (2007). While Roberts and Gettman (2004) found a direct relationship between self-objectification and appearance anxiety, the current study provides support for an indirect relationship through body monitoring, once again reflecting Aubrey's work. The significant relationship between body shame and female sexual dysfunction revealed in the condensed model analysis reflects research by Sanchez and Kiefer (2007) who found support for an indirect path through body self-consciousness. As discussed, however, this relationship was not significant when sexual assertiveness for refusal was included in model analyses. Like previous research by Williams, et al. (2009), support was found for a negative relationship between sexual assertiveness for initiation and both femininity ideology and sexual victimization. Likewise, the current study supports research by Testa, VanZile-Tamsen, and Livingston (2007) and Williams, et al. who both found a significant relationship between sexual victimization and sexual assertiveness for refusal.

This study clearly provides additional support for the Objectification model; however, it also offers some unique contributions to the field of objectification research. Because external objectification was operationalized as experience of sexual victimization, our understanding of the relationship between external and internal objectification is expanded beyond studies investigating milder forms alone. Much research has been conducted on the Objectification model, and the effects of sexual victimization have received equal attention. Few studies, however, have tried to bridge the two fields. Finding a significant relationship between sexual victimization and the rest of the Objectification model provides justification for theorizing links between two research fields often studied independently.

Unique to this Objectification Theory research was the inclusion of sexual assertiveness variables. While sexual assertiveness for initiation was not found to relate to the primary Objectification variables, sexual assertiveness for refusal had an undeniable impact. Given the inconsistency in results, the association to body shame and appearance anxiety remains unclear; however, sexual assertiveness for refusal was revealed to be the strongest correlate of female sexual dysfunction, statistically eliminating any significant relationship between dysfunction and other Objectification variables. Similarly, the significant association with sexual victimization suggests sexual assertiveness for refusal should be incorporated when attempts to bridge the fields of victimization and objectification occur.

Lastly, the failure of this study to support previous research regarding predictors of female sexual dysfunction suggests more clarification is needed in identifying what aspects of sexual functioning are affected by Objectification variables. As discussed previously, it may be found that psychological and physiological aspects of sexual functioning relate differently to the variables traditionally studied. More specifically, it may be that female sexual dysfunction is found in Objectification research when operationalized as negative perceptions of one's body during sex rather than as organic problems in functioning.

Limitations

As a statistical method, LVM is comprehensive but not devoid of limitations. Cross-sectional data, when well-specified, can contribute to hypothesizing causal relationships, but true causality requires not only advanced research designs, but designs that include temporal ordering in addition to evidence of association and sufficient isolation of potential confounds (Bullock, Harlow, and Mulaik, 1994). While cross-sectional data helped clarify the relationships among the independent and dependent variables investigated, it did not allow causal conclusions to be drawn. In the current study, for example, it was expected that latent variable modeling would identify self-objectification as a predictor of body monitoring; however, this relationship, even though significant, would have been revealed regardless of the directionality of the variables. It

is only with longitudinal data that one has the ability to argue the direction of influence between the variables tested.

Additionally, due to problems with their statistical fit, items related to participants' experience of childhood sexual abuse were not included in analyses as originally planned. Thus, results only reflect relationships to adult sexual victimization and cannot be generalized to participants' abuse experiences during childhood. Extensive research exists highlighting the negative effects of childhood sexual abuse, and it would be expected that these experiences relate to the broader Objectification model as clearly as experiences in adulthood do, if not more so. Future research would benefit from investigating the role of childhood sexual abuse and whether it mimics or diverges from results found when incorporating adult victimization experiences alone.

Lastly, use of university students was essential in providing immediate availability of the greatest number of research participants; however, it must be kept in mind that a relatively ethnically and socioeconomically homogenous sample was the result of using this source. The fact that most participants were white and college educated should automatically challenge any temptation to generalize study findings. Before broader generalizations are considered, studies incorporating nationally representative samples must be conducted. Currently, findings only apply to individuals matching the demographics of this participant pool; further application of these findings must be limited to hypotheses regarding a similar sample.

Conclusions

In final review, this study offers an additional variable for consideration when conducting Objectification research while questioning the link to female sexual dysfunction and offering a bridge to the field of sexual victimization. The central model proposed by Fredrickson and Roberts (1997) remains intact and gains more support; however, additional research is needed to refine its relationship to female sexual dysfunction.

Future research is plainly needed to clarify the particular aspects of sexual functioning impacted by objectification. Additionally, the role of sexual assertiveness for refusal deserves further investigation and consideration as an addition to the Objectification model. Given the relationships between sexual assertiveness for refusal, sexual victimization, and female sexual dysfunction, it seems assertiveness must be taken into account when trying to explain female sexual dysfunction from the perspective of objectifying experiences.

Tables

Table 1

*Demographics indicating percentage groups for each response option

Variable and Answer Option	Count	%
Race		
White	302	80.11
Hispanic American	33	8.75
African American	16	4.24
Asian American	8	2.12
Native American	3	.80
Multiracial	7	1.86
Other	5	1.33
No response	3	.80
Grade		
Freshman	239	63.40
Sophomore	87	23.08
Junior	36	9.55
Senior	10	2.65
Non-matriculating	1	.27
No response	4	1.06
Religion		
Catholic	224	59.42
Protestant	47	12.47
Jewish	8	2.12
Eastern	4	1.06
Muslim	1	.27
Other	26	6.90
None	64	16.98
No response	3	.80
Religiosity		
"Not at all"	80	21.22
"Slightly"	106	28.12
"Somewhat"	112	29.71
"Fairly"	55	14.59
"Very"	22	5.84
No response	2	0.53

* Table continued on following page

Table 1 continued

Variable and Answer Option	Count	%
Age		
18	226	59.95
19	86	22.81
20	41	10.88
21	13	3.45
22	4	1.06
Other	7	1.87

Table 2

*Descriptive statistics

Variable Name	M	SD	Skewness	Kurtosis
Age	18.57 years	2.34	-0.89	57.73
Race	Categorical	Categorical	2.15	3.28
Grade	Categorical	Categorical	1.44	1.74
Religion	Categorical	Categorical	1.08	-0.62
Religiosity	2.54 (2 = "slightly")	1.16	.28	-0.66
COER	1.56	0.64	1.17	0.77
FOR	1.35	0.60	2.24	4.94
DD	1.68	0.51	1.12	3.92
PUR	2.12	0.65	0.39	0.37
SO-IP1	8.12	2.11	0.21	-0.17
SO-IP2	4.59	1.44	0.41	0.16
BM-IP1	3.80	0.71	-0.27	0.03
BM-IP2	3.19	0.70	-0.02	0.08
BM-IP3	3.36	0.73	-0.13	-0.08
SAS-I-IP1	2.89	0.87	0.12	-0.25
SAS-I-IP2	3.23	0.84	-0.01	-0.28
SAS-I-IP3	3.46	0.77	-0.07	-0.48
SAS-R-IP1	4.13	0.81	-0.69	-0.40
SAS-R-IP2	3.50	1.23	-0.35	-1.04
BS-IP1	2.61	0.79	0.14	-0.44

