Sexual Objectification, Self-Objectification, Body Appreciation, and Quality of the Sexual Relationship in Relation to Preventative Sexual Health Behaviors in a Sample of Emerging Adult Women

By

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Abstract

Poor body image has negative consequences for women's sexual health, but existing scholarship in this area fails to account for the relationship context in which sexual behaviors occur. Furthermore, the majority of existing research in this area focuses on pathology. A better understanding of how objectification, body image, relationship quality, and sexual behaviors are related can help scholars and practitioners identify appropriate avenues for intervention. This dissertation marries two theoretical frameworks—objectification theory and relational-cultural theory—to provide a better understanding of the relationships between sexual objectification, self-objectification, body appreciation, quality of the sexual relationship, and preventative sexual health behaviors. A theoretically- and empirically-informed model was tested using Structural Equation Modeling (N = 399). The findings suggest that when women internalize objectification, it may have a negative impact on their body image. Further, findings indicate that body image is related to preventative sexual health behaviors directly and indirectly through relationship quality. Recommendations for social work practice, education, policy, and research are discussed.

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Chapter 1: Introduction

Body image, a complex, multidimensional construct, is a term used to represent the way an individual subjectively views her body, the significance she puts on her appearance, and the feelings and experiences she associates with her view of her body. Body image has been studied and applied far more to women than to men, and research indicates that it specifically impacts women's quality of life (Cash & Henry, 1995; Cash, Winstead, & Janda, 1986; Rodin, 1985). One component of body image, body dissatisfaction, is so prevalent among women it is considered a normative discontent (Rodin, 1985). In fact, one study of college students found that 94 percent of the women in the sample were dissatisfied with their bodies (Monteath & McCabe, 1997). Poor body image can have negative consequences for women's mental health (Cash & Deagle, 1997; Simonelli & Heinberg, 2009), physical health (Stice, Mazotti, Krebs, & Martin, 1998; Wilson, Latner, & Hayashi, 2013), and sexual health (Woertman & van den Brink, 2012), making improvements in body image a pressing issue for women in the United States.

The complex ways in which a woman thinks and feels about her body may directly impact the experiences when her body is most exposed, and potentially most vulnerable: in the sexual encounter. In a review of articles that explore relationships between women's body image and sexuality, Woertman and van den Brink (2012) provided an overview of the research on relationships between body image and the following sexuality constructs: sexual desire, subjective sexual arousal and lubrication, orgasm, satisfaction, pain, and sexual behavior (e.g., frequency of sex, coital onset, risky sexual behaviors). The authors concluded that "Body evaluations and cognitions not only interfere with sexual responses and experiences during sexual activity, but also with sexual behavior, sexual avoidance, and risky sexual behavior" (p. 184).

The overall goal of this dissertation is to explore the relationship between body image and sexual behaviors among women. To accomplish this, this dissertation will describe the relevance of body image to social work practice with women, explore the historical context of women's body image and sexuality, and establish body image as a social problem (Chapter 1). After grounding the relationship between body image and sexual behavior in objectification theory and relational-cultural theory, a thorough review and critique of the empirical literature linking body image and sexual behavior among women will be conducted (Chapter 2). Finally, this dissertation will provide the methodology, analysis (Chapter 3), and findings (Chapter 4) of the current study. In the final chapter, a discussion of the most salient findings, their contributions to the existing body of knowledge, and their implications for continued research and social work practice, will be discussed.

Relevance to Social Work

Body image is directly related to mental health, as relationships between body image, eating disorders (Cash & Deagle, 1997; Crowther & Williams, 2011; Delinsky, 2011), and depression (Gillen, 2015; Simonelli & Heinberg, 2009) are well established in the literature. Addressing body image as a source of negative mental health and other consequences may help improve women's quality of life and health in these areas (Pruzinsky & Cash, 2002). Social work scholars agree that body image should be addressed in social work practice; in fact, prominent social work scholars have called for attention to the body in the social work profession (Saleebey, 1992; Tangenberg & Kemp, 2002). According to Saleebey (1992), "The mind and body exist in a continuing interaction" (p. 116) and the absence of attention to the body in social work practice impairs social workers' ability to facilitate access to clients' strengths and

resources. Thus, to help clients make changes in their lives and, ultimately improve their health and mental health, social workers must attend to issues about clients' bodies.

Body image also has relevance to the social work profession as an issue of social justice, one of social work's core values. According to the National Association of Social Workers' Code of Ethics (2008), one of social work's ethical principles is to challenge the social injustices oppressed populations experience. McKinley (2002) suggests that sexual objectification and poor body image keep women from achieving equality or equity, as "Working to achieve cultural body standards deprives women of time, energy, and economic resources" (p. 52). Furthermore, because the ideal female body type is young, able, White, and heterosexual, status differences between women are maintained and reinforced. Thus, body dissatisfaction plays a role in the oppression, subordination, and separation of women. According to Saleebey (1992), by failing to address body issues such as body image, social workers contribute to the oppression of women. Since women experience life in their bodies from birth to death (Cash, 1990), the oppression caused by body issues impacts women's quality of life across the lifespan.

In sum, the social work profession's commitment to social justice on behalf of oppressed individuals and populations demands that social workers pay attention to the body. To better understand women's current body image issues and to inform theory, research, and practice, an exploration of how women's bodies and sexuality have been viewed throughout U.S. history is warranted.

Women's Sexuality in America from 1880-Present

1880s – 1910s: Rethinking women's sexual health and choices. Perceptions of women's bodies and sexuality have changed over time; these views have been influenced by researchers as well as by shifts in cultural values, norms, and expectations. Clelia Mosher

(1918) began her 25-year research study of 1,907 women through 12,000 menstrual cycles in the late 1800s, at a time when women were viewed as physically and otherwise inferior to men. Mosher's research addressed two of the reasons women were viewed as physically inferior. First, Mosher's studies disproved the widely-accepted theory that women breathe costally (from the chest), establishing that women breathe through the diaphragm as men do. However, corsets and other restrictive clothing women wore during the Victorian era to help them achieve the ideal hour glass body type (Simonelli & Heinberg, 2009) did not allow women to breathe diaphragmatically. Second, menstruation was, at the time, treated as an illness and was considered disabling. In fact, women were expected to miss work at home or in the workforce during menses. Mosher's research found that pain during menstruation was at least partially a consequence of costal breathing. Removing popular, restrictive fashion styles allowed women to breathe properly and helped with menses pain (Mosher, 1918). Thus, Mosher's research challenged hegemonic ideas about women's physical inferiority.

Around the time Mosher's research was published, the women's movement sought to gain legal access to birth control. However, the Comstock Act, enacted by the Federal government in 1873, defined what material was considered obscene. This definition included information about contraceptives and abortion; therefore, the Comstock Act prohibited contraceptives and information about contraceptives and abortion from being distributed by mail (D'Emilio & Freedman, 1997). Margaret Sanger, a leading activist in the birth control movement, was arrested in 1914 for violating the Comstock Act and again in 1916 for providing birth control at her New York clinic (McCann, 1994). Sanger argued that women's sexuality should not be more restricted than men's and that "bodily integrity for women, as for men, included the right to refuse sex when they did not desire it and the right to engage in pleasurable

sex without the risk of pregnancy, if they so desired" (McCann, 1994, p. 37). Thus, Mosher's and Sanger's efforts ushered in a shift in how society viewed women's bodies and sexuality: women began to understand that their menstrual cycles did not limit their abilities, and the birth control movement promoted women's control over their fertility and family planning.

1920s – 1930s: A shift in cultural norms and a new focus on appearance in the media. As women continued to fight for access to birth control, changes in cultural norms and cultural practices impacted women's sexuality, sexual expression, and sexualization. According to D'Emilio and Freedman (1997), the advent of coed high schools, the development of movie theatres, and the availability of cars in the 1920s brought adolescent boys and girls together in unprecedented ways. Although kissing and petting were common during this time, cultural norms dictated that intercourse should only occur within a committed relationship. Sexual boundaries were widening, but they did so within a sexual double standard. This double standard took the shape of gendered expectations regarding the purposes of sex. For instance, women were expected to pursue sex only within the context of emotional intimacy, while men were encouraged to pursue sex for sexual release and conquest. Deviation from these expectations resulted in degrading consequences (D'Emilio & Freedman, 1997). For example, women who "gave themselves up" too easily or had many sex partners were considered sluts, while men who did not actively pursue sexual relationships or had too few partners were considered weak.

As appraisals of women's sexuality changed during the first few decades of the twentieth century, depictions of women's appearance impacted women's body image. The media, a male-dominated industry, played a role in how women were depicted and viewed in advertising. The focus on women's appearance in the media grew exponentially. For instance, the cosmetics

industry grew by more than 800 percent between 1914 and 1925 (D'Emilio & Freedman, 1997). Images of the ideal small-breasted flapper in the early 1900s and the ideal large-breasted, thin body type in the mid 1900s (Simonelli & Heinberg, 2009) influenced a new obsession with dieting and thinness for women (Sentilles & Callahan, 2012). Advertising designed by men to sell women products led to mainstream American culture viewing women's bodies as objects for consumption. This media objectification did more than sell women products, it also sold women the ideal body type and, ultimately, poor body image when they could not achieve this body type.

As the focus on women's appearance increased, the birth control movement forged ahead with policy changes that eased restrictions on access to contraception. The Comstock Act was overturned in 1936, making it possible for physicians to prescribe birth control for any reason they deemed necessary. Additionally, when the Comstock Act was repealed, portrayal of sexuality in the public sphere was no longer prohibited (D'Emilio & Freedman, 1997), making this legislative success a double-edged sword. Women were gaining reproductive rights, but they simultaneously experienced an increase in objectification as sexual images of women began to make their way into public American life.

1940s – 1950s: A time of scientific discoveries and policy changes. In the mid 20th century, science brought sexuality to the forefront of American culture. "The publication of Alfred Kinsey's studies of male and female sexual behavior, in 1948 and 1953 respectively, propelled sex into the public eye in a way unlike any previous book or event had done" (D'Emilio & Freedman, 1997, p. 285). Despite Kinsey's unorthodox research methods, his research contributed much to the understanding of female sexuality (Hite, 2006). Among their many findings, Kinsey, Pomeroy, Martin, and Gebhard (1953) confirmed that most women do

not easily reach orgasm during intercourse, but do so during masturbation. Kinsey encouraged diversity in sexual behavior by suggesting that intercourse to achieve orgasm need not be the main focus of sexual behavior (Hite, 2006). This was a controversial idea at the time because it meant that women's sexual experiences do not always need to be tied to reproduction, but could instead be solely pursued for the purpose of pleasure.

The Supreme Court, in resolving many obscenity cases in the 1950s, "affirmed the appropriateness of sex as a matter for public consumption" (D'Emilio & Freedman, 1997, p. 287). The biggest impact of these decisions was on mainstream media. Suddenly, the standards for movies loosened, and sexually objectifying images of women appeared in books, magazines, newspapers, and films. This resulted in women's increased exposure to a female body type most women cannot achieve. In sum, science and policy in the 1940s and 1950s brought women's sexuality into the cultural limelight in an unprecedented way.

1960s – 1970s: A rise in sexual freedom and feminism. Depictions and discussions of sexuality became part of mainstream American culture in the 1940s and 1950s, and in the 1960s and 70s continued to shift due in part to the hippie culture, second-wave feminism, and the work of prominent scholars. During the late 1960s, politics mixed with culture in a way that made rebellion possible (D'Emilio & Freedman, 1997). Youth protested war and the lack of sexual freedom. The hippie culture rejected the institution of marriage and family and played a pivotal role in moving U.S. culture away from marriage-centered sexual relationships. Second-wave feminism also played a role in changing views of marriage. Betty Friedan (1963), who is credited with triggering the beginning of the second wave, published *The Feminine Mystique* detailing the discontent of White American housewives. The women's movement questioned

marital ideals around women's responsibility to provide eroticism to her partner (D'Emilio & Freedman, 1997).

Meanwhile, Masters and Johnson (1966), the first researchers to observe and study human sexual behavior in a laboratory setting (Hyde & DeLamater, 2000), identified that women's orgasms come primarily from the clitoris, not the vaginal canal. This research provided scientific evidence that women's sexuality had been limited by activities designed for male pleasure (i.e., vaginal intercourse). For the first time, some women publicly acknowledged that intercourse could be a mechanism of their own oppression and that they did not need men for sexual pleasure (D'Emilio & Freedman, 1997).

Additional key events that occurred during this time had bearing on the issues of gender oppression and control over women's bodies: 1) the birth control pill was approved by the Federal Drug Administration in 1960, giving women unprecedented access to hormonal contraception; 2) the Civil Rights Act of 1964 addressed the issue of sex discrimination in the hiring, promotion, and firing of women; 3) the Supreme Court lifted remaining restrictions on contraception use within marriage in 1965, with its important decision in *Griswold v. Connecticut*, 381 U.S. 479 (1965); and 4) The National Organization for Women, an organization devoted to women's equality, was formed in 1966 (D'Emilio & Freedman, 1997). These successes were credited to the feminist movement and led more women to get involved in the movement.

As feminism took hold in the late 1960s and early 1970s, an underlying theme was the lack of ownership women had over their bodies. This lack of ownership was in part a result of the objectification of women in American culture and in their relationships (Freedman, 2007). The rise of feminism and quest for control of their bodies led a group of women known as the

Boston Women's Collective to come together and publish *Our Bodies, Ourselves* in 1970 (Davis, 2007). As the first book by and for women, *Our Bodies, Ourselves* covered topics such as anatomy, pregnancy, and abortion. Its first commercial printing was in 1973, the same year as the landmark Supreme Court decision, *Roe v. Wade*, when the legalization of abortion combined with accessible birth control "…highlighted the degree to which the erotic had been divorced from procreation" (D'Emilio & Freedman, 1997, p. 338). Moreover, many women gained more control over their bodies, the size of their families, and when to have or not to have children.