* Table continued on following page

Table 2 continued

Variable Name	M	SD	Skewness	Kurtosis
BS-IP2	2.95	0.75	0.00	-0.17
BS-IP3	2.16	0.85	0.61	0.04
AA-IP1	1.98	0.58	0.74	0.33
AA-IP2	2.32	0.48	0.32	0.14
AA-IP3	2.61	0.54	-0.05	0.18
ARO	2.60	1.02	0.48	0.72
D/S	1.51	0.65	1.25	1.01
S/A	2.02	0.81	0.51	-0.50

Table 3:

*Variable correlation matrix

	DD	PUR	†FGI	SO-IP1	SO-IP2	SO
DD	1.0					
PUR	.51	1.0				
FGI	.83	.90	1.0			
SO-IP1	.05	.03	.04	1.0		
SO-IP2	.13	.07	.11	.60	1.0	
SO	.09	.05	.08	.93	.85	1.0
BM-IP1	-.17	-.13	-.17	.33	.26	.34
BM-IP2	-.06	-.01	-.04	.48	.45	.53
BM-IP3	-.03	.00	-.01	.49	.36	.49
BM	-.10	-.05	-.08	.50	.41	.52
SAS-I-IP1	-.03	-.05	-.05	-.03	-.06	-.05
SAS-I-IP2	-.14	-.13	-.16	-.06	-.02	-.10
SAS-I-IP3	-.18	-.18	-.20	-.04	-.12	-.07
SAS-I	-.14	-.14	-.16	-.05	-.11	-.09
SAS-R-IP1	-.17	-.03	-.11	-.08	-.17	-.13
SAS-R-IP2	-.10	-.04	-.07	-.04	-.14	-.09
SAS-R	-.14	-.04	-.10	-.06	-.17	-.12
BS-IP1	.07	.00	.04	.46	.41	.49
BS-IP2	.01	-.02	-.01	.42	.39	.46
BS-IP3	.20	.09	.16	.36	.33	.39
BS	.11	.03	.07	.48	.43	.51
AA-IP1	.07	-.03	.01	.39	.36	.42
AA-IP2	.01	-.04	-.02	.41	.32	.41
AA-IP3	.01	-.06	-.04	.32	.30	.34
AA	.04	-.05	-.01	.40	.36	.43
COER	.06	.03	.05	.21	.19	.22
FOR	.11	.06	.09	.21	.22	.23
SV	.08	.05	.07	.22	.22	.24
ARO	.09	.13	.13	.03	.01	.03
D/S	.15	.05	.11	.13	.09	.12
S/A	.14	-.01	.06	.18	.23	.22
FSD	.16	.09	.14	.14	.14	.16

* Matrix continued on following pages

†Bold items denote full scale correlation coefficients

Table 3 continued

	BM-IP1	BM-IP2	BM-IP3	BM
BM-IP1	1.0			
BM-IP2	.62	1.0		
BM-IP3	.57	.71	1.0	
BM	.84	.89	.89	1.0
SAS-I-IP1	-.12	-.10	-.91	-.12
SAS-I-IP2	-.01	-.09	-.03	-.05
SAS-I-IP3	-.07	-.00	-.03	.01
SAS-I	-.03	-.08	-.06	-.07
SAS-R-IP1	.01	-.08	-.08	-.06
SAS-R-IP2	.00	-.11	-.11	-.08
SAS-R	.01	-.11	-.12	-.08
BS-IP1	.28	.38	.33	.38
BS-IP2	.35	.43	.47	.48
BS-IP3	.13	.26	.25	.24
BS	.29	.40	.40	.42
AA-IP1	.43	.47	.52	.54
AA-IP2	.40	.47	.46	.51
AA-IP3	.35	.37	.35	.41
AA	.43	.48	.49	.53
COER	.16	.11	.17	.17
FOR	.15	.13	.13	.16
SV	.17	.13	.16	.18
ARO	.02	-.01	.05	.03
D/S	.07	.03	.03	.05
S/A	.08	.11	.10	.11
FSD	.07	.05	.08	.08

Table 3 continued

	SAS-I-IP1	SAS-I-IP2	SAS-I-IP3	SAS-I
SAS-I-IP1	1.0			
SAS-I-IP2	.61	1.0		
SAS-I-IP3	.47	.44	1.0	
SAS-I	.86	.84	.76	1.0
SAS-R-IP1	.03	.10	.14	.11
SAS-R-IP2	.20	.16	.12	.20
SAS-R	.15	.15	.14	.18
BS-IP1	-.05	-.05	-.08	-.07
BS-IP2	-.03	.00	-.04	-.03
BS-IP3	.02	-.09	-.06	-.05
BS	-.02	-.05	-.07	-.06
AA-IP1	-.08	-.04	-.08	-.08
AA-IP2	-.09	-.02	-.05	-.07
AA-IP3	-.11	-.05	-.10	-.10
AA	-.10	-.04	-.08	-.09
COER	-.15	-.14	-.14	-.17
FOR	-.12	-.14	-.11	-.15
SV	-.15	-.15	-.13	-.17
ARO	-.09	-.06	-.05	-.08
D/S	-.11	-.09	-.10	-.12
S/A	-.24	-.22	-.20	-.27
FSD	-.20	-.16	-.15	-.21

Table 3 continued

	SAS-R-IP1	SAS-R-IP2	SAS-R
SAS-R-IP1	1.0		
SAS-R-IP2	.53	1.0	
SAS-R	.82	.93	1.0
BS-IP1	-.14	-.10	-.14
BS-IP2	-.08	-.09	-.10
BS-IP3	-.15	-.04	-.10
BS	-.15	-.09	-.13
AA-IP1	-.15	-.08	-.13
AA-IP2	-.11	-.08	-.11
AA-IP3	-.17	-.14	-.17
AA	-.16	-.11	-.15
COER	-.28	-.19	-.25
FOR	-.22	-.12	-.19
SV	-.27	-.17	-.23
ARO	-.07	-.05	-.07
D/S	-.28	-.15	-.27
S/A	-.27	-.20	-.26
FSD	-.26	-.17	-.23

	BS-IP1	BS-IP2	BS-IP3	BS
BS-IP1	1.0			
BS-IP2	.64	1.0		
BS-IP3	.64	.56	1.0	
BS	.88	.85	.87	1.0
AA-IP1	.55	.59	.46	.61
AA-IP2	.58	.58	.43	.61
AA-IP3	.50	.52	.37	.53
AA	.59	.62	.46	.64
COER	.27	.27	.21	.29
FOR	.25	.23	.25	.28
SV	.28	.27	.25	.30
ARO	.03	.05	.07	.06
D/S	.16	.15	.13	.17
S/A	.27	.18	.32	.30
FSD	.19	.16	.22	.22

Table 3 continued

	AA-IP1	AA-IP2	AA-IP3	AA	COER	FOR	SV
AA-IP1	1.0						
AA-IP2	.81	1.0					
AA-IP3	.70	.77	1.0				
AA	.92	.93	.90	1.0			
COER	.24	.18	.17	.22	1.0		
FOR	.28	.20	.20	.25	.77	1.0	
SV	.28	.20	.20	.25	.94	.94	1.0
ARO	.02	.02	-.01	.01	.05	.04	.05
D/S	.19	.13	.12	.16	.24	.26	.26
S/A	.31	.28	.25	.30	.27	.25	.28
FSD	.21	.18	.15	.20	.23	.22.	.24

	ARO	D/S	S/A	FSD
ARO	1.0			
D/S	.43	1.0		
S/A	.26	.42	1.0	
FSD	.78	.78	.68	1.0

Table 4

Variable and indicator abbreviations

Abbreviation	Full Name
SV	Sexual Victimization
COER	Coercion
FOR	Force
FGI	Feminine Gender Ideology
DD	Dependence/Deference
PUR	Purity
SO	Self-Objectification
ORB-IP1	Objectified Relationship with Body Item Parcel 1
ORB-IP2	Objectified Relationship with Body Item Parcel 2
BM	Body Monitoring
BM-IP1	BM Item Parcel 1
BM-IP2	BM Item Parcel 2
SAS-I	Sexual Assertiveness - Initiation
SAS-I-IP1	SAS-I Item Parcel 1
SAS-I-IP2	SAS-I Item Parcel 2
SAS-I-IP3	SAS-I Item Parcel 3
SAS-R	Sexual Assertiveness – Refusal
SAS-R-IP1	SAS-R Item Parcel 1
SAS-R-IP2	SAS-R Item Parcel 2
BS	Body Shame
BS-IP1	BS Item Parcel 1
BS-IP2	BS Item Parcel 2
BS-IP3	BS Item Parcel 3
AA	Appearance Anxiety
AA-IP1	AA Item Parcel 1
AA-IP2	AA Item Parcel 2
AA-IP3	AA Item Parcel 3
FSD	Female Sexual Dysfunction
ARO	Arousal
D/S	Distress/Shame
S/A	Satisfaction/Attitude toward sex

Table 5

Indicator loadings from final reduced-path LVM with all SAS-R parameters

Variable	Indicator	Loading
SV	COER	Fixed
	FOR	.82
FGI	DD	Fixed
	PUR	.80
SO	IP1	Fixed
	IP2	.73
BM	IP1	Fixed
	IP2	.87
	IP3	.82
SAS-I	IP1	Fixed
	IP2	.78
	IP3	.59
SAS-R	IP1	Fixed
	IP2	.63
BS	IP1	Fixed
	IP2	.79
	IP3	.72
AA	IP1	Fixed
	IP2	.93
	IP3	.82
FSD	D/S	Fixed
	S/A	.51
	ARO	.47

Table 6

Reliability statistics for each survey measure included in LVM analyses.

Survey Measure	Variable	Cronbach's alpha
*Sexual Victimization Scale	SV	.91
*Femininity Ideology Scale	FGI	.81
Objectified Relationship with Body Subscale	SO	.66
Body Surveillance Subscale	BM	.83
Sexual Assertiveness Scale – Initiation	SAS-I	.73
Sexual Assertiveness Scale – Refusal	SAS-R	.71
Body Shame Subscale	BS	.82
Appearance Anxiety Scale	AA	.90
* Female Sexual Functioning	FSD	.77

* Indicates subscales have been combined for reliability estimate

Figures

Key:

Variables
SV = Sexual Victimization
FGI = Feminine Gender Ideology
SO = Self-Objectification
BM = Body Monitoring
SAS-I = Sexual Assertiveness-Initiation
SAS-R = Sexual Assertiveness-Refusal
BS = Body Shame
AA = Appearance Anxiety
FSD = Female Sexual Dysfunction

Indicators
Tch = Touch
Pnt = Penetration
Coer = Coercion
Force = Force
HypF = Hyperfemininity Scale
Pur = Purity
DD = Dependency/Deference
PSC = Physical Self-concept
ORB = Objectified relationship with body
IP = Item Parcel
Des = Desire
Aro = Arousal
Org = Orgasm
D/S = Distress and Shame

Figure 1. Hypothesized latent variable model illustrating prediction of female sexual dysfunction via twenty-two direct and indirect paths.

Figure 2. Objectification Theory as applied to the experience of lesbian women in Kozee and Tylka (2006).

Figure 3. Original LVM goodness-of-fit showing ten statistically significant direct and indirect relationships involving eight of nine investigated variables. Significant paths are shown in red and have path coefficients displayed in boxes.

Figure 4. Modified model showing two additional direct paths suggested by original LVM results - self-objectification to body shame and sexual assertiveness for refusal to female sexual dysfunction. Additional paths are shown in blue.

Figure 5. Reduced model showing removal of all prediction paths leading from FGI, SAS-I, and SAS-R to the traditionally studied Objectification Theory variables.

$\chi^2(213) = 471.28, n = 377, p < .001, CFI = .93, RMSEA = .06$

Figure 6. Goodness-of-fit of final reduced-path model including prediction paths from SAS-R to FSD as well as to BS and AA as originally proposed. Significant paths are shown in red and have path coefficients displayed in boxes.

$\chi^2(122) = 299.37, n = 377, p < .001, CFI = .95, RMSEA = .06$

Figure 7. Condensed model LVM illustrating goodness-of-fit with inclusion of all SAS-R parameters after deletion of FGI and SAS-I. Significant paths are shown in red and have path coefficients displayed in boxes.

Appendix A

Synthesis of Reviewed Research

Many components of Fredrickson and Roberts' (1997) Objectification Theory are thoroughly supported by existing research. Self-objectification, body monitoring and body shame have been revealed as integral parts of an understanding of women's experience of their bodies, and while the degree of influence of factors mediating the relationships between these constructs and health conditions such as sexual dysfunction is less abundant, the research clearly suggests Objectification Theory variables contribute to women's health.