As women gained reproductive rights, inability to orgasm during intercourse was still pathologized. Kinsey et al. (1953) and Masters and Johnson (1966) made great strides in understanding women's source of orgasm, but women's pleasure was still discussed in the context of activity that often only led to pleasure for men. The pathologizing of women's means of orgasming is evident by the inclusion of women's sexual dysfunction in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) and in more recent editions, effectively viewing the inability to orgasm as solely an individual issue, ignoring the socio-cultural and personal contexts that shape women's sexual experiences (Angel, 2010). Frustrated with this pathologizing view of women's sexuality, Hite (1976) suggested the need to redefine sex to include "whatever seems right to you" (p. 387). Hite also encouraged the adoption of a more objective view by accepting women's bodies the way they are built (Hite, 2006). Unfortunately, many women's bodies were not accepted the way they were built nor were average women's bodies depicted in media images. This period in American history saw a dramatic change in the ideal White woman's body, from the voluptuous Marilyn Monroe in the 1950s to the thin ideal of Twiggy in the 1960s. This was a dramatic shift in the ideal body type

and impacted women's body image as the new ideal was at least equally difficult for women to achieve as the previous one.

In sum, the 1960s and 1970s were times of scientific discovery, policy enactments, and social change that ultimately shaped the way Americans view women's sexuality and bodies. During this time, sexual relationships outside of marriage became more acceptable, scholars further explored the sources of women's sexual pleasure, and the feminist movement achieved great strides in reproductive rights. Still, women continued to be sexually objectified resulting in poor body image, and women's physical constraints to achieving sexual pleasure in ways defined by male standards continued to be pathologized.

1980s – Present: Technology's role in objectification and attacks on reproductive rights. According to D'Emilio and Freedman (1997), the two biggest changes during this time are new technology's impact on mainstream media and the rise of a more conservative political philosophy. Technology has greatly influenced how women's sexuality and bodies are viewed in American culture. Although technology has not changed the ideal female body type, it has made sexual images of women more widespread and accessible. Although some physical aspects of the ideal body type have changed since the 1960s (e.g., ideal breast size is now much larger), a very thin body is idealized to this day (Simonelli & Heinberg, 2009). Current technology brings women's idyllic body type more readily into the mainstream, negatively impacting women's body image (Calogero, Tantleff-Dunn, & Thompson, 2011).

At present, a renewed attack on reproductive rights is impacting legislative and social policies in many states, and the proliferation of recent anti-choice legislation is unprecedented. According to the Guttmacher Institute (n.d.), 92 statutes in 2011 and 42 statutes in 2012 were put in place by states and the District of Columbia that restricted access to abortion services. These

restrictions include requiring unnecessary procedures prior to receiving an abortion such as mandatory waiting periods and the requirement that the woman view the embryo or fetus during an ultrasound. Other restrictions include bans on later term abortions and bans on insurance coverage for abortion-related care. Looking forward, further attempts are expected to reduce access to reproductive health services, including access to birth control and abortion services (Guttmacher Institute, n.d.). It has been argued that legislative measures that block or curtail access to abortion and birth control keep women, particularly the most vulnerable women, in subordinate positions by limiting women's ability to control their bodies, their fertility, and the size and timing of their families (Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009; Weitz, 2010). In sum, recent decades have seen the clock turned back on reproductive rights while technology continues to impact women's body image negatively, with sexualized images of the female body increasingly more available for consumption.

Women's Body Image: A Normative Discontent

The prevalence of body dissatisfaction among women, coined "a normative discontent" (Rodin, 1985), has increased over time (Cash & Henry, 1995; Cash, Winstead, & Janda, 1986; Crowther & Williams, 2011). Rodin (1985) suggests that this may be, in part, because the female ideal body type continues to get thinner over time and women overestimate their own body size. This results in a larger discrepancy between ideal and actual (or perceived) body sizes over time. Advances in technology may also be partly to blame for the changes in body image, as sexualized images are more mainstream than they were even ten years ago (Calogero et al., 2011). Regardless of the reasons, research suggests that women experience higher levels of discontent today than they did when the discrepancy between ideal and actual body size was smaller.

Despite being normative, women do not experience body dissatisfaction equally. Body size (Schwartz & Brownell, 2004), age (Smolak & Mumen, 2011), race/ethnicity (Grabe & Hyde, 2006), and sexual orientation (Morrison, Morrison, & Sager, 2004) all influence how women feel about their bodies. It is important to note that women do not experience any one of these identities in isolation from the others. Furthermore, the majority of body image scales have been tested and validated with young, heterosexual, White women. To do body image research justice, measures used must reflect the diversity of the samples, which may require development of more culturally sensitive instruments and constructs.

Social and Familial Influences on Women's Negative Body Image

In the U.S., the promotion of the ideal body, that is, a tall, thin, young, White woman with large breasts, has created pressure on women to achieve this body type. This image is on display around every corner of American life, whether on a street corner, in a magazine at a doctor's office, or in the newsfeeds of popular social networking websites. Despite the reality that the body ideal is not possible for most women, American women internalize this ideal and use it as the measure by which they judge themselves (Tiggemann, 2011). Body dissatisfaction occurs when a woman is unable to achieve what may be physically impossible for her body and this is distressing for her. Although this idealized woman's body is clearly promoted in sexually objectifying images in U.S. media, family and peers also reinforce it. This section will investigate how the media, family, and peers promote negative body image among women, as proposed by the Tripartite Influence Model (Grabe, Ward, & Hyde, 2008). Although they will be explored separately, media, family, and peers come together in a unique way for each woman to impact her body image.

Media. The media endorses and encourages the ideal body, which can lead to body dissatisfaction. Although the existing literature does not currently establish mass media exposure as a causal variable of body dissatisfaction, it is well established as a risk factor (Levine, 2012; Levine & Chapman, 2011). In a meta-analysis of 77 experimental and correlational studies that measured body dissatisfaction, body self-consciousness/objectification, internalization of the thin ideal, and/or eating behaviors or beliefs as outcome measures, Grabe et al. (2008) found that exposure to media images depicting a thin body type was significantly related to an increase in women's body dissatisfaction. The established relationships between media exposure and body dissatisfaction are particularly concerning because women cannot escape images of an impossible beauty standard that present women's bodies and body parts as objects.

Media exposure to an unrealistic body type also encourages internalization of this ideal. Grabe et al. (2008) found significant relationships between exposure to the thin ideal portrayed in the media and internalization of this ideal. Further, an increase in the effect size between media exposure to the thin body type and internalization of this body type in more recent years (Grabe et al., 2008) suggests that proliferation of new media outlets (e.g., social media) that allow objectifying images of women to be more visible in everyday life may lead to greater internalization today than did the media images of 10 or 20 years ago. This is especially troubling given that internalization of an unrealistic ideal body type and the values surrounding it set women up for failure when they are unable to achieve this goal.

Though relationships between media depictions and body image have been established, the research has limitations. To determine a causal relationship between media exposure and body image constructs, more rigorous studies are needed. The majority of research in this area

has been conducted with White, heterosexual, young samples; thus, inclusion of diverse women in future samples is warranted.

Familial relationships. Although the media propagates sociocultural norms and values around appearance, family and peers adopt and potentially enforce these values and norms in their daily lives. Parents play a role in communicating appearance norms to their daughters. According to a review of 56 studies of the parental impact on children's body image and eating disturbances (Rodgers & Chabrol, 2009), parental criticism, teasing, and support for weight loss with their daughters significantly impacted girls' body image and eating behaviors. Girls' body dissatisfaction is significantly associated with parental teasing related to their appearance and parental encouragement to diet (e.g., Fulkerson, Strauss, Neumark-Sztainer, Story, & Boutelle, 2007). In a study of young (ages 5-8) boys and girls (N = 135) by Lowes and Tiggemann (2003), the girls reported more maternal control over their diet than did their male counterparts in every age group. The authors suggest that when women's value is tied to thinness and beauty, parents try to control their daughters' diets to achieve this ideal on their daughters' behalf. Unfortunately, this type of attention can negatively impact girls' body image.

Parents also influence their daughters' body image by modeling behaviors related to body image. Rodgers and Chabrol (2009) found that parental modeling of body image, eating behaviors, and exercise behaviors influence children. In fact, several studies concluded that girls' body dissatisfaction is significantly related to their mothers' body dissatisfaction and that girls' perceptions of their mothers' diet and exercise behaviors influence their behavior (e.g., Keery, Eisenberg, Boutelle, Neumark-Sztainer, & Story, 2006; Lowes & Tiggemann, 2003). Fewer studies have investigated parental modeling as a protective factor, but these studies suggest that behaviors such as regular family meals may have a positive impact on children's

eating behaviors (Rodgers & Chabrol, 2009). However, the relationship between parental modeling and children's body image may change as children age. In a longitudinal study of middle school boys and girls, Paxton, Eisenberg, and Neumark-Sztainer (2006) did not find a significant relationship between the parental dieting environment and increases in body dissatisfaction. Thus, mother and father influences on body image may be most relevant during early childhood, while peer influences are more salient during the adolescent years.

Peer relationships. Although each friend brings their own families' values and norms about appearance to their friend groups, together these groups create and reinforce an appearance culture (Carlson Jones, 2011). One way that peers model, influence, and reinforce this culture is through conversation. "Fat talk" describes how girls and women belittle their bodies to others. Girls and women use fat talk to express shared values around appearance in peer groups, to bond, and to gain body-related validation (Nichter, 2009). Fat talk and other appearance conversations demonstrate concern about appearance, which is related to body dissatisfaction (Carlson Jones, 2011). It is possible that this relationship is mediated by social comparisons. Carlson Jones (2004) conducted a longitudinal study of adolescent body image (N = 304) and found that when seventh and tenth grade girls engaged in appearance conversations at Time 1, they were more likely to demonstrate higher levels of body dissatisfaction a year later. This relationship was significantly mediated by an increase in social comparison. The author suggests that establishing and reinforcing a peer group appearance culture through appearance conversations results in a heightened reliance on social comparisons, which leads to greater body dissatisfaction.

Another peer influence on body image takes the form of teasing which occurs within small peer groups and in the larger adolescent culture. Appearance and weight are among the most frequent topics about which adolescents tease each other (Carlson Jones, 2011). In a cross-

sectional study of adolescent teasing among a sample of eighth grade students (N = 131), weight teasing was more harmful for adolescents than academic teasing, who responded to the weight teasing with greater negative emotional response and less humor than they did to academic teasing (Carlson Jones, Newman, & Bautista, 2005). The researchers also found that when the gender of the person doing the teasing was the same as the receiver of the teasing and when the teasing occurred between friends (as opposed to acquaintances), the impact of academic teasing was minimized, but these factors did not minimize the impact of weight teasing. Thus, appearance and weight teasing may be more harmful to adolescents than academic teasing.

Adolescent girls' attitudes toward their bodies are also partially determined by concerns of being viewed as attractive to potential dating partners (Carlson Jones, 2011). In a study of tenth grade Australian adolescents (N = 573 girls, 145 boys), Paxton, Norris, Wertheim, Durkin, and Anderson (2005) found that the majority of male participants likened girls' thinness to attractiveness. This is consistent with other research that suggests boys internalize appearance-related sociocultural beliefs by the time they reach adolescence when they begin to look for dating partners based on appearance (Carlson Jones, 2011). In the study by Paxton et al. (2005), girls also reported a strong belief that thinness is attractive to boys. In fact, this variable fully mediated the girls' belief in the importance of being popular with boys and body dissatisfaction. The authors suggest that strong beliefs regarding the importance of thinness to being beautiful and attractive to a potential romantic partner may be associated with the internalization of a thin beauty ideal. This has relevance for body image interventions, as the standards that equate thin and attractive must be altered to improve women's body image.

Responses to Negative Body Image

The previous review of influences on women's negative body image reveals how existing societal structures can negatively impact girls' and women's body image. A review of existing prevention and practice interventions will highlight the strengths and gaps in current responses to women's normative discontent with their bodies.

Prevention interventions. Body dissatisfaction prevention efforts include the use of school-based, computer, and macro-level approaches. According to O'Dea and Yager (2011), school-based prevention strategies have shifted over time. In the 1980s, school presentations were didactic and based on psychological counseling techniques. A 2005 review of 21 existing body image and obesity prevention programs found that early prevention programs result in improvement in knowledge, but no change in behavior (O'Dea, 2005). More recent school-based prevention programs are interactive, partially led by peers, and focus on improving self-esteem, rejecting media images, and changing the school environment (O'Dea & Yager, 2011). Recent school-based prevention programs have produced moderate to high levels of success in improving knowledge, beliefs, attitudes, and/or behaviors (O'Dea, 2005). Thus, changes in school-based approaches since the 1980s have led to more successful prevention interventions.

Approaches that use computer technology to prevent poor body image are also gaining ground. The most widely-researched computer-based intervention for body image is *Student Bodies*. Developed at Stanford University, evaluations of the eight-week *Student Bodies* course showed improvement in participants' overall body image, reductions in their concerns about weight and shape, and adoption of healthier eating attitudes and behaviors (e.g., Taylor et al., 2006). Another computer-based intervention utilizes a two-hour CD ROM titled *Food, Mood, and Attitude*, which reduced body image concerns among high-risk college women at a 10-week

follow up (Franko et al., 2005). Although additional empirical evaluations of computer-based interventions are needed, results from these early studies suggest that computer-based approaches have small, but consistent effects on girls' and women's weight and shape concerns (O'Dea & Yager, 2011).

There is even less known about macro-level approaches to prevention of negative body image, as they are scarcer than school- and computer-based approaches. Activism and ecological approaches seek to change societal norms and structures around women's appearance. For instance, the 2006 anorexia-related deaths of three models spurred activism in the fashion industry and led to policy changes in several countries (e.g., Spain's ban on models with a BMI under 18 in runway shows) (Piran & Mafrici, 2011). Activism and ecological approaches have also proven successful in a school setting. Using a community-partnership research approach to be inclusive of various stakeholders, researchers used cognitive dissonance and media advocacy in collaboration with sorority members (Becker, Jilka, & Polvere, 2002; Becker, Smith, & Ciao, 2005). This interactive cognitive dissonance and advocacy program became an orientation requirement and led to other events around campus and other larger initiatives (e.g., Fat Talk Free Week) (Piran & Mafrici, 2011). More research on activism and ecological approaches to preventing negative body image among women is necessary.

Public policy is an additional strategy for macro-level prevention; however, the use of public policy to prevent body dissatisfaction is in its infancy. Very little legislation about body image exists in the U.S.; what does exist focuses on public policy interventions that increase body size diversity in media images while reducing the number of very thin models and images in the media (Paxton, 2011). In contrast, Spain banned television advertisements before 10:00 p.m. that promote beauty products and treatments to achieve the ideal body. The Australian

government successfully used persuasion to prevent body dissatisfaction through their Voluntary Media Code of Conduct on Body Image, which provides national guidance on body image for media, fashion, advertising, and entertainment industries (Paxton, 2011). Public policy holds promise as a prevention method, but has yet to gain ground in the U.S.

Practice interventions. Intervention responses to negative body image have traditionally taken place in the therapeutic setting. These responses seek to change either a woman's cognitions about her body or her actual body. Whether a cognitive or bodily change is sought through intervention, the goal is to improve women's body image on an individual level. This section will explore research on existing practice interventions.

Cognitive change responses. Cognitive behavioral therapy (CBT) is the most common intervention used to improve body image among individual women. In CBT, "maladaptive thoughts are identified, challenged, and restructured into adaptive ones" (Jarry, 2012, p. 327). Clinicians using CBT may use a technique to gradually expose clients to anxiety-provoking situations either in imagination or in real life. For example, a client struggling with body image might learn to view herself in the mirror without criticism, which may require potentially anxiety-provoking views of her body in a mirror. To examine the impact of CBT on women's body image, Jarry and Ip (2005) conducted a meta-analysis of 19 studies that evaluated CBT treatment for body image that was not embedded in an eating disorder treatment program. They found that various aspects of body image did not improve by the same amount; CBT led to significantly more body satisfaction improvements than body image investment improvements. The meta-analysis also found that therapist-assisted CBT was more effective than self-directed CBT. Further, body image continued to improve over time as a result of CBT (Jarry & Ip, 2005).

As the most common individual-level intervention for poor body image, CBT is well supported by evidence.

Body change responses. Body change, through weight loss or exercise, has been explored as a treatment for poor body image among women. According to Sarwer, Dilks, and Spitzer (2011), weight loss is associated with a significant decrease in body dissatisfaction among women. However, weight loss is often followed by weight regain, resulting in a significant increase in body dissatisfaction. The same is true for massive weight loss from surgical procedures: Physical and psychosocial functioning as well as physical health and body image improve significantly in the first few years after massive weight loss, but patients often regain the weight after a few years and regress. Weight loss surgery can also lead to new sources of body dissatisfaction, as many patients experience dissatisfaction with loose skin post-surgery. Taken together, weight loss appears to lead to improvements in body image among women, but this is often reversed with weight regain.

Women who wish to lose weight often engage in exercise to achieve their goal. Research indicates that exercise is fruitful for improving women's body image, as body satisfaction is significantly increased as a result (Campbell & Hausenblas, 2009; Hausenblas & Fallon, 2006). However, in a study of men and women (N = 44) who completed a 12-week strength training program, Martin Ginis, Eng, Arbour, Hartman, and Phillips (2005) did not find a significant relationship between actual body composition change and body image change among women, but perceptions of body change with regard to size and muscularity were significantly related to body image changes in women. Thus, it is possible that the influence of exercise on women's body image occurs as a result of women's perception of body change.

Chapter Summary

This chapter established the relevance of body image to social work practice with women and explored the historical context of women's body image and sexuality. This historical context demonstrates how women's body image has been impacted by birth control debates and policies, early sexuality research, the feminist movements, and media depictions of the female body. Finally, this chapter established body image as a social problem that warrants attention. Moving forward, a review of the existing theoretical and empirical literature serves to ground this dissertation study and provide the springboard from which new knowledge can develop.

Chapter 2: Theoretical Frameworks and Literature Review

This chapter provides a comprehensive review of the existing theoretical and empirical literature on the relationship between body image and sexual behavior among women. Two theories, both with feminist roots, will be explored. Objectification theory contributes a framework for understanding the impact of sociocultural sexual objectification on women's body image and several negative consequences, including eating disorders, depression, and sexual dysfunction. Relational-cultural theory adds a relational component to understanding women's experiences with shame and isolation and emphasizes the benefits of growth fostering relationships, such as a greater sense of self-worth. Both theories have implications for research on women's body image and sexual behavior and for social work practice.

Objectification Theory

Objectification theory (OT) offers a framework for understanding psychological experiences (including normative body dissatisfaction) that are unique to female-bodied individuals across the lifespan, and which are a result of sexual objectification. As was discussed in chapter one, sexually objectifying images became mainstream in the U.S. after the repeal of the Comstock Act, which led to a culture in which women are sexually objectified in the media and in relationships with family and peers. Fredrickson and Roberts (1997) suggest that although sexual objectification varies in its form, "the common thread running through all forms of sexual objectification is the experience of being treated *as a body* (or collection of parts) valued predominantly for its use to (or consumption by) others" (p. 174). Objectification theory posits that sexual objectification of the female body, a form of gender oppression, leads women to internalize objectification and view themselves as objects. That said, OT is mostly concerned with the most subtle form of sexual objectification, sexually objectifying gazes, which

are present in social and interpersonal encounters and visual media (Fredrickson & Roberts, 1997). Thus, women experience sexual objectification continuously, across varied social settings.

Objectification theory suggests that sociocultural sexual objectification leads to internalized objectification among women, called self-objectification. The authors define this as "the tendency to introject an objectifying third-person perspective on one's own body, evaluating it in terms of its value and attractiveness to others, rather than its value and function for the self" (Fredrickson, Hendler, Nilsen, O'Barr, & Roberts, 2011, p. 690). They suggest this is evident in women's self-monitoring behaviors, such as checking one's appearance in a mirror. Self-objectification is particularly troubling because it sets women up to internalize a body type that is impossible for most women to achieve. Further, external pressure is no longer necessary to objectify women, as we do it to ourselves.

Key concepts. Consequences of self-objectification include shame, anxiety, not achieving peak motivational states, and a lack of awareness of internal bodily states (Fredrickson & Roberts, 1997). Shame and appearance anxiety are the consequences of sexual objectification that most closely relate to body image. Fredrickson and Roberts (1997) conceptualize shame as an emotion women experience when their evaluations of themselves do not allow them to achieve the unattainable internalized cultural body ideal, whereas appearance anxiety is the constant concern about how one looks. This anxiety manifests itself in habitual monitoring of body appearance (e.g., looking in the mirror to check one's appearance). Thus, according to OT, women who self-objectify spend more time feeling shameful and anxious about their bodies than women who do not self-objectify. This is particularly concerning because the time spent feeling shame and anxiety about appearance detracts from time spent on other areas of women's lives,

such as their career, education, and families. Furthermore, shame and anxiety may move women toward depression, sexual dysfunction, and eating disorders at a higher rate than men (Fredrickson & Roberts, 1997).

Depression. Women are twice as likely as men to experience depression, a serious mental illness that impacts a person's ability to function in daily life (Nolen-Hoeksema, 2001). Objectification theory seeks to explain this gender difference by proposing that sexual objectification may be a root cause for the gender difference in depression (Fredrickson & Roberts, 1997). Researchers have found support for this idea with samples of college women. In a cross-sectional study of 98 female introductory psychology students, Miner-Rubino, Twenge, and Fredrickson (2002) found a significant correlation between self-objectification and depression symptoms. Similarly, Muehlenkamp and Saris–Baglama (2002) found that self-objectification significantly predicted depressive symptoms among a sample of 384 undergraduates recruited from an introductory psychology course. In a longitudinal study of adolescents (N = 399), Grabe, Hyde, and Lindberg (2007) found that the relationship between self-objectification measured by self surveillance at Time 1 (end of fifth grade) and depression measured at Time 2 (end of seventh grade) was significantly mediated by body shame at Time 2. Thus, in line with the OT model, the gendered difference in depression appears to be at least partially a result of both self-objectification and body shame. However, much of this research is cross-sectional and was tested in samples of predominantly White college women (Moradi & Huang, 2008) and adolescents. Thus, the results of these studies are not generalizable to all women. Experimental studies on diverse samples of women, found in diverse locations, are necessary to further establish these relationships.

Eating disorders. According to OT, the relationship between self-objectification and eating disorders is mediated by body shame and appearance anxiety (Fredrickson & Roberts, 1997). Experimental research on relationships between self-objectification, body shame, and eating behaviors yields conflicting findings. In an experimental study of 72 predominantly White undergraduate women from Duke University, Fredrickson, Roberts, Noll, Quinn, and Twenge (1998) disguised their study as one of sampling consumer products and randomly assigned students to try on either a sweater or a swimsuit. While wearing the article of clothing they were assigned, participants completed questionnaires about self-objectification and body shame, and were asked to sample a cookie. The researchers found that among participants wearing the swimsuit, self-objectification led to greater body shame, which resulted in higher levels of restrained eating during the cookie taste test. In another experimental study, Calogero (2004) tested similar relationships among a sample of 104 primarily White, female undergraduate psychology students. Participants were asked to complete demographic and self-objectification measures, then were told they would either be interacting with a male or a female stranger, and then they completed measures on body shame and intent to diet. The authors found that heightened self-objectification led to significantly higher levels of body shame among the women who anticipated male gazes than among the women who anticipated female gazes. Further, no relationship was established between body shame and intent to diet. Taken together, these studies suggest self-objectification and eating behaviors and disorders may be mediated by body shame, but additional experimental research studies with diverse samples of women are needed to provide more definitive support for this claim.

Sexual dysfunction. The final consequence of body shame and appearance anxiety identified by OT is sexual dysfunction (i.e., difficulty experienced during sexual activity)

(Fredrickson & Roberts, 1997), though this construct has received much less attention in the literature. Sexual dysfunction is experienced at a greater rate by women than men, to the point that it has been regarded as normative for women. Objectification theory posits that shame and anxiety may help explain these gender differences regarding sexual satisfaction and pleasure. The limited existing research provides some support for this assertion. In a cross-sectional study of 116 undergraduate women in Australia, Steer and Tiggemann (2008) found that self-objectification was related to body shame, appearance anxiety and self-consciousness during sexual activity. Further, self-consciousness during sexual activity mediated the relationships between body shame and appearance anxiety with sexual function. This suggests that self-consciousness during sexual activity may be an important variable on which to focus future research and an area to target interventions. Although this study provides some support for the connection between self-objectification and sexual dysfunction via shame and anxiety as proposed by OT, this area of research is in its early stages.

Sexual behavior. Although OT does not specifically address sexual behavior (e.g., condom use), a few studies have examined the relationships between objectification, self-objectification, and sexual behavior. In a qualitative study of adolescent girls ($N = 6$) from a larger longitudinal study, Hirschman, Impett, and Schooler (2006) found that girls who perceived themselves as more objectified were better at communicating boundaries than sexual desires with sexual partners while less self-objectified girls were able to communicate both boundaries and desires. Further, although both groups of girls described using protection (condoms and birth control), the more self-objectified girls did not practice open communication about the use of protection with their parents or their sexual partners. Another study of 116 ethnically diverse, female high school seniors from a northeast urban school district found that objectification led to

diminished feelings of sexual self-efficacy; inhibiting them from acting on their own desires (e.g., condom use, pleasure) in sexual relationships (Impett, Schooler, & Tolman, 2006). In a dissertation study of adult women (N = 1,594, M age = 23.52), Lustig (2012) found that body surveillance is not significantly related to risky sexual behavior, but interpersonal sexual objectification and risky sexual behavior are significantly related. Although there are few existing studies and all were conducted with samples of women with male partners, this research suggests that self-objectification may impede a woman's ability to be an equal partner and speak up for her needs and wants in her sexual relationships.

Critique of objectification theory. Although OT has received a great deal of attention in the body image literature and provides a theoretical framework that links objectification, body image, and sexual behavior, it has several limitations worth noting. First, while OT has roots in the tripartite model which suggests that peers, parents, and the media are the three most influential sociocultural factors that impact female body image (Cash, 2005), relationships with peers and parents are not explored in the OT model. This is especially concerning given the existing literature that suggests that parents (Rodgers & Chabrol, 2009) and peers (Carlson Jones, 2011) have an influence on girls' and women's body image. Second, objectification theory does not acknowledge causes of poor body image that may not be related to sexual objectification, such as being a victim of sexual abuse or biological or neurological factors that may impact the way a woman thinks about her body.

Objectification theory also does little to acknowledge the diversity of women experiencing sexual objectification. Fredrickson and Roberts (1997) "propose that having a reproductively mature female body may create a shared social experience, a vulnerability to sexual objectification, which in turn may create a shared set of psychological experiences" (p.