Eighteen empirical articles dating from 2001 to 2007 were reviewed to inform the preceding discussion. Of these articles, four tested relationships involving objectifying experiences – through either direct interpersonal interactions or exposure to sexually objectifying media images. Results across the four articles found support for a positive association between participants' reports of objectifying experiences and self-objectification, body surveillance, body shame, appearance anxiety, and symptoms of disordered eating (Moradi, Dirks, and Matteson, 2005; Aubrey, 2006; Kozee and Tylka, 2006; Aubrey, 2007). Additionally, one article provided support for the relationship between objectifying experiences and reduced awareness of internal bodily cues (Kozee and Tylka, 2006). While the effects of objectifying experiences themselves are one of the least studied variables in tests of Objectification Theory, the literature does support Fredrickson and Roberts' (1997) initial claims that a culture which consistently evaluates women by their physical appearance and highlights bodies and sexuality over competence or intelligence is bound to encourage women's negative self-appraisals. Tests of more varied examples of objectifying experiences (e.g., sexual harassment) would further strengthen the support for this relationship.

Fifteen of the reviewed articles tested relationships involving self-objectification. As previously discussed, the conceptualization of this variable as contributing to or being synonymous with body monitoring is inconsistent; however, of the articles claiming to test self-

objectification, support was provided for a positive correlation with body monitoring, body shame, appearance anxiety, symptoms of disordered eating, body-related self-consciousness during physical intimacy, and depression (Tiggemann and Lynch, 2001; Tiggemann and Slater, 2001; Muehlenkamp and Saris-Baglama, 2002; Slater and Tiggemann, 2002; Calogero, 2004; Roberts and Gettman, 2004; Tylka and Hill, 2004; Moradi, Dirks, and Matteson, 2005; Muehlenkamp, Swanson, and Brausch, 2005; Aubrey, 2006; Greenleaf and McGreer, 2006; Kozee and Tylka, 2006; Quinn, Kallen, and Cathey, 2006; Aubrey, 2007; Szymanski and Henning, 2007). Additionally, evidence was provided for the negative relationship between self-objectification and awareness of internal bodily states, peak motivational states, and the appeal of physical aspects of sex (Muehlenkamp and Saris-Baglama, 2002; Roberts and Gettman, 2004; Kozee and Tylka, 2006; Szymanski and Henning, 2007). When body monitoring was explicitly listed as the variable being tested, support was found for a positive correlation with body shame, appearance anxiety, body-related self-consciousness during physical intimacy, rumination, depression, and disordered eating (Tiggemann and Lynch, 2001; Tiggemann and Slater, 2001; Slater and Tiggemann, 2002; Tylka and Hill, 2004; Moradi, Dirks, and Matteson, 2005; Greenleaf and McGreer, 2006; Kozee and Tylka, 2006; Aubrey, 2007; Grabe, Hyde, and Lindberg, 2007; Szymanski and Henning, 2007). A negative relationship was found between body monitoring and both peak motivational states (Tiggemann and Slater, 2001; Greenleaf and McGreer, 2006; Szymanski and Henning, 2007) and awareness of internal bodily states (Tylka and Hill, 2004). These results suggest that even with the inconsistent conceptualization of self-objectification as synonymous with or independent of body monitoring, preoccupation with one's body and physical appearance as perceived by others is a major contributor to women's experience of themselves. Additional clarification is needed in regard to which is the best way to organize and operationalize the relationship between self-objectification and body monitoring; however, these constructs are arguably two of the three most salient, most empirically supported elements of Objectification Theory.

Body shame, the third strongly supported Objectification Theory construct, was tested in thirteen of the reviewed articles. Support was found for positive correlations between body shame and both depression (Muehlenkamp, Swanson, and Brausch, 2005; Grabe, Hyde, and Lindberg, 2007; Szymanski and Henning, 2007) and disordered eating (Tiggemann and Lynch, 2001; Tiggemann and Slater, 2001; Slater and Tiggemann, 2002; Tylka and Hill, 2004; Moradi, Dirks, and Matteson, 2005; Greenleaf and McGreer, 2006; Kozee and Tylka, 2006; Sanchez and Kwang, 2007). Additionally, body shame was shown to be positively related to body-related self-consciousness during physical intimacy (Sanchez and Kiefer, 2007) and negatively related to awareness of internal bodily states (Tylka and Hill, 2004; Kozee and Tylka, 2006). As can be seen from reviewing the relationships mentioned in the above paragraphs, not only has body shame been upheld as asserting its own influence *on* other Objectification Theory variables, but it has also clearly been established as a variable that is influenced *by* other Objectification Theory variables. In this sense, body shame has emerged as one of the central mediating factors between women's experience of objectification, body monitoring, and health factors such as disordered eating, sexual dysfunction, and depression.

Arguably one of the most important aims of Objectification Theory is the prediction or explanation of health conditions found to be predominant among women. Of the eighteen articles reviewed, fourteen tested predictors of depression, eating disorders, and/or elements of sexual dysfunction. Among those examining depression, positive correlations were found between symptoms of depression and self-objectification (Muehlenkamp and Saris-Baglama, 2002); appearance anxiety (Szymanski and Henning, 2007); rumination, and body shame (Grabe, Hyde, and Lindberg, 2007). Furthermore, depression was found to be negatively correlated with participants' peak motivational states (Szymanski and Henning, 2007). Elements of sexual dysfunction were related to self-objectification (Aubrey, 2007; Roberts and Gettman, 2004); body surveillance (Aubrey, 2007); and body shame (Sanchez and Kiefer, 2007). Across studies, eating disorder symptomatology was found to be correlated with sexually objectifying experiences, self-

objectification, body monitoring, body shame, lowered awareness of internal bodily states, appearance anxiety, relationship contingency, and depression (Tiggemann and Lynch, 2001; Tiggemann and Slater, 2001; Slater and Tiggemann, 2002; Muehlenkamp and Saris-Baglama, 2002; Tylka and Hill, 2004; Moradi, Dirks, and Matteson, 2005; Greenleaf and McGreer, 2006; Kozee and Tylka, 2006; Sanchez and Kwang, 2007). While some health risks (e.g., eating disorders) have received more attention and support than others (e.g., sexual dysfunction), none has received as much attention as the relationships among variables hypothesized to predict them. In terms of testing the overall appropriateness of the Objectification Theory model, however, studies incorporating these variables in hypothesized explanations of depression, eating disorders, and sexual dysfunction are frequently considered successful.