175). Although this gives diversity a nod by suggesting that OT applies to all people with a biologically female body, it does not sufficiently address the diverse experiences through which women experience sexual objectification. According to Szymanski, Moffitt, and Carr (2011), "minority women's experiences of sexual objectification and victimization occur against a backdrop of other forms of oppression, which may influence both their risk and response to sexual objectification as well as compound to negatively affect their mental health" (p. 12). Age (Smolak & Mumen, 2011), race/ethnicity (Grabe & Hyde, 2006), body size (Schwartz & Brownell, 2004), and sexual orientation (Morrison et al., 2004), impact a woman's experience with body image, but OT does not account for how a woman's multiple identities come together to influence her body image.

Moradi (2010) developed an amended OT model that addresses these concerns by suggesting that socialization experiences (e.g., sexual objectification, racism) influence how and if women internalize cultural standards of appearance. Buchanan, Fischer, Tokar, and Yoder (2008) also recommended a culture-specific extension to objectification theory to make it more relevant for Black women. The authors found empirical support for their model (N = 117 Black college women), which includes skin-tone specific body surveillance and skin-tone dissatisfaction in addition to body surveillance and body shame. As such, these models (Buchanan et al., 2008; Moradi, 2010) are more socioculturally appropriate and provide frameworks for addressing a call for an expansion of theory and research to better understand the societal context of body image (McKinley, 2002). However, these models have not been widely adopted and empirical research reflects the biases of the original model, since the vast majority of research on OT has been conducted with White college women. Despite many calls for

research with diverse populations (Buchanan et al., 2008; Moradi, 2010; Moradi & Huang, 2008; Szymanski et al., 2011), this has not changed.

Perhaps the most troublesome limitation of OT is its focus on pathology. By only predicting body shame, OT does not provide a framework for understanding positive body image. Reducing body image to shame does not capture the breadth and depth of body image as a construct. Cash (2005) suggests that, "from a 'positive psychology' point of view, one can just as accurately interpret their findings in terms of correlates of body image satisfaction or acceptance. The latter raises important questions of protection rather than risk" (p. 440). Objectification theory is also pathology-driven in that it does not recognize women's strengths. By viewing women as passive receptors of sexual objectification, OT does not leave room for understanding the strengths of women who do not self-objectify. What qualities do these women possess that help them to reject these images and ideals? Theoretical and empirical research on women with positive body image is necessary to inform prevention interventions.

The final limitation of OT is its focus on the individual. Objectification theory raises an important issue of social justice (McKinley, 2002), as women are disproportionately impacted by sexual objectification, poor body image, and other negative consequences of self-objectification. Yet, OT does not provide a framework to challenge these injustices, since OT-informed interventions focus primarily on the woman experiencing the negative consequences of sexual objectification and do little to address the larger cultural milieu that precipitates individual-level pathology. In order to effectively reduce sexual objectification and its consequences, a theoretical framework is needed that addresses both micro- and macro-level changes.

Relational-Cultural Theory

In her groundbreaking book, *Toward a New Psychology of Women*, Dr. Jean Baker Miller (1976) described how Western culture views the desire to connect with others as a weakness that works to keep women subordinate to men. She suggests that the desire to connect is, in fact, a strength because human growth and development occur through and toward connections with others. Still, in a culture where women are members of the subordinate group, men and women are socialized to believe that women are the weaker sex and their openly expressed desire for relationships with others is a weakness that sets them apart from men. The dominant group uses several tactics, including objectification, to maintain women's subordinate status. According to Miller (1976), "objectification adds a deep and thoroughgoing reason for women's readiness to accept the evil assigned to them" (p. 58). To fully realize their strength and potential, women must cultivate their strengths, one of which is the desire for connection, and not accept the subordinate status assigned to them.

The first core tenet of relational-cultural theory (RCT) asserts that all individuals develop through and toward growth-fostering relationships over the lifespan, and that this process requires mutuality (Comstock et al., 2008). When one achieves such growth-fostering connections, everyone in the relationship experiences five outcomes: 1) a greater sense of zest, 2) a greater ability to act in the world, 3) a more accurate picture of her/himself and the other person(s), 4) a greater sense of worth, and 5) a greater connection to the other person(s) and greater motivation to connect with others (Comstock et al., 2008). To achieve a strong connection, the relationship must be mutual. This occurs when two people are open to influence from the other and are receptive and responsive while each person simultaneously maintains a sense of self. Mutuality requires openness to many ideas and possibilities and when it is

achieved, women have found a growth-fostering relationship and can experience the five outcomes listed above (Comstock & Dongxiao, 2005).

Mutuality also requires authenticity and honesty in relationships, which can be difficult to achieve. By taking context and sociocultural challenges into account, RCT acknowledges the myriad of barriers to authenticity, mutuality, and ultimately, growth-fostering relationships including cultural oppression, objectification, and other forms of marginalization (Comstock & Dongxiao, 2005; Jordan, 2008). Jordan (2008) suggests that "marginalization poses a major threat to our sense of connection, to our authenticity, often to our physical well-being" (p. 191). Society reinforces the objectification of marginalized individuals and groups and ultimately those at the margin may end up believing that they are the problem, rather than the society that has marginalized them. For instance, women who are unable to achieve the thin body ideal blame themselves for this shortcoming rather than the society that promotes an impossible standard. This can result in disconnection in relationships and disconnection from self (poor body image) and eventually can lead to shame and isolation.

Intermittent disconnection in relationships is expected and normal; it is only when disconnection is not moved back into connection that it is problematic and can have implications for women's sexuality. When disconnections are not moved back into enhanced connections, the disconnection is considered chronic. According to Comstock et al. (2008), chronic disconnection in relationships can be associated with feelings of shame and humiliation. Hartling, Rosen, Walker, and Jordan (2004) provide a model for understanding how women respond to shame. Typical behaviors include: 1) moving away; 2) moving toward; or 3) moving against. When a woman moves away, she separates herself from the relationship. Moving toward is characterized by attempting to "appease or please the other to secure the relationship or

just to survive the relationship" (p. 109). Finally, moving against results in directing feelings of anger and resentment toward the person(s) she thinks is responsible for her shame and humiliation. The way a woman responds to shame may have implications for her sexual relationships. For example, if she responds by moving toward relationship, she may engage in risky or unwanted sexual behavior in order to please her partner.

The experience of shame has a tremendous impact on relationships with others and relationship with self. According to Jordan (2008), shame is used as a means to isolate and silence marginalized individuals and groups. For example, media images of women set an impossible standard for women's bodies, leading them to be disconnected from their own bodies and feel shame when they cannot achieve the ideal body type. This shame often serves to keep women who do not meet these standards at the margins and can lead to isolation. According to RCT, "…isolation, shame, humiliation, oppression, marginalization, and microaggressions are relational violations and traumas that are at the core of human suffering" (Comstock et al., 2008, p. 280).

Unfortunately, people often respond to isolation by using strategies that lead to more disconnections. Relational-cultural theorists refer to this as the "central relational paradox" (Comstock et al., 2008). Strategies may include withholding love, criticizing others, and additional self-destructive tactics like substance use, eating disorders, and risky sexual behavior. In sum, when women are objectified and marginalized, the resulting feelings of shame and isolation can negatively impact a woman's physical, mental, and sexual health.

Scholars have established relationships between mutuality in relationships and body image. Disconnection from one's own body can result from objectification (Nakash, Williams, & Jordan, 2004), which is similar to the self-objectification concept in OT. Connection with

oneself is essential for connection with others and requires being in sync with one's body, thoughts, feelings, and needs (Nakash et al., 2004; Sanftner, Ryan, & Pierce, 2009). The connection-disconnection cycle occurs with oneself just as it does with others, but chronic disconnection from oneself can result in poor body image. In a study of 450 undergraduate women from a small liberal arts college in the northeast, researchers found that higher levels of relationship mutuality resulted in improved body image (Nakash et al., 2004). Researchers have also found the inverse to be true; poor relational health is associated with poor body image (Cash, Thériault, & Annis, 2004; Sanftner et al., 2009). In a study of 228 college students, Cash et al. (2004) found that worse body image scores were significantly related to more anxious attachment in romantic relationships. In another study of college students (N = 180), Sanftner et al. (2009) found that low mutuality in romantic relationships significantly predicted greater body dissatisfaction among women. Further exploration of relational health and body image could highlight important areas for possible interventions.

Critique of relational-cultural theory. Relational-cultural theory addresses some of the weaknesses of OT. One of the strengths of RCT is that it theoretically explains both positive and negative relationships and consequences, as opposed to the sole pathology focus of OT. However, empirical research on RCT and body image has only acknowledged how disconnections with oneself can lead to poor body image. In keeping with its balanced focus on positive relationships, RCT must be developed so that connections with oneself in terms of positive body image are made explicit. This will open the doors to understanding both positive and negative body image for women in the context of relational development. Another strength of RCT is that it provides a framework for understanding how mutuality (or lack thereof) in familial and peer relationships may impact body image, something that OT fails to do.

Relational-cultural theory also has several limitations. Although the authors specifically recognize the limitations of their perspectives as coming from the lens of White, heterosexual women, their attempts to represent diverse women's experiences in the conceptualization of RCT are insufficient (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Relational-cultural theorists suggest that oppression and marginalization impact connection, but stop short of fully exploring this dynamic. One is left wondering how race, ethnicity, class, body size, and sexual orientation impact women's relational development. Though Tatum (1997) started this conversation with regard to the impact of racism on middle-class Black women's relational development, there is much work to do to understand how women's multiple identities impact their connections with themselves and others. Oppression and marginalization experienced by women with various minority identities will make relational disconnection, shame, and isolation more difficult to overcome within existing power structures. In other words, relational development, just like body image, is linked to women's many identities (Tatum, 1997). Unfortunately, RCT does not reflect the diversity of women in the United States.

Finally, RCT sets the sociocultural context in which women develop, but does not prescribe how women move toward growth-fostering relationships and communities within the existing power structures. How will the power shift described by Miller and Richards (2000), necessary for achieving mutuality in our social institutions, be achieved? Is it solely or primarily up to women to make this change happen? The theory, as written, does not explicitly answer these questions.

Empirical Literature: Body Image and Identity

The following sections of this literature review explore women's body image with regard to different aspects of their identity. Though several descriptive characteristics of women will be

explored separately, it is the dynamic influence of these features that work together to influence women's body image.

Body size. Actual body size and body dissatisfaction, an evaluative component of body image, are often positively correlated (Schwartz & Brownell, 2004), but actual body size does not always predict body image for women. After reviewing the literature, Schwartz and Brownell (2004) concluded that while it appears that as body size increases, so does body dissatisfaction for women in general, this is not the case for subgroups of women (e.g., women with Binge Eating Disorder; women currently gaining weight). Furthermore, perceived body size may be as important as actual body size. In a study of public school adolescents in urban Minnesota (N = 4,746), Neumark-Sztainer, Story, Hannan, Perry, and Irving (2002) found that 64 percent of average-weight girls perceived themselves as overweight and were dissatisfied with their bodies. Thus, although body size is often associated with body image, the deterministic view that an increase in body size leads to greater body dissatisfaction does not account for the complex reality of women's body image.

Age. Messages around appearance begin in infancy and persist throughout childhood, adolescence, and adulthood (Smolak & Mumen, 2011). By the age of 15 months, infants have an awareness of their appearance (Smolak, 2012). By age six, girls are developing appearance standards; girls at this age know it is socially better to be thin than fat. Body image among girls continues to change during their time in elementary school. According to Smolak (2002), children in elementary school report high levels of body satisfaction, but near the end of elementary school, half of girls express body dissatisfaction around issues of weight and shape. This trend carries on into adolescence with body satisfaction continuing its decline from ages 12-15, coinciding with puberty, when body shape changes and girls gain an average of 50 pounds

(Levine & Smolak, 2002). After age 15, the rise in body dissatisfaction plateaus and remains high for most adolescent girls. In a large scale body image survey (N = 30,000), Cash, Winstead, and Janda (1985) found that concern about appearance and body dissatisfaction peaks in adolescent and young adult years and declines thereafter.

The discrepancy between the ideal body size and shape increases over the lifecourse as women's bodies change shape and size with age, leading researchers to expect body dissatisfaction to increase as women age. Recent research on body image among adult women explores this assertion (Runfola et al., 2013; Tiggemann, 2004). Child bearing is often the cause of significant changes in women's bodies and likely influences body dissatisfaction during reproductive years, with most studies suggesting that young pregnant women are most dissatisfied after giving birth, compared to before and during pregnancy (Grogan, 2012; Tiggemann, 2004). However, despite the fact that women move farther away from the ideal body as they bear children and age, their body dissatisfaction remains stable instead of increasing (Grogan, 2012; Liechty, 2012; Tiggemann, 2004). This is likely a result of concern with appearance becoming secondary to increasing concerns with physical health and functioning with age (Knight, 2012; Liechty, 2012).

However, body image in adult women is not very well understood since most of the existing body image research utilizes samples of college women. In a recent review of body image literature across the female life span, Kilpela, Becker, Wesley, and Stewart (2015) concluded that research on body images' correlates and outcomes is insufficient among adult women. The authors call for more research on the relationship between body image and depression among adult women. Further, they suggest longitudinal studies are needed to sufficiently "disentangle the effects of aging on body image from cohort effects" (p. 15). In sum,

concerns with body appearance start in very young girls, and body dissatisfaction peaks during adolescence and young adulthood when girls and women most often experience their first sexual relationships. From there, body image appears to remain stable through adulthood despite physical changes, though much more research is warranted to better understand body image in older adult women.

Research on body image by age has several significant limitations. First, most of the existing research on body image across the lifespan relies on scales that measure the body satisfaction-dissatisfaction continuum, which fail to address the complexity of body image. Further, this body of research has largely been conducted by only a few researchers. Lastly, most of this research has been conducted on White girls and women. Thus, more complex measures of body image need to be studied among more diverse samples of girls and women.

Race/Ethnicity.

Black women. Body image can vary based on race and/or ethnicity, though research findings are conflicting. Despite the fact that Black women are, on average, larger than White women, several studies on body image have found that Black women are generally more satisfied with their bodies than White women (Celio, Zabinski, & Wilfley, 2002; Franko & Roehrig, 2011; McClure, 2012). However, a meta-analysis of 98 articles that included studies of body image evaluation (satisfaction-dissatisfaction) on at least two racial groups of women with samples greater than 100 U.S. women found that although Black women were significantly more satisfied with their bodies than White women, the effect size was very small (Grabe & Hyde, 2006).

The differences in body image between Black and White women may be attributable to differing beauty standards and a connection to an ethnic group that is more accepting of body

size diversity than White women. Black women's beauty standards, when compared to White women, put less focus on body size standards, have greater acceptance of larger bodies, and include other non-body-size factors (e.g., clothing, hairstyle, skin tone) (Celio et al., 2002; Franko & Roehrig, 2011). In a recent study of Black women's body appreciation (N = 228 undergraduate Black women, M age = 19.89), Cotter, Kelly, Mitchell, and Mazzeo (2013) found that women in their study had higher body appreciation than White women in previously reported studies with the same measure of body appreciation. Further, the researchers found that women with higher ethnic identity were less likely to have internalized the Western body ideal and had higher levels of body appreciation. However, with the exception of the aforementioned study (Cotter et al., 2013), body image research often uses measures that better relate to White beauty standards than to Black standards. Taken together, it appears that positive body image among Black women may depend on the level their ethnic identity and be related to different standards of beauty.

Hispanic women. Research on body image among Hispanic women is limited, conflicting, and must be interpreted with caution due to sampling and measurement limitations. A recent meta-analysis using 98 body evaluation articles found no effect size for the difference in body dissatisfaction between Hispanic women and White women (Grabe & Hyde, 2006). Altabe and O'Garo (2002) suggest that Hispanic women who are more acculturated to U.S. culture may internalize the White thin body ideal more than those who are less acculturated, resulting in similar levels of body dissatisfaction as White women. However, this premise has not been entirely supported by empirical evidence, with some researchers finding strong positive relationships between acculturation and body dissatisfaction and others not substantiating these relationships (Schooler, Lowry, & Biesen, 2012). It is possible that existing empirical evidence

is conflicting due to the collapsing of Hispanics and Latinos into one group, ignoring the diversity within each subpopulation (Schooler et al., 2012). Similar to body image studies among Black women, most studies that investigate body image among Hispanic women utilize measures that have been tested and validated on White samples. Given that Hispanic women may prefer a different body size and shape than White women, these measures may not be appropriate (Schooler et al., 2012). Body image research among Hispanic women is in its infancy, leaving readers unable to draw definitive conclusions.

Asian American women. Very little is known about body image among Asian American women. Although existing research on Asian American women's body image is conflicting, Grabe and Hyde's meta-analysis (2006) found that Asian American women's body dissatisfaction did not differ significantly from White, Black, or Hispanic women. Similar to Hispanic and Latina women, Asian American women are a very diverse group. According to Kawamura (2012), Asian American women are quite heterogeneous, belonging to one of at least 24 different ethnic groups in the U.S. Additionally, body appearance concerns are different for Asian American women than White women. For example, facial features such as the double eyelid, skin color (preference for light skin), and height are particularly important for some Asian American women (Kawamura, 2012). Unfortunately, body image studies have not used measures of body image that reflect Asian American women's unique appearance concerns. A lack of understanding of Asian American women's body image is a large gap in this field of study.

In sum, the findings from body image studies on racially and ethnically diverse women are incomplete and difficult to interpret outside of Grabe and Hyde's meta-analysis (2006). The difficulty in interpreting the findings of existing literature may be in part a result of measurement

issues. Measures of body image among diverse populations should reflect the diverse body appearance concerns and priorities of these populations. Additionally, results of the aforementioned meta-analysis on body image and race "directly challenge the belief that there are large differences in levels of body dissatisfaction between White and non-White women" (Grabe & Hyde, 2006, p. 633). Thus, "perhaps the most relevant conclusion regarding race-associated body image is that, alone, the fact of it does not tell us very much" (McClure, 2012, p. 91). Therefore, race and ethnicity should be included in body image research, but at this juncture they are theoretically underdeveloped in terms of advancing the understanding of diverse women's body image concerns and experiences.

Sexual orientation. In addition to body size, age, and race/ethnicity, sexual orientation has been linked to differences in body image experiences among women, but this research is conflicting. The results of studies on lesbian body image, in particular, are inconsistent. Two studies of lesbian and heterosexual women (*N*s = 2,512 and 54,865) found that, despite the lesbian participants having a significantly higher BMI than their heterosexual counterparts, body satisfaction was not significantly different (Peplau et al., 2009). Peplau et al. (2009) also found that lesbian women in their study were less concerned about being overweight than their heterosexual counterparts. Morrison et al. (2004) conducted a meta-analysis on 32 studies that measured body satisfaction/ dissatisfaction and compared heterosexual women and lesbian women or heterosexual men and gay men. They found that body satisfaction did not differ significantly between lesbian and heterosexual women (Morrison et al., 2004). The conflicting nature of lesbian body image research may be due in part to methodological concerns (Rothblum, 2002). Although many researchers argue that lesbian women are more accepting of body diversity than heterosexual women (Rothblum, 2002), this does not take diversity within

lesbian communities into account (Morrison & McCutcheon, 2012). For example, butch, femme, and androgynous subgroups within the lesbian community may have their own body ideals. Lesbian women receive body image messages from the dominant heterosexual culture, as well as from the lesbian culture they are members of, requiring them to navigate both cultures (Morrison & McCutcheon, 2012).

Although the lesbian identity is one of many on the queer spectrum, there is a dearth of research on any other non-heterosexual identity. In the one known qualitative study of bisexual and lesbian women's experiences with body image, the bisexual participants described different degrees of pressure to conform to the mainstream heterosexual body ideal depending on the gender of their dating partner (Leavy & Hastings, 2010). However, this study included only two bisexual participants. The lack of literature on body image among bisexual women represents a large gap in body image research.

Empirical Literature: Body Image and Sexual Behavior

A thorough review of empirical literature on body image and sexual behavior in women reveals established relationships between body image and the likelihood of being sexually active, frequency of sexual activity, coital onset, sexual avoidance, risky sexual behavior, and protective sexual behavior. Research findings suggest that body image's relationship to women's sexuality varies depending on the type of sexuality outcome being measured. This section will review and critique this empirical literature.

Sexually active status. Body image is related to the likelihood of a woman being sexually active. In a cross-sectional study of a racially-diverse sample (39% European American, 32% African American, 29% Latino American) of college students in their first year of college (N = 434), Gillen, Lefkowitz, and Shearer (2006) found that students who had ever

engaged in penetrative sex (vaginal or anal) were more likely to have more positive views of their appearance and less body dissatisfaction than their counterparts that had never engaged in penetrative sex. Although the authors used a validated measure of multidimensional body image, they were unable to determine causation due to methodological limitations. Similarly, Merianos, King, and Vidourek (2013) found that students with high body satisfaction were 1.84 times more likely to have ever had sex than those with low body image in a study of 465 college students (64.9% female, *M* age = 21.62). These authors used a single-dimension measure of body image and a cross-sectional study design. In sum, this area of research is in its infancy and despite the limitations of the study designs and samples, existing studies suggest that body image plays a role in the likelihood of engaging in sexual activity.

Frequency of sexual activity. In addition to being related to the likelihood of being sexually active, body image may be related to frequency of sexual behavior. In a cross-sectional study of women's body image and sexual practices among a sample of mostly White women recruited via advertising in *Shape* magazine (*N* = 3,627, *M* age = 28.5, 81.1% White), Ackard and colleagues found that women with higher levels of body satisfaction had sex more often than women with lower body satisfaction (Ackard, Kearney-Cooke, & Peterson, 2000). Unfortunately, the convenience sample and lack of information about measures are significant limitations to this research. Similarly, with a sample of 319 Dutch female university students (*M* age = 22.05), van den Brink, Smeets, Hessen, Talens, and Woertman (2013) found that lower body image self-consciousness was significantly associated with higher frequency of sexual activity. However, this study has significant limitations, namely that the study relied on a convenience sample of Dutch women and it is not representative of women in the United States where body image and sexual activity are viewed differently. Koch, Mansfield, Thurau, and

Carey (2005) conducted a cross-sectional study using 1993 data from the longitudinal TREMIN Research Study on Women's Health. Primarily White, college educated women (*n* = 307, *M* age = 50, 99.2% White) were recruited in the 1930s from the University of Michigan to explore mid-life body image and sexual experience. Using unvalidated measures the authors found that body image significantly predicted frequency of sexual activity, with better body image associated with an increase in sexual activity. These authors did not define sexual activity or provide information on the sexual orientation of participants.

The role of attitudes. Attitudes toward sexuality may have a role in the relationship between body image and the frequency of sexual activity. Faith and Schare (1993) conducted a cross-sectional study with a convenience sample of undergraduate and graduate psychology students (*N* = 248) to test the impact of body image on sexual behavior. They discovered that women with negative body image, measured by the Body Image Scale of the Derogatis Sexual Functioning Inventory (DSFI), had less sexual experience based on a cumulative score of 24 different sexual behaviors outlined in the Sexual Experience Scale of the DSFI. Furthermore, body image significantly predicted sexual frequency, with better body image resulting in more frequent sexual experiences. However, body image accounted for only four percent of the variance in the frequency of sexual experiences. These authors found that having more liberal and accepting sexual attitudes were better predictors of the frequency of sexual activity, accounting for 10 percent of the variance (Faith & Schare, 1993).

In a recently published study, Lemer, Salafia, and Benson (2013) further explored the relationships between sexual attitudes, body image, and frequency of sexual activity (including anal, oral, and vaginal intercourse) by testing for a mediation relationship using a sample of primarily White college women (*N* = 401, *M* age = 20.66, 95% White) recruited through in-class

advertisements and email. Using the Body Image Scale of the DFSI, they found that body satisfaction significantly mediated the relationship between sexual attitudes and frequency of sexual activity, "more liberal sexual attitudes were associated with higher body image satisfaction, which, in turn, was associated with increased sexual activity" (Lemer et al., 2013, p. 110). Although these two studies use the same measure of body image, they are difficult to compare, given that they used different measures of sexual experience and activity. Despite the various measures, cross-sectional study designs, and convenience samples, these findings suggest that significant relationships exist between body image and the frequency of sexual activity, at least among White, college enrolled women. Further, it appears that sexuality-related attitudes may influence these relationships.

Age at first intercourse. Understanding the relationship between body image and coital onset is a critical area of body image research in women, and existing research provides conflicting information. Early coital onset, the time at which a person first engages in sexual intercourse, can be a risk factor for unintended pregnancy and sexually transmitted infections (STIs), both of which can have serious consequences for adolescent and adult women. Several studies substantiate relationships between body image and coital onset among adolescent girls. Using an early version of the validated Body Areas Satisfaction Scale, a study of Norwegian adolescents (n = 2,535 girls; 2,525 boys), Lundin Kvalem, vos Soest, Traeen, and Singsaas (2011) found that the group of 14-17-year-old girls without intercourse experience were more satisfied with their bodies than their counterparts with coital experience. In another study of Norwegian adolescents (N = 7,187 10^{th} graders, 50.6% female), Valle, Røysamb, Sundby, and Klepp (2008) found that higher body dissatisfaction was significantly associated with early age at first intercourse. Both studies of Norwegian adolescents (Lundin Kvalem et al., 2011; Valle et

al., 2008) utilized single-dimension measures of body satisfaction and cross-sectional study designs.

Akers et al. (2009) found contradictory results in a cross-sectional study exploring the relationship between weight perception and sexual behavior. Among a nationally representative sample of 7,193 racially-diverse high school girls (62% White) using the 2005 Youth Risk Behavior Surveillance Survey, girls who perceived themselves as overweight were less likely to have ever had vaginal sex than girls who perceived themselves as normal weight. However, they did not explicitly evaluate body image, only weight perception. In a longitudinal study (N = 104, 56% White, 34% Latina, 6% Black) that assessed students in the eighth and tenth grades, Pearson, Kholodkov, Henson, and Impett (2012) found that among some girls, high body dissatisfaction was significantly related to being less likely to engage in intercourse by the tenth grade. Although this study did account for temporal precedence, the authors used a single-dimension measure of body satisfaction and conducted recursive partitioning, which is an exploratory analytic technique; thus, the findings should be interpreted with caution until they are repeated in future studies.

The other known study of similar relationships was a cross-sectional study conducted among German adolescent boys and girls (N = 687) which found that girls with higher body satisfaction, measured by the validated Attractiveness Scale of the Body Image Questionnaire, had sex for the first time at an earlier age than those girls with lower body satisfaction (Pinquart, 2010). However, sex was not defined as vaginal, anal, oral, or some combination of these, leaving each study participant to interpret the definition of sex differently. Thus, the results of the Lundin Kvalem et al. (2011) and Valle et al. (2008) studies suggest that body satisfaction may be a protective factor in early coital onset, but the opposite appears to be true in the Akers et

al. (2009), Pearson et al. (2012), and Pinquart (2010) studies. However, these findings should be interpreted with caution since the studies were conducted in different cultural milieus (Norwegian, German, and American), limiting their generalizability since body image and sexual cultural standards are likely to differ by culture. A better understanding of these relationships could lead to interventions that delay early coital onset, a beneficial outcome for young adolescents.