Clearly the research to date provides compelling evidence in support of Objectification Theory, particularly in regard to relationships among self-objectification, body monitoring, and body shame. The role of variables less often studied, however, (e.g., appearance anxiety, flow, internal awareness), is not as well understood. This imbalance in research focus muddles the clear outline of a path from experience of objectification to health factors like depression, eating disorders, and sexual dysfunction. As with most theories, additional research is needed.

Appendix B

Objectification Theory Expanded

Sanchez and Kwang (2007) introduced a potential addition to Objectification Theory by investigating the role of relationship-based self-esteem. They argue women are more likely to experience body shame and disordered eating if they base their self-esteem on being in or maintaining romantic relationships, a pattern the authors conceptualize as relationship contingency. Just as Fredrickson and Roberts' (1997) argue that social pressures to match a culturally specified beauty ideal are internalized by women as measures of self-worth, Sanchez and Kwang argue the pressures women feel to find romantic partners may be internalized and similarly affect their self-worth via changes in self-esteem. When romantic relationships fail or are not momentarily present, the authors argue there is the potential for women to devalue themselves because of an internalization of the message that women need romantic relationships. Furthermore, aware of the value men attach to physical appearance in selecting a partner, the authors argue a preoccupation with one's body image may serve as a means of finding and maintaining romantic relationships.

Like Fredrickson and Roberts' (1997) assertion that body shame contributes to disordered eating, Sanchez and Kwang (2007) hypothesize body shame and self-esteem mediate the relationship between relationship contingency and women's reports of eating disorder symptomatology. In line with their predictions, structural equation modeling of data from a survey of 146 undergraduate women ($M = 18.4$ y/o) and 294 community women recruited over the internet ($M = 27.35$ y/o) revealed relationship contingency significantly predicted participants' reports of both body shame and self-esteem; both variables mediated the relationship between relationship contingency and participants' reports of bulimic symptoms. Given the focus on internalization of beauty ideals in most conceptualizations of self-objectification, these results provide compelling evidence to consider broadening that conceptualization to include the messages women receive about their need for romantic relationships. While the cross-sectional

study design limits the inferences drawn from these results, the inclusion of both college students and women recruited from the community at large adds force to these findings beyond that from more restricted samples. An unfortunately common drawback to this and most other Objectification Theory studies, however, is the homogenous sample, comprised of primarily white, heterosexual women. This fact automatically limits the degree to which these results can be generalized.

Appendix C

Objectification and Lesbian Women

Kozee and Tylka (2006), noting the focus of Objectification Theory research on heterosexual women to the near exclusion of other orientations, investigated the fit of Fredrickson and Roberts' (1997) model to the experience of lesbian women. The authors posited two possible hypotheses: 1) viewing the thin-ideal as heterosexist, lesbian women may reject it as a standard of beauty and thus report less experience of self-objectification, or 2) sexual objectification may be so pervasive from such a young age in western culture that lesbian women are impacted as much as all women. In an effort to begin clarifying the fit of Objectification Theory to lesbian women's experiences, the authors tested a model whereby interpersonal experiences of sexual objectification were hypothesized to predict body monitoring. Body monitoring was then hypothesized to predict body shame and awareness of internal bodily states. Lastly, these variables were hypothesized to mediate the relationship between body monitoring and participants' reports of disordered eating. Recruited from Lesbian, Gay, Bisexual, and Transgender student services across the country and from undergraduate psychology courses at a Midwestern state university, the final sample consisted of 181 lesbian women ages 18 to 26 ($M = 21.2$ y/o) and 196 heterosexual women ages 18 to 22 ($M = 18.7$ y/o).

Group comparisons revealed lesbian women reported more body monitoring and fewer symptoms of disordered eating than heterosexual women, but no other significant differences between groups were revealed. As expected, path analyses indicated the proposed model was an excellent fit to the data provided by the sample of heterosexual women, the only non-significant path being from body monitoring to internal awareness. The same model, however, was a poor fit to the data provided by the sample of lesbian women. Results suggested four model modifications, and a second analysis following these changes revealed the adjusted model provided a much better fit to the lesbian sample data. This final model suggested interpersonal experiences of sexual objectification predicted body shame and awareness of internal bodily

states in addition to body monitoring. Furthermore, eating disorder symptomatology was directly predicted by body monitoring as well as through the mediational relationship with body shame. Finally, body shame predicted awareness of internal bodily states, but internal awareness had no significant effect on disordered eating.

While both sets of analyses support the inclusion of the same set of variables, results suggest objectification is indirectly related to negative consequences among heterosexual women but directly related to negative consequences among lesbian women. Kozee and Tylka (2006) assert their results suggest the relationships among Objectification Theory variables may likely be more complex for lesbian women as compared to heterosexual women. They claim the lower reports of eating disorder symptomatology among lesbian participants supports the first hypothesized explanation of how objectifying experiences affect lesbian women, namely that the lesbian identity protects women against disordered eating through a resistance to what is considered a heterosexual thin-ideal. While this study suggests Objectification Theory models differ according to sexual orientation, the overarching message remains the same: sexual objectification is related to women's experience of negative body-based consequences.

Appendix D

Diversity

University of Rhode Island records for the fall 2009 semester (<http://www.uri.edu/ir/pdf/factsheet09.pdf>) revealed a total of 13,234 undergraduate students. Of these, 7,341 (55.5%) were women and 800 (5.5%) were psychology majors. Students identifying as Caucasian comprised the majority of undergraduates (73.6%) followed by those identifying as Hispanic (5.5%), African American (5.0%), Asian (2.6%), and Native American (0.4%). 12.4% of undergraduate students did not report a racial demographic. It was expected that the make-up of the study sample would reflect these underlying demographics; however, because participants were recruited from psychology courses specifically rather than the university at large, the demographic characteristics of the final sample were also expected to vary slightly. In the largest psychology lecture, the ratio of women to men was higher than the demographics for the university population; however, no additional statistics reflecting the subset of students enrolled in psychology courses were available. Because the purpose of this study was to investigate hypotheses derived from Objectification Theory which was developed to explain the consequences of women's experiences of objectification, only women were recruited to participate in this study. Additionally, as mentioned previously, sexual abuse is more prevalent among women.

Just as racial and ethnic homogeneity was expected, participants were expected to fall within a very limited age range, 18-22. Using a young adult sample was in line with the majority of research in the field of Objectification Theory, but this limitation must be kept in mind when considering research results. The current study sought to expand our understanding of variables that influence the sexual functioning of young adult women; however, additional research will be needed before any significant relationships can be judged to be independent of participants' developmental stage.