Sexual avoidance. It is possible that women who avoid sexual activity within an established relationship do so, in part, because of issues related to their body image. In a study assessing body image among Canadian university students (N = 411; M age = 19.41), researchers used validated measures of multidimensional body image and sexually avoidant behavior. They found that women and men with poor body image were significantly more likely to avoid sexual behaviors, while women and men with better body image were significantly less likely to avoid sexual contact (La Rocque & Cioe, 2011).

Three other studies that used two different measures of body image found results that are similar to the La Rocque and Cioe (2011) study. Schooler, Ward, Merriwether, and Caruthers (2005) conducted a study of 199 mostly White, heterosexual, female psychology students and found that women who experienced general body dissatisfaction were more likely to avoid sexual activity, including oral and vaginal intercourse. These authors used validated measures and structural equation modeling to test these relationships. In another study, researchers found that among sample of primarily White, collegiate women recruited from an introductory psychology course (N = 192; M age = 18.91, 89.6% White), those who perceived themselves as physically attractive were less likely to avoid heterosexual oral and vaginal intercourse than those with lower perceptions of attractiveness (Wiederman & Hurst, 1998). Although this study

used validated measures, like many before it, it relied on a convenience sample. Reissing, Laliberté, and Davis (2005) found that higher body dissatisfaction was related to higher levels of sexual aversion among their sample of 18-29-year-old Canadian women, though the authors did not use a multi-dimensional measure of body image and had a small sample size (N = 84). There is a dearth of research on body image and sexual avoidance and each study measures body image and sexual avoidance differently, making it difficult to compare results. Despite these and other limitations, it appears that White college women with negative body image may avoid sexual activity while White college women with positive body image may not.

Sexual behavior that may confer physiological risk. The relationships between body image and several risky sexual behaviors, including unprotected sex with a partner whose STI status is unknown, lack of contraception use, and higher number of sexual partners, have been explored in several studies. In a rare study of a minority population, Wingood, DiClemente, Harrington, and Davies (2002) found that among 462 sexually active, African-American adolescents seeking reproductive healthcare, girls with higher levels of body dissatisfaction were more likely to report unprotected sexual intercourse, never using condoms in the previous 30 days, and fearing the results of negotiating condom use than were girls with positive bodily regard. Unfortunately, the authors failed to explicate what results participants feared about condom negotiation. This study utilized a cross-sectional design and a single-dimension measure of body image. Despite these limitations, this study suggests that future research on relationships between body image and risky sexual behaviors with samples of African-American adolescents is warranted.

Using an unvalidated measure of weight perception, Akers et al. (2009) explored the relationships between weight perception and sexual behaviors. They found that among a sample

of 7,193 racially-diverse adolescent girls (62% White), those who perceived themselves as overweight were less likely to report condom use at last sex than girls who perceived themselves as normal weight. Another study found that among a sample of 199 undergraduate women recruited from a psychology course, those with more body shame had lower levels of sexual assertiveness and less belief that they could successfully utilize condoms, though this study did not measure actual condom use (Schooler et al., 2005). Although these researchers utilized a validated measure of body image, the measure only captured body image evaluation. Similarly, Littleton, Radecki Breitkopf, and Berenson (2005) found a significant positive relationship between appearance shame and inconsistent condom use and more sexual partners in the previous year among 1,547 racially-diverse women (*M* age = 25, 37% Caucasian, 34% Hispanic, 29% African-American) recruited from university family planning clinics.

Conversely, several studies produced null findings in this area. Wiederman and Hurst (1998) found no significant relationship between body dissatisfaction and the number of sexual partners among a sample of 192 undergraduate women. Using bivariate analyses, Simonelli and Heinberg (2009) also found no significant differences by body image in the number of lifetime intercourse partners or recent number of intercourse partners among a sample 465 college students (64.9% women, *M* age = 21.62). In a cross-sectional study of university students (*N* = 465, 64.9% female), researchers found that condom use at last sexual encounter and frequency of condom use did not differ significantly by a single-dimension, dichotomous measure of body satisfaction (Merianos et al., 2013). Although these three studies reveal conflicting results on the relationship between body image and sexual behavior, they utilized different samples and different validated measures, making it difficult to compare the results across studies.

The only known study to assess the relationship between body image and contraceptive use found that among a sample of adolescent boys and girls (N = 687), girls with lower body satisfaction were less likely to have used contraceptives (Pinquart, 2010). Although these studies are limited by cross-sectional designs, convenience samples of mostly White, college women, and inconsistent and sometimes inadequate measures of body image and sexual behavior, it appears that lower body image may be a risk factor for certain risky sexual behaviors among some populations of women.

Sexually transmitted infection diagnosis. The relationship between body image and STI diagnosis, explored in one known study, is important because an understanding of this relationship will provide a clearer picture of the possible benefits of interventions that seek to improve women's body image. Using waves 1 (1995, ages 12-19) and 3 (2001, ages 18-26) from the National Longitudinal Study of Adolescent Health, Merten and Williams (2014) conducted stratified sampling for a total sample size of 20,745. The researchers found that from adolescence to young adulthood, women who reported a decrease in their weight contentment were 1.31 times more likely to have an STI diagnosis than women with consistently high weight contentment. This study's design addresses the issue of temporal precedence, but measures weight contentment, not body image. Additionally, participants' responses were self-reported; thus, it is possible that some women who reported no STI diagnosis may have an undiagnosed STI. Although it has limitations, the results of this study point to the need for additional research on body image and STI diagnosis.

Protective sexual behaviors. Several researchers investigated relationships between positive body image and protective sexual behaviors (e.g., using barrier methods in sexual intercourse with partners whose STI status is unknown). Using a validated measure of

multidimensional body image in a study of racially-diverse college students in their first year of school (*N* = 434), Gillen et al. (2006) found that women with better body image had less vaginal intercourse without a condom in their lifetime than women with negative evaluations of their bodies. Similarly, Auslander, Baker, and Short (2012) found that among a sample of heterosexual college women recruited through psychology courses (*N* = 149, *M* age = 21.6, 53% White), greater body esteem was significantly related to being able to insist that partners use condoms when they refuse to do so.

Schooler et al. (2005) also used a validated measure of body image and identified a relationship between body image and condom use self-efficacy, confidence in one's ability to use condoms in difficult situations, among undergraduate women (*N* = 199, *M* age = 19.7) who received extra credit in a psychology course for participating in the study. Specifically, more body comfort was significantly associated with more condom use self-efficacy. Inversely, among a racially-diverse sample of 595 college women (*M* age = 19) Parent and Moradi (2014) found that higher body shame was significantly related to lower condom use self-efficacy and that body shame significantly mediated the relationships between internalization of cultural beauty standards, body surveillance, and condom use self-efficacy. In a meta-analysis of nine studies that explored relationships between body dissatisfaction and condom use self-efficacy, Blashill and Safren (2015) found a medium effect size (Cohen's *d* = -0.52) for women, suggesting that higher body dissatisfaction is related to lower condom use self-efficacy.

One known study explored relationships between body image and HIV testing and communication about HIV testing. Gillen and Markey (2014) found that college students (*N* = 277, 53% women, 43% White, 33% Asian American/Asian, 16% Black, *M* age = 19.27) with better body image were more likely to have ever asked about a partner's HIV status and more

likely to have ever asked a partner to get tested for HIV. Body image was not related to ever having had an HIV test, however. This study did not use a multi-dimensional measure of body image and utilized a cross-sectional study design. In a study of a community sample of African American women (N = 262, M age = 38.98), researchers found that higher body esteem was significantly related to being more likely to ask partners about their previous sexual experiences, but was not significantly related to condom use (Brown, Webb-Bradley, Cobb, Spaw, & Aldridge, 2014). This study used a single-dimension measure of body esteem, a cross-sectional study design, and a convenience sample.

The relationship between positive body image and number of sex partners has been explored in two known studies. Walsh (1993) found that among a sample of students recruited from undergraduate courses (N = 480), the more positively women evaluated their appearance, the fewer intercourse partners they reported. However, this study did not use a validated measure of body image. In another study of undergraduate students (N = 465), Merianos et al. (2013) found that the number of lifetime intercourse partners did not differ significantly by body dissatisfaction. Cumulatively, this research suggests that positive body image may lead women to engage in certain protective sexual behaviors, but further research with more rigorous study designs, diverse samples, and multidimensional measures of body image are needed.

Possible moderating variables. It is possible that additional variables, including early sexual experience and sexual relationship status, may moderate relationships between positive body image and condom use. Schooler (2013) demonstrated that the relationship between body image and condom use may depend on the age of coital onset. Among a sample of 182 racially-diverse, adolescent girls, early sexual experience moderated body satisfaction and later condom use; body satisfaction was positively related to later condom use among girls who initiated sex

later (Schooler, 2013). In another cross-sectional study of a non-collegiate sample of women recruited online (n = 285, M age = 30.51), researchers found that sexual relationship status moderated the relationship between body appreciation and current male condom use with higher body appreciation positively related to current condom use among women who had more than one current sexual partner (Ramseyer Winter & Satinsky, 2014). However, the Schooler (2013) study utilized a racially-diverse sample of adolescents and the Ramseyer Winter and Satinsky (2014) utilized a sample diverse in body size and sexual orientation, making the results difficult to compare. Further, the two studies used different validated measures of body image. Thus, these studies suggest that additional variables may contribute to the relationships between body image and condom use, but further research is needed to begin to explicate these moderating relationships.

Critique and Gaps in Empirical Literature

Although the existing empirical research on the connections between body image and sexual behaviors among women establishes important relationships that might inform interventions to ultimately improve body image and lessen the likelihood of STIs and unintended pregnancies, all of the studies have significant conceptual and methodological limitations. There is no consistency in the measurement of body image across the studies. According to Cash and Pruzinsky (1990), body image is a multidimensional construct that includes evaluation, investment, and affect. In their view, body evaluation is how one sees one's body, investment refers to the meaning and significance one puts on appearance, and affect refers to the emotional feelings and experiences associated with body evaluation. However, in the research explored above, body image is commonly conceptualized with only two opposing constructs of body evaluation: 1) body dissatisfaction—the subjective negative evaluation of one's body or body

parts and 2) body satisfaction—the subjective positive evaluation of one's body or body parts. Furthermore, researchers have used many different validated and unvalidated measures for these constructs. Thus, existing research exploring body image and sexual behavior has not sufficiently or consistently measured the multidimensionality of body image.

Additional methodological limitations include the use of nonexperimental, cross-sectional designs. Each of the studies measure current body image using retrospective accounts of sexual activity, which relies on participants' memories and does not account for changes in body image that occur concurrently with sexual behavior. Creating interventions that will improve body image and lessen risky sexual behavior among women requires an understanding of directionality. Does poor body image lead women to delay coital onset or does earlier coital onset lead to better body image? Does poor body image lead to riskier sexual behaviors or do riskier sexual behaviors cause women to feel worse about their bodies?

Moreover, the lack of generalizability of most of the existing studies' findings, due to the study designs and convenience samples, is also of concern. The vast majority of the studies utilized primarily White, heterosexual adolescent or college student samples, many of which were recruited from undergraduate psychology courses. This is an especially important limitation in this area of study, as experiences with body image vary by body size (Schwartz & Brownell, 2004), race/ethnicity (Grabe & Hyde, 2006), age (Smolak & Mumen, 2011), and sexual orientation (Morrison et al., 2004). The homogeneous samples in existing research do not allow for analyses that lead to an understanding of how women's multiple identities come together to impact the relationship between body image and sexual behaviors. Further, the college milieu of many samples in this body of literature may indicate a certain level of privilege and socioeconomic status. To improve generalizability and provide opportunity for

intersectional perspectives, future research should include samples that draw on the experiences of communities of women whose perspectives are not necessarily represented in currently available research.

Another limitation of the existing research is its focus on pathology. Although there is much to be learned from the study of negatively-focused constructs, a strengths-based perspective is important to incorporate into research initiatives exploring aspects of women's body image and sexual behaviors. A greater understanding of how positive body image relates to protective sexual behaviors can help inform if and how body image serves as a protective factor against STIs, unintended pregnancies, and other potential negative sexuality-related outcomes. If positive body image leads to more protective sexual behaviors, interventions that promote positive bodily regard may also simultaneously lessen negative bodily regard, STI infections, and unintended pregnancies.

Further, given that sexual behavior occurs in the context of a relationship, the lack of research on how the type of relationship (e.g., monogamous), type of partner (new vs. ongoing), gender of the partner, and how the quality of the romantic relationship, or the mutuality of that relationship, impacts body image and sexual behavior is a significant gap in this area of inquiry. Lastly, existing research on body image and sexuality focuses on the individual, when in reality women's body image is impacted by interpersonal, cultural, and individual factors. To assume that an impact on an individual woman's body image will, in turn, change her sexual behaviors does not account for larger, sociocultural and interpersonal influences on her body image and sexual behavior.

To that end, the present study addresses several important limitations and gaps in the literature. First, this study utilizes a multidimensional construct of positive body image that

addresses the evaluation and investment components of body image, the Body Appreciation Scale (Avalos, Tylka, & Wood-Barcalow, 2005). Further, the current study used purposive sampling by recruiting some participants from community colleges in the Kansas City metropolitan area with high minority enrollment. Finally, by combining two theoretical perspectives, this study is strengths-focused and incorporates the quality of the sexual relationship in the model. The type of relationship, type of partner (e.g., monogamous), and gender of partner are also accounted for in the current study. This provides a unique contribution to the study of body image and sexual behavior while being closely aligned with social work values.