While research has yet to reveal that Objectification Theory (Fredrickson and Roberts, 1997) applies differently according to women's race or ethnicity, the vast majority of research participants have identified as white or Caucasian, making it difficult to draw any conclusions in this regard. An important issue is whether model predictions might be different for women of different ethnic/racial identifications. It is highly likely that a woman's racial and ethnic background influences her perception of "ideal beauty"; however, a major premise of Objectification Theory is that a perceived failure to meet social standards of beauty promotes negative consequences. The particulars of that beauty standard could, presumably, vary across cultures without challenging Fredrickson and Roberts's original model. For example, while weight may dictate the standard of beauty for one culture, hair and skin color may do so for another. It is the way a woman evaluates her approximation to a standard of beauty that matters, not the specifics of that standard. Following this logic, the current study presumes that Objectification Theory will apply to women of different ethnic/racial backgrounds. It should be noted that this study did not test these assumptions. As stated, this study was expected to draw a primarily white sample; however, research has yet to suggest the proposed hypotheses would not be supported by data from a more racially and ethnically diverse sample. Future research should test these assumptions by investigating more diverse samples.

Appendix E

Sample Size Determinants

Assuming that an effect truly exists in the population, power is the probability that a statistical test will be significant. Increasing power decreases the chance of falsely concluding that no effect exists, in other words, the possibility of committing a Type II error is decreased. For example, in this study, committing a Type II error would mean that sexual victimization and femininity ideology both affect one's sexual functioning, but statistical analyses failed to recognize a significant association. Because statistical power increases as a function of sample size, if the aim is to avoid this error, a larger sample must be recruited. Large samples facilitate finding significance because the effect size does not need to be as big as would be required for some small samples. When distinguishing between results that are consequential and those that are negligible, effects sizes and theory are crucial. The current LVM design investigated sexual victimization, femininity ideology, and seven additional mediating and dependent variables. When associations were found to be significant, large effect sizes and strong theoretical support were used to decide which relationships were central to understanding the model. Because this study recruited a University sample versus a national sample, having too large a sample size was not a considerable threat. Furthermore, by implementing the commonly used $p < .05$ alpha value to determine statistical significance, a significant finding was attributed to chance factors in no more than 5% of cases.

According to Kline (2005), because SEM is considered a large sample model, no less than 200 participants should comprise any SEM design. As such, having small ($N < 100$) or medium ($N = 100-200$) samples could have resulted in problems during analysis. In addition, because some protection must be in place in expectation of incomplete data or individuals not completing the study, the participant pool recruited initially ($n=500$) was even larger than what was expected to be used in the end.

Appendix F

Demographics

For the following questions, please check or provide the answer that is best for you.

1. How old are you? _____ years
2. What is your race or cultural group?
A = White
B = African American
C = Native American
D = Asian American
E = Hispanic American
F = Other (please specify) _____
3. What year are you in school?
A = Freshman
B = Sophomore
C = Junior
D = Senior
E = Other (please specify) _____
4. What is your religion?
A = Catholic
B = Protestant
C = Jewish
D = Muslim
E = Eastern
F = Other (please specify) _____
G = None
5. How religious are you?
A = Not at all
B = Slightly
C = Somewhat
D = Fairly
E = Very
6. Have you ever engaged in voluntary sexual activity or intercourse?
A = No B = Yes

Femininity Ideology

Please indicate how much you agree or disagree with each of the following statements.

1. Women should not marry younger men.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
2. Women should not initiate sex.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
3. Women should not expect to be sexually satisfied by their partners.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
4. Women should act helpless to attract a man.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
5. Women should have men make decisions for them.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
6. Women should not read pornographic material.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
4. Women should remain virgins until they are married.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
8. Women should not masturbate.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
9. Women should not tell dirty jokes.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
10. Women should dress conservatively so they do not appear loose.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
11. Women should always be ready to accept the financial responsibility for a date.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
12. Women should state their sexual needs clearly and concisely.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
13. Women should feel flattered when men whistle at them.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
14. Women should state their sexual intentions honestly and openly.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
15. Women should act sexy to get what they want from men.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree

Self-Objectification

Please rank the following list of body attributes in ascending order (1 = most impact, 10 = least impact) according to their importance to your physical self-concept.

Physical attractiveness
Muscular strength
Weight
Physical coordination
Sex appeal
Health
Measurements
Physical fitness
Muscle tone
Physical energy level

Please indicate how much you agree or disagree with each of the following statements.

1. The way I can tell that I am at a good weight is when I fit into a small size.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
2. I think that a girl has to be thin to feel beautiful.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
3. I am more concerned about how my body looks than how my body feels.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
4. The way I decide I am at a good weight is when I feel healthy.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
5. I decide how much to eat by how hungry I am.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree

Alternative Self-Objectification Questions

1. The way I can tell that I am at a good weight is when I fit into the right size.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
2. I think that a girl has to be the right weight to feel beautiful.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree

Body Monitoring

Please indicate how much you agree or disagree with each of the following statements.

1. I rarely think about how I look.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
2. I think it is more important that my clothes are comfortable than that they look good on me.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
3. I think more about how my body feels than how my body looks.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
4. I rarely compare how I look with how other people look.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
5. During the day, I think about how I look many times.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
6. I often worry about whether the clothes I am wearing make me look good.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
7. I rarely worry about how I look to other people.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
8. I am more concerned with what my body can do than how it looks.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree

Sexual Assertiveness Scale

Think about a person you usually have sex with or someone you used to have sex with regularly. Answer the next questions with that person in mind. Think about what you would do even if you have not done some of these things. Please check your best answer.

1. I let my partner know if I want my partner to touch my genitals.
A = Never B = Sometimes C = About half the time D = Usually E = Always
2. I begin sex with my partner if I want to.
A = Never B = Sometimes C = About half the time D = Usually E = Always
3. I let my partner know how I like to be touched.
A = Never B = Sometimes C = About half the time D = Usually E = Always
4. I give in and kiss if my partner pressures me, even if I already said no.
A = Never B = Sometimes C = About half the time D = Usually E = Always
5. I wait for my partner to touch my breasts instead of saying that's what I want.
A = Never B = Sometimes C = About half the time D = Usually E = Always
6. I wait for my partner to touch my genitals instead of saying that's what I want.
A = Never B = Sometimes C = About half the time D = Usually E = Always
7. Women should wait for men to start things like breast touching.
A = Never B = Sometimes C = About half the time D = Usually E = Always
8. I let my partner know if I want to have my genitals kissed.
A = Never B = Sometimes C = About half the time D = Usually E = Always
9. I refuse to let my partner touch my breasts if I don't want that, even if my partner insists.
A = Never B = Sometimes C = About half the time D = Usually E = Always
10. I have sex if my partner wants me to, even if I don't want to.
A = Never B = Sometimes C = About half the time D = Usually E = Always
11. If I said no, I won't let my partner touch my genitals even if my partner pressures me.
A = Never B = Sometimes C = About half the time D = Usually E = Always
12. I refuse to have sex if I don't want to, even if my partner insists.
A = Never B = Sometimes C = About half the time D = Usually E = Always

Body Shame

Please indicate how much you agree or disagree with each of the following statements.

1. When I can't control my weight, I feel like something must be wrong with me.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
2. I feel ashamed of myself when I haven't made the effort to look my best.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
3. I feel like I must be a bad person when I don't look as good as I could.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
4. I would be ashamed for people to know what I really weigh.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
5. I never worry that something is wrong with me when I am not exercising as much as I should.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
6. When I'm not exercising enough, I question whether I am a good enough person.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
7. Even when I can't control my weight, I think I'm an okay person.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree
8. When I'm not the size I think I should be, I feel ashamed.
Strongly disagree / Disagree / Neutral / Agree / Strongly Agree

Appearance Anxiety

For each of the items below, indicate to what extent the statement is true or characteristic of you.

1. I feel nervous about aspects of my physical appearance.
Sometimes / Often / Very Often / Almost Always
2. Concern about my appearance has prompted me to diet.
Sometimes / Often / Very Often / Almost Always
3. I enjoy looking at myself in the mirror.
Sometimes / Often / Very Often / Almost Always
4. I am self-conscious about the way I look.
Sometimes / Often / Very Often / Almost Always
5. I am aware of my appearance.
Sometimes / Often / Very Often / Almost Always
6. I am unconcerned about how aging will affect my appearance.
Sometimes / Often / Very Often / Almost Always
7. I worry about how others are evaluating how I look.
Sometimes / Often / Very Often / Almost Always
8. I am comfortable with my appearance.
Sometimes / Often / Very Often / Almost Always
9. I like how I look.
Sometimes / Often / Very Often / Almost Always
10. I feel ill at ease if I do not have enough time to make myself look good in the morning.
Sometimes / Often / Very Often / Almost Always
11. I am unconcerned with how others feel about my appearance.
Sometimes / Often / Very Often / Almost Always
12. Because much of my physical appearance is beyond my control, I do not dwell on it.
Sometimes / Often / Very Often / Almost Always
13. I get nervous when others comment on my appearance.
Sometimes / Often / Very Often / Almost Always
14. My appearance bothers me enough that I have thoughts about having cosmetic surgery.
Sometimes / Often / Very Often / Almost Always
15. Negative remarks about how I look do not bother me.
Sometimes / Often / Very Often / Almost Always
16. I feel helpless to change my appearance.
Sometimes / Often / Very Often / Almost Always

17. If I wear a hat on very cold days, I worry it might make me look less attractive.
Sometimes / Often / Very Often / Almost Always
18. I worry about how I'll look as I grow older.
Sometimes / Often / Very Often / Almost Always
19. I feel comfortable with my facial attractiveness.
Sometimes / Often / Very Often / Almost Always
20. I am satisfied with my body weight.
Sometimes / Often / Very Often / Almost Always
21. I would like to change the way I look.
Sometimes / Often / Very Often / Almost Always
22. I am satisfied with my body's build or shape.
Sometimes / Often / Very Often / Almost Always
23. I would be uncomfortable without products to enhance my appearance.
Sometimes / Often / Very Often / Almost Always
24. I feel uncomfortable with certain aspects of my physical appearance.
Sometimes / Often / Very Often / Almost Always
25. I feel ashamed of my physique or figure.
Sometimes / Often / Very Often / Almost Always
26. I feel that most of my friends are more physically attractive than me.
Sometimes / Often / Very Often / Almost Always
27. I wish that I was better looking.
Sometimes / Often / Very Often / Almost Always
28. I am concerned or worried about my ability to attract (a romantic partner).
Sometimes / Often / Very Often / Almost Always
29. I am confident that others see me as physically appealing.
Sometimes / Often / Very Often / Almost Always
30. I am satisfied with my height.
Sometimes / Often / Very Often / Almost Always

Sexual Victimization

As children, many women are in sexual situations with someone older than them. A sexual situation could mean someone showing his or her genitals to you. It could mean someone touching you in a sexual way. It could also mean a man or boy putting his penis in your mouth, vagina, or rectum.

Think back to when you were a child up to 14 years of age, and answer the next questions. I understand that these may be difficult questions to answer, but please try to answer them as honestly as you can. Please check your best answer.

Before you were 14 years old:

1. Did anyone older ever touch your breasts or genitals?
A = No B = Once C = A few times D = Many times
2. Did anyone older ever try to make you touch his or her genitals?
A = No B = Once C = A few times D = Many times
3. Did anyone older ever rub his or her genitals against your body?
A = No B = Once C = A few times D = Many times
4. Did an older man or boy ever **try** to put his penis in your mouth, vagina, or rectum?
A = No B = Once C = A few times D = Many times
5. Did an older man or boy ever **put** his penis in your mouth, vagina, or rectum?
A = No B = Once C = A few times D = Many times

In this next set of questions, a “sex partner” is any person that you have done any of these things with:

Oral sex: your mouth on your partner’s genitals or your partner’s mouth on your genitals;
Vaginal sex: a man putting his penis in your vagina;
Anal sex: a man putting his penis in your rectum.

“Having sex” is doing any of these things with a sex partner.

Please think about whether these things have ever happened to you since the age of 14 years. I understand that these may be difficult questions to answer, but please try to answer them as honestly as you can. Please check your best answer.

Since the age of 14, have you ever...

1. ...had a partner mistake how far you wanted to go with sex?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
2. ...been with a partner who got so turned on that you couldn’t stop that partner, even though you didn’t want to have sex?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no

3. ...had sex with a partner even though you didn't want to because you thought he or she might break up with you?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
4. ...had sex with a partner when you didn't want to because that partner argued and put pressure on you?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
5. ...found out that a partner talked you into sex by saying things he or she didn't mean?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
6. ...had a partner use force (twist your arm, hold you down, etc.) to make you kiss or feel him or her when you didn't want to?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
7. ...had a partner **try** to have sex with you when you didn't want to by saying he or she would use force, but then sex didn't happen?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
8. ...had a partner **use** force to make you have sex when you didn't want to, but then sex didn't happen?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
9. ...had sex with a partner when you didn't want to because you thought that partner would use force (twist your arm, hold you down, etc.)?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
10. ...had vaginal sex (penis in your vagina) with a man when you didn't want to because he used force?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
11. ...had anal or oral sex (penis in your rectum or mouth) with a man when you didn't want to because he used threats or force?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
12. ...ever been raped?
A = Definitely yes B = Probably yes C = Probably no D = Definitely no
13. By approximately how many different people have you been sexually victimized over the course of your life?
14. Approximately how many times have you been sexually victimized over the course of your life?