Chapter 3: Methodology

Research Questions and Design

Based on existing theoretical and empirical research and their limitations, the following research questions seek to address the gaps in literature (see Figure 1 for the proposed model):

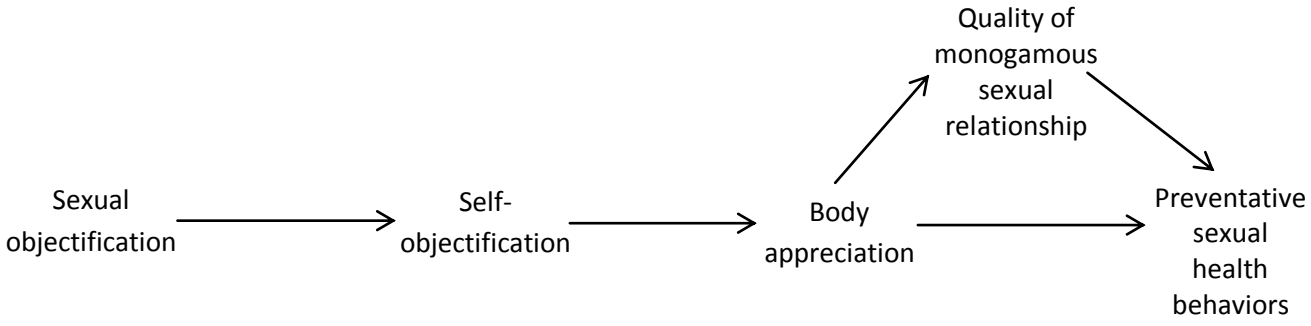
1. Does the proposed model—which describes the relationships among the variables sexual objectification, self-objectification, quality of monogamous sexual relationship, body appreciation, and preventative sexual health behavior—fit well enough to account for the observed correlations among these variables?
    a. What is the statistical effect of sexual objectification on self-objectification while controlling for BMI, race, and history of previous pregnancy?
        i. Hypothesis 1: Lower levels of sexual objectification will be related to lower levels of self-objectification.
    b. What is the statistical effect of self-objectification on body appreciation while controlling for BMI, race, and history of previous pregnancy?
        i. Hypothesis 2: Lower levels of self-objectification will be related to higher levels of body appreciation.
    c. Is there a statistical direct effect of body appreciation on preventative sexual health behavior while controlling for BMI, race, and history of previous pregnancy?
        i. Hypothesis 3: Higher levels of body appreciation will be related to more preventative sexual health behaviors.

d. Is there a statistical indirect effect of body appreciation on preventative sexual health behavior through quality of the monogamous sexual relationship while controlling for BMI, race, and history of previous pregnancy?

    i. Hypothesis 4: There will be a statistical indirect effect of body appreciation on preventative sexual health behavior through quality of the monogamous sexual relationship with higher body appreciation being related to higher quality of the monogamous sexual relationship and higher quality of the monogamous relationship being related to more preventative sexual health behaviors.

In this study, a quantitative, cross-sectional design was utilized to better understand relationships between sexual objectification, self-objectification, body appreciation, quality of sexual relationship, and preventative sexual health behavior among a diverse sample of emerging adult women. Using data collected from a survey questionnaire with young women enrolled in Kansas City-area community colleges and 4-year universities, structural equation modeling was used to answer the research questions.

Figure 1: Proposed Theoretical Model



Sampling Strategy

To qualify for the study, participants were required to: 1) identify as women; 2) be between 18-25 years old; 3) be in a monogamous relationship with a male partner for at least the past 3 months; 4) currently be sexually active with monogamous male partner; and 5) not be pregnant. Purposive sampling from community colleges and four-year universities with high minority enrollment was used to recruit racially diverse women from the Kansas City metro area. An a priori power analysis was conducted using Mplus version 7.2 (Muthén & Muthén, 2010) to determine the appropriate sample size. Power was set at a minimum of .80 for each path in the model, a commonly accepted value (Cohen, 1992). A sample size of 175 was needed to achieve power of .80.

Procedures

After obtaining approval from the Human Subjects Committee of Lawrence (HSCL) to ensure protection of the study participants (see Appendices A, B, and C), IRB approval was obtained for each of the three institutions where participants were recruited. The researcher contacted instructors at the community colleges and four-year universities by email to request permission to provide students with information about the study during a class session (see Appendix D for the recruitment flier) or to forward a recruitment email (see Appendix E) to their students. Participants were directed to an online survey (see Appendix F). Data were collected and stored using REDCap (Harris et al., 2009), which was chosen due to the sensitive nature of the information and its ability to provide HIPAA-level protection of data. Participants were offered a small incentive, in the form of $10 on a Mastercard® debit card through the KU Center for Research, for their participation in the survey. Once they completed the survey, participants were taken to the Greenphire secure system where they entered their contact information in order

to receive the incentive. The payment was then mailed to the participant by the researcher. Data entered in the survey remained independent of the data entered for the incentive; thus, the anonymity of the survey was not compromised.

Measures

Demographics. Demographic information collected included: sexual orientation, race, age, and education level. See Appendix F for the survey instrument.

Sexual objectification. Sexual objectification was measured using the Interpersonal Sexual Objectification Scale (ISOS; Kozee, Tylka, Augustus-Horvath, & Denchik, 2007). Developed with OT as a theoretical framework, the ISOS was created to reflect two forms of interpersonal sexual objectification resulting in two subscales: the Body Evaluation subscale and the Unwanted Explicit Sexual Advances subscale. Sample items from the Body Evaluation subscale include: "How often have you been whistled at while walking down a street" and "How often have you felt that someone was staring at your body." Sample items from the Unwanted Explicit Sexual Advances subscale include: "How often have you been touched or fondled against your will" and "How often has someone made a degrading sexual gesture towards you." A 15-item measure, the ISOS uses a 5-point response format (1=never, 5=almost always). Kozee et al. (2007) tested the psychometric properties of the ISOS among a sample of mostly White college women (N = 342, M age = 18.45) and found high internal consistency (Cronbach's α = .92) and stability over a 3-week period for each of the subscales and the total ISOS score. Further, the ISOS demonstrated evidence of convergent and incremental validity. The internal consistency of the total ISOS score with the current sample is high (Cronbach's α = .92).

Self-objectification. Self-objectification was measured with the Self-Surveillance Subscale (SSS) of the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 2006).

The OBCS includes three subscales with a total of 24 items and has a 7-point response format (1=strongly disagree, 7=strongly agree). Participants are also given the option to circle "not applicable", which is scored as missing. The SSS measures the degree to which women view their bodies from an outside perspective with eight items. Some items are reverse-coded. Sample items include: "I rarely think about how I look" and "I am more concerned with what my body can do than how it looks." McKinley and Hyde (2006) found moderate to high internal consistency (Cronbach's α = .76 to .89) for the SSS with a sample of mostly White undergraduate women (N = 502) and middle-aged women (N = 151). They also found good test-retest reliability over a two-week period. Validity of the SSS was demonstrated by a significant negative relationship between surveillance and body esteem for college women (r = -.27, p < .001), but this correlation was not significant for middle-aged women. Internal consistency of the SSS with the current sample is acceptable (Cronbach's α = .80).

Body appreciation. Body appreciation was measured with the Body Appreciation Scale (BAS; Avalos et al., 2005), a 13-item scale with response options of 1 (never) to 5 (always). The scale measures four aspects of appreciation: favorable opinions about one's body, acceptance of one's body, respect for one's body, and rejecting unreachable cultural ideals for women's appearance. Sample items include: "I feel good about my body" and "I engage in healthy behaviors to take care of my body." Avalos et al. (2005) measured test-retest reliability with college women over a three week period (Cronbach's α = .91 to .93) and found that BAS is inversely correlated with negative body image measures. The internal consistency of the BAS with the current sample is high (Cronbach's α = .91).

Quality of relationship. Quality of the monogamous sexual relationship was measured using a modified version of the Relational Health Indices Peer Subscale (RHI-P; Liang et al.,

2002). The Relational Health Indices was developed using RCT as a theoretical framework and includes three subscales to measure mutuality in women's peer, mentor, and community relationships. The RHI-P is a 12-item scale with responses of 1 (never) to 5 (always). Sample items include: "Even when I have difficult things to share, I can be honest and real with my friend" and "I have a greater sense of self-worth through my relationship with my friend." For the purposes of the current study, the RHI-P was modified by replacing the word "friend" with "sexual partner" in each of the items and one item was removed, leaving the scale with a total of 11 items. The psychometric properties of the RHI-P were tested with 448 female college students (Cronbach's $\alpha = .85$), suggesting that the measure has good internal consistency (Liang et al., 2002). The internal consistency of the RHI-P with the current sample is high (Cronbach's $\alpha = .89$).

Preventative sexual health behavior. For the purposes of this study, preventative sexual health behavior is conceptualized as any behavior that leads to physical sexual health, including behaviors that: 1) prevent unplanned pregnancies; 2) prevent STIs; and 3) take care of one's sexual anatomy. The Preventative Sexual Health Behavior Inventory (PSHBI) was created for this study to measure this construct. After its initial conceptualization by the researcher, a sex researcher, a former sexuality educator, and two social welfare scholars reviewed the measure. Feedback from these individuals led the researcher to remove several items and edit the wording of others. The PSHBI was developed to be used with women who are in a current sexual relationship with a man and includes 13 items, all of which are measured with yes/no responses and some include "I don't know" or "Does not apply" responses. Examples of items include: "Have you had a Pap smear (exam done by a medical provider to detect cervical cancer) in the past 3 years" (yes/no/I don't know) and "My current sexual partner was tested for

sexually transmitted diseases/infections in the time between being with his last sexual partner and being with me" (yes/no/I don't know/does not apply because I am his first sexual partner). The PSHBI is a count scale; thus to score the scale each "yes" response was coded as a 1. One question, "The vaccines to prevent HPV (Gardasil® or Cervarix®) require three shots. In regard to the vaccine: a) I have had all 3 shots; b) I am in the process of getting the shots (I have had at least 1); c) I have not had any of the 3 shots; d) I don't know." Given that getting all three vaccine shots provides more protection than getting one or two vaccine shots (CDC, n.d.a), this item was coded 2 for a response of a, 1 for a response of b, and 0 for a response of c or d. Therefore, the total possible score for each participant was 14. The sum of the scale was calculated for each participant, resulting in a continuous, observed variable. See Table 1 for more information on how the scale was coded.

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Table 1: Preventative Sexual Health Behavior Inventory Coding

Question	Response Option 1 (code)	Response Option 2 (code)	Response Option 3 (code)	Response Option 4 (code)
Q_1: Have you and your partner talked about preventing pregnancy?	Yes (1)	No. But, I do NOT want to get pregnant. (0)	No. But, I DO want to get pregnant. (0)	
Q_2: Do you and your partner agree on your plan to prevent pregnancy?	Yes (1)	No (0)	I don't know (0)	Does not apply (1)
Q_3: Do you take precautions to prevent pregnancy every time you engage in penile-vaginal intercourse?	Yes (1)	No (0)		
Q_4: My current sexual partner told me about his complete history of protected and unprotected sex.	Yes, he told me about his complete history. (1)	Yes, he told me about some of his history. (0)	He hasn't told me about any of his history. (0)	I don't know if he has told me his complete history. (0)
Q_5: I was tested for sexually transmitted diseases/infections in the time between being sexual with my last sexual partner and being sexual with my current sexual partner.	Yes (1)	No (0)	I don't know (0)	Does not apply because my current sexual partner is my first sexual partner. (1)
Q_6: I know my partner was tested for sexually transmitted diseases/infections in the time between being sexual with his last sexual partner and being sexual with me.	Yes (1)	No (0)	I don't know (0)	Does not apply because I am his first sexual partner. (1)
Q_7: My current sexual partner has used IV drugs (putting a needle in one's arm or other body part to inject drugs).	Yes (0)	No (1)	I don't know (0)	
Q_8: My current sexual partner and I have talked about how we will prevent transmitting sexually transmitted infections/diseases.	Yes (1)	No (0)	Does not apply (1)	
Q_9: Do you take precautions to prevent sexually transmitted diseases/infections every time to engage in sexual behavior?	Yes (1)	No (0)	Does not apply (We have both been tested, we have talked about our previous sexual history) (1)	
Q_{10}: The vaccines to prevent HPV (Gardasil® or Cervarix®) require three shots. In regard to getting the vaccine:	I have had all 3 shots (2)	I am in the process of getting the shots (I have had at least 1) (1)	I have not had any of the 3 shots (0)	I don't know (0)
Q_{11}: Have you had a Pap smear (exam done by a medical provider to detect cervical cancer) in the past 3 years?	Yes (1)	No (0)	I don't know (0)	
Q_{12}: Have you had a breast exam by a medical provider in the last 12 months?	Yes (1)	No (0)	I don't know (0)	
Q_{13}: Are you currently taking a daily vitamin with Folic Acid for your sexual well-being?	Yes (1)	No (0)	I don't know (0)	

Blank fields = N/A; >0 = preventative; 0 = not preventative

Covariates.

Body mass index. The model controlled for BMI, consistent with research that suggests that body size may influence how women experience body image (Schwartz & Brownell, 2004). Body mass index was computed from participants' self-reported height and weight. The mean BMI for the sample is 23.66 (*SD* = 4.09). According to the Centers for Disease Control and Prevention (n.d.b), a BMI equal to or less than 18.5 is underweight, between 18.5 and 24.99 is a normal/healthy weight, between 25 and 29.99 is considered overweight, and 30 and above is obese. Thus, the current sample mean is in the healthy BMI range.