Female Sexual Functioning

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. 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 penetration (entry) of the vagina.

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

CHECK ONLY ONE BOX PER QUESTION.

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. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

Very high / High / Moderate / Low / Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

No sexual activity
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

No sexual activity / Very high / High / Moderate / Low / Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?
 - No sexual activity
 - Very high confidence
 - High confidence
 - Moderate confidence
 - Low confidence
 - Very low or no confidence
6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
 - No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never
7. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
 - No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never
8. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?
 - No sexual activity
 - Extremely difficult or impossible
 - Very difficult
 - Difficult
 - Slightly difficult
 - Not difficult
9. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
 - No sexual activity
 - Very satisfied
 - Moderately satisfied
 - About equally satisfied and dissatisfied
 - Moderately dissatisfied
 - Very dissatisfied
10. Over the past 4 weeks, how discouraged have you felt by your sexual response (e.g., desire, ability to become aroused)?
 - Not at all / Slightly / Moderately / Very / Extremely

11. Over the past 4 weeks, how much fear, shame, or guilt have you felt during sexual activity or intercourse?
None / A little / A moderate amount / A lot / Extreme fear, shame, or guilt
12. I do not like some parts of my sex life.
Never / Rarely / Sometimes / Most of the time / Always
13. I have control of my sex life.
Never / Rarely / Sometimes / Most of the time / Always
14. I like the way my sex life is going.
Never / Rarely / Sometimes / Most of the time / Always

Impression Management

Please indicate how much you agree or disagree with each of the following statements.

1. I sometimes tell lies if I have to.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
2. There have been occasions when I have taken advantage of someone.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
3. I never swear.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
4. I have said something bad about a friend behind his or her back.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
5. When I hear people talking privately, I avoid listening.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
6. I have received too much change from a salesperson without telling him or her.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
7. I have never dropped litter on the street.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
8. I never take things that don't belong to me.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
9. I have some pretty awful habits.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True
10. I don't gossip about other people's business.
1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7
Not True Somewhat True Very True

Appendix G

As noted by Noar (2003), “To have confidence in the findings of our studies, we must first have confidence in the quality of our measures (pg. 622).” Throughout the history of gender role studies, instruments such as the Bem Sex Role Inventory (BSRI: Bem, 1974), and Attitudes Towards Women Scale (AWS: Spence and Helmreich, 1972) have been frequently used, and while research has both critiqued and supported the validity of these scales (Holt and Ellis, 1998; Tolman and Porche, 2000; Hoffman, 2001; Hoffman and Borders, 2001), a more recent concern has been their appropriateness for the shift toward studying gender ideology rather than gender traits or an individual’s enactment of a gender role. When it becomes clear from a review of the literature, as is the case with feminine gender ideology, that empirically developed and validated measurement instruments fall short of meeting the researcher’s current needs, the temptation to embark on addressing that absence with a new scale may immediately present itself. The process is by no means simplistic, but with a clearly articulated theory and a series of sound methodological steps, the result may be a much needed alternative to a bevy of poorly designed or ill-fitting scales.

Given the existing plethora of psychological studies, it is generally unlikely that no one has ever investigated a researcher’s interest area before. With this in mind, scale developers are encouraged to conduct a thorough review of the literature to verify no established scales exist that appropriately and sufficiently meet the needs of the task at hand. As explained by Meyer, Edwards, and Rossi (1995), “the process of test selection serves to ensure that the instrument is of good quality and is appropriate to the clinical or research question at hand (pg. 25).” Concerning the field of femininity ideology, a number of existing scales deserved review before deciding on a measurement approach for the current study.

The Adolescent Femininity Ideology Scale (AFIS: Tolman and Porche, 2000) was developed in response to the perception that gender-research measures focused on personality traits or gender roles rather than widespread internalization of feminine gender norms.

Additionally, noting the adult samples used for the development of most gender-related measures, the authors wished to develop a scale specific for use with adolescents. The resulting instrument was created to target adolescents' internalization of two components of femininity ideology: an "inauthentic self in intimate relationships with others and having an objectified relationship with one's body (pg. 365)." The measure was developed using a highly diverse sample and focus groups that provided qualitative in addition to quantitative guidance. The current study, however, aimed to measure women's internalization of different social messages than those assessed by the AFIS. While Tolman and Porche (2000) were interested in self-objectification and girls' inauthentic self in relationships, the present study was concerned with women's expectations of adult sexual relationships and what they considered to be appropriate sexual behavior for women.

The Femininity Ideology Scale (FIS; Levant, 2007) was recently developed for use with adult samples and more closely satisfied the needs of the current research. The FIS is presented as a broad-spectrum measure of femininity ideology and thus measures respondents' attitudes across five broad domains: 1) Stereotypic image and activities, 2) Dependence or deference, 3) Purity, 4) Caretaking, and 5) Emotionality. While the full FIS scale is a general measure of femininity ideology rather than a focused assessment of perceptions of appropriate female sexuality, two of the domains represented by FIS scores were relevant to the current study. Dependency/Deference and Purity items such as "Women should not initiate sex" and "Women should dress conservatively so they do not appear loose" are consistent with a traditional understanding of femininity and thus served as appropriate items for the study. The Purity and Dependency/Deference subscales satisfied the theoretical needs of the study; however, adding items to improve the scale's reliability was expected to help satisfy the study's psychometric needs, as initial estimates of internal consistency suggested the FIS has an adequate but low reliability (Cronbach's $\alpha = .70$).

The Hyperfemininity Scale (Murnen and Byrne, 1991) targets women's enactment of traditional feminine gender role behaviors; however, it falls short of measuring femininity

ideology by focusing on women's personal beliefs as opposed to behaviors or attitudes they consider universally appropriate for women. Nevertheless, because the scale was designed for women respondents and assesses gender role endorsements specifically in the context of sexual relationships, it provides a useful resource for supplementing the items provided by the FIS subscales. With simple modifications, (e.g., "Women should state their sexual needs clearly and concisely" vs. "I try to state my sexual needs clearly and concisely"), Hyperfemininity Scale items were adjusted to assess participants' attitudes about appropriate sexual behavior for women in general rather than just the attitudes that dictate individuals' own personal behaviors.

Given all of the above considerations, using the Purity and Dependency/Deference subscales of the FIS and a selection of modified Hyperfemininity Scale items appeared to be the best approach to measuring the target ideology of the current study, feminine sexuality.

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