History of previous pregnancy. The model controlled for previous pregnancies, as research suggests that pregnancy impacts a woman's body image (Grogan, 2012; Tiggemann, 2004). This information was collected by asking participants: "How many times have you been pregnant?" (0, 1 or more). The variable was collapsed into a dichotomous variable with no pregnancies coded as a 0 and 1 or more pregnancies coded as a 1. The majority of the sample reported never having been pregnant (91%; *n* = 346).

Race. The model controlled for race to account for differences in women's experiences with body image based on race and ethnicity (Grabe & Hyde, 2006). This information was collected from participants by asking: "What is your race/ethnicity (select one)?" The following response options were provided: White/Caucasian, Black/African American, Hispanic/Latina, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Multiracial, and Other (please specify). Due to a lack of diversity within the sample, race was collapsed into two categories: Nonwhite (coded as a 0) and White (coded as a 1). The majority of the sample reported being White/Caucasian (81%; *n* = 308) and the largest nonwhite group

reported being Black/African American (8%; *n* = 30) (refer to Table 3 for a complete list of sample characteristics).

Data Analysis Procedures

The research questions were answered using Structural Equation Modeling (SEM). Prior to conducting SEM, a number of steps were taken, including data screening, assessment of missing data, and assessment of the measurement model using confirmatory factor analysis (CFA).

Data screening. Data were imported into IBM SPSS Statistics version 21 for data screening. First, participants were removed if they did not meet the qualifications of the study. This resulted in removing participants who did not identify as women (*n* = 11), participants who were not between 18-25 years old (*n* = 23), participants who were currently pregnant (*n* = 4), and those who were not currently in a monogamous sexual relationship (*n* = 63). To reduce the influence of extreme scores, outliers that were more than 3 standard deviations beyond the mean were removed before conducting further analyses (Kline, 2011). Participants with a BMI greater than 39.68 (*n* = 8) were removed. This resulted in a final sample of 399 participants.

Next, the data were examined for skewness and kurtosis to assess normality of all scale items, BMI, and the PSHBI score. One item of the RHI-P ("It is important to us to make our relationship grow") was skewed more than the threshold of 2 (skew = −2.112), but none of the items had a kurtosis above the threshold of 7. Curran, West, and Finch (1996) found problems with results only when all items had skew and kurtosis above these thresholds, so the test statistics were expected to be robust to the small amount of nonnormality observed in the data. See Table 2 for a complete list of normality statistics. However, to be conservative, 2000 bootstrapped samples were used to calculate standard errors and confidence intervals that are

robust to nonnormality because no assumptions are made about the shape of the data (Rodgers, 1999).

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Table 2: Normality Statistics for Latent Variables

Item	*N*	*M*	Skewness		Kurtosis	
			Statistic	SE	Statistic	SE
Sexual Objectification						
ISO_1	398	2.85	-.182	.122	-.340	.244
ISO_2	399	2.82	.132	.122	-.572	.244
ISO_3	397	3.59	-.336	.122	-.102	.244
ISO_4	398	3.40	-.326	.122	-.192	.244
ISO_5	399	2.91	-.022	.122	-.516	.244
ISO_6	398	2.72	.195	.122	-.583	.244
ISO_7	398	2.70	.032	.122	-.597	.244
ISO_8	399	3.13	-.162	.122	-.310	.244
ISO_9	399	2.50	.221	.122	-.683	.244
ISO_{10}	399	2.40	.313	.122	-.523	.244
ISO_{11}	398	2.62	.142	.122	-.685	.244
ISO_{12}	398	1.82	.857	.122	.102	.244
ISO_{13}	396	2.02	.917	.123	.224	.245
ISO_{14}	396	1.81	1.012	.123	.645	.245
ISO_{15}	399	2.17	.517	.122	-.399	.244
Self-Objectification						
$OBCS\text{-}SSS_{1R}$	399	5.36	-.864	.122	.108	.244
$OBCS\text{-}SSS_{2R}$	397	3.94	-.070	.122	-.807	.244
$OBCS\text{-}SSS_{3R}$	397	3.98	.043	.122	-.691	.244
$OBCS\text{-}SSS_{4R}$	399	4.85	-.608	.122	-.589	.244
$OBCS\text{-}SSS_{5}$	398	4.54	-.301	.122	-.923	.244
$OBCS\text{-}SSS_{6}$	398	4.71	-.424	.122	-.690	.244
$OBCS\text{-}SSS_{7R}$	398	4.71	-.504	.122	-.694	.244
$OBCS\text{-}SSS_{8R}$	398	4.02	-.111	.122	-.182	.244
Body Appreciation						
BAS_1	398	4.33	-.915	.122	.114	.244
BAS_2	399	3.43	-.147	.122	-.112	.244
BAS_3	399	3.47	-.357	.122	-.263	.244
BAS_4	397	3.77	-.632	.122	-.269	.244
BAS_5	399	4.26	-.985	.122	.653	.244
BAS_6	397	3.67	-.369	.122	-.451	.244

BAS_7	395	3.94	-.501	.123	-.383	.245
BAS_8	395	3.66	-.495	.123	-.702	.245
BAS_9	399	2.96	.130	.122	-.571	.244
BAS_{10}	399	3.57	-.384	.122	-.435	.244
BAS_{11}	399	3.75	-.261	.122	-.610	.244
BAS_{12}	396	3.59	-.490	.123	-.794	.245
BAS_{13}	398	3.91	-.647	.122	-.336	.244
Relationship Quality						
$RHI\text{-}P_1$	399	4.35	-1.261	.122	1.411	.244
$RHI\text{-}P_2$	398	4.22	-.889	.122	.159	.244
$RHI\text{-}P_3$	399	4.46	-1.648	.122	2.727	.244
$RHI\text{-}P_4$	399	4.15	-.944	.122	.457	.244
$RHI\text{-}P_5$	399	4.58	-2.112*	.122	4.563	.244
$RHI\text{-}P_6$	398	4.21	-1.173	.122	1.021	.244
$RHI\text{-}P_{7R}$	398	3.73	-.808	.122	-.644	.244
$RHI\text{-}P_8$	399	4.14	-1.074	.122	.710	.244
$RHI\text{-}P_9$	399	4.24	-1.052	.122	.585	.244
$RHI\text{-}P_{10}$	398	4.40	-1.557	.122	2.073	.244
$RHI\text{-}P_{11}$	395	4.40	-1.336	.123	1.272	.245

R = Reverse coded; * = skewness > ±2

Missing data. None of the variables were missing more than five percent, and data were assumed to be missing at random. Thus, full-information maximum likelihood (FIML) was used to estimate parameters using all available information from the data that were observed. This is a commonly recommended state-of-the-art method for dealing with missing data (Baraldi & Enders, 2010).

Sample Characteristics

The final sample size for the analysis was 399 participants (Table 3). The sample is primarily White (80.8%), heterosexual (89.3%), and never married (95.6%). The average age of the participants is 20.15 years old (*SD* = 2.04) and the mean BMI is 23.66 (*SD* = 4.09; range = 16.29-39.06). With regard to relationship length, 19.1 percent of the participants have been with

their current sexual partner for 3-6 months, 14.3 percent for 6-9 months, 7.3 percent for 9-12 months, 24.1 percent for 1-2 years, 20.4 percent for 2-3 years, and 14.8 percent for more than 4 years. To prevent pregnancy, more than half of the participants reported currently using birth control pills (56.4%), almost half reported currently using male condoms (48.1%), and 28.6 percent reported using the withdrawal method. Just under a tenth (9.4%) of the sample reported having one or more pregnancies in the past.

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Table 3: Participant Demographics

Characteristic	*N*	*%*
Sexual Orientation		
Heterosexual	342	89.3
Bisexual	29	7.6
Homosexual	1	0.3
Pansexual	5	1.3
Asexual	3	0.8
Other	3	0.8
Marital Status		
Married	16	4.2
Divorced	1	0.3
Never married	366	95.6
Number of Pregnancies		
0	346	90.6
1+	36	9.4
Race/Ethnicity		
White/Caucasian	308	80.8
Black/African American	30	7.9
Hispanic/Latina	23	6.0
Asian	7	1.8
Native Hawaiian or Other Pacific Islander	1	0.3
Multiracial	11	2.9
Other	1	0.3
Current Economic Class		
Poor	26	6.8
Working class	89	23.4
Lower middle class	77	20.2
Middle class	144	37.8
Upper middle class	43	11.3
Upper class/wealthy	2	0.5
Length of Relationship		
3-6 months	76	19.1
6-9 months	57	14.3
9-12 months	29	7.3
1-2 years	96	24.1
2-3 years	81	20.4
4+ years	59	14.8
	M	***SD***
Age	20.15	2.04
Partner's Age	21.89	3.70
BMI	23.66	4.09

To provide context for the SEM results, Table 4 provides means, standard deviations, score ranges, and skewness and kurtosis statistics for the study indicators. The mean ISOS score for the current sample was 2.63 (*SD* = 0.67), which is similar to another sample of college women with a mean ISOS score of 2.57 (*SD* = 0.62) (Kozee et al., 2007). The mean OBCS_SSS score for the current sample was 4.50 (*SD* = 1.04), which is slightly higher than the mean of 4.22 (*SD* = 0.91) of a study of undergraduate women (McKinley & Hyde, 2006). The mean BAS score for the sample was 3.73 (*SD* = 0.68), which is similar to the mean BAS score for other young samples of women (Avalos et al., 2005). The mean RHI-P composite score for the current sample was 35.86 (*SD* = 7.01) with a total possible score of 44 (11 items on a 0-4 Likert scale). This is lower than a similar sample that has a mean score of 38.63 (*SD* = 7.35) (Frey, Beesley, & Miller, 2006), but the current study has one fewer items resulting in a total possible score of 44 (11 items on a 0-4 Likert scale) instead of the total possible score of 48 (12 items on a 0-4 Likert scale) in the study by Frey and colleagues (2006).

Table 4: Descriptive Statistics for Study Indicators

Construct	Measure	*N*	*M*	*SD*	Range	Skewness		Kurtosis	
						Statistic	SE	Statistic	SE
Sexual Objectification	ISO Score	385	2.63	0.67	1.00-4.80	.138	.124	-.044	.248
Self-Objectification	OBCS-SSS Score	391	4.50	1.04	1.63-7.00	-.178	.123	-.081	.246
Body Appreciation	BAS Score	384	3.73	0.68	1.85-5.00	-.222	.125	-.558	.248
Quality of the Sexual Relationship	RHI-P Score	391	35.86	7.01	6.00-44.00	-1.186	.123	1.466	.246
Preventative Sexual Health	PSHBI Score	377	9.18	2.26	2.00-14.00	-.345	.126	-.140	.251
Continuous Covariates	BMI	385	23.66	4.09	16.29-39.06	1.168	.124	1.584	.248

Chapter 4: Results

According to Kline (2011), SEM has several advantages over other statistical models (e.g., multiple regression), including the ability to test models based on strong theoretical foundations, explicitly represent measurement error, and give better estimates of effect sizes. An SEM can be rejected if it fits the data poorly by using a χ^2 fit statistic or a number of alternative fit indices. Based on theoretical and empirical evidence, the researcher expects to find that the proposed model is consistent with the data. For these reasons, SEM was appropriate for testing the research questions in this study. Mplus version 7.2 (Muthén & Muthén, 2010) was used to run the SEM analyses.

Confirmatory factor analysis (CFA) is used to assess the relationship between the measures and latent variables and is a critical first step before running structural models. Consequently, a CFA model was run that included the measurement model for the four latent constructs in Figure 1, which were allowed to freely covary with the observed PSHBI outcome and covariates. The CFA parameter estimates implied statistically significant discrepancies between the model and the observed data, $\chi^2(1200) = 3245.24$, $p < .001$, so the null hypothesis of perfect fit can be rejected. However, models are merely meant to be useful approximations of reality, not perfect representations of true natural processes, so researchers cannot reasonably expect models to fit perfectly, making this hypothesis of no interest (Browne & Cudeck, 1992). Alternative fit indices have been proposed as a way to quantify the degree of misfit, similar to a measure of effect size that accompanies a statistical test for comparing group means. Browne and Cudeck (1992) recommend a Root Mean Square Error of Approximation (RMSEA) < 0.08 for acceptable fit, and Hu and Bentler (1999) proposed a two-index approach utilizing RMSEA close to 0.06 (or less) and Standardized Root Mean Residual (SRMR) close to .08 (or less). The

RMSEA values are reported with a 90 percent confidence interval. The CFA model showed an acceptable fit based on these criteria (SRMR = 0.064; RMSEA = 0.065; RMSEA 90% *CI* = [0.063, 0.068]), so the measurement model is sufficient to describe how indicators within and between constructs are related to each other and to other observed variables in the model. Refer to Table 5 for estimates of factor loadings, residual variances, and R^2 values for the CFA model.

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Table 5: CFA Model Loadings, Residual Variances, and R^2 Values

Constructs and Indicators	Unstandardized Loading (*SE*)	Residual Variance	Standardized Loading (*SE*)	R^2
Sexual Objectification				
$ISOS_1$	0.566 (0.047)	0.674	0.571 (0.036)	0.326
$ISOS_2$	0.598 (0.050)	0.677	0.569 (0.036)	0.323
$ISOS_3$	0.489 (0.042)	0.693	0.554 (0.037)	0.307
$ISOS_4$	0.667 (0.044)	0.518	0.694 (0.029)	0.482
$ISOS_5$	0.697 (0.046)	0.526	0.689 (0.029)	0.474
$ISOS_6$	0.734 (0.046)	0.497	0.709 (0.027)	0.503
$ISOS_7$	0.616 (0.050)	0.662	0.581 (0.035)	0.338
$ISOS_8$	0.700 (0.044)	0.489	0.715 (0.027)	0.511
$ISOS_9$	0.831 (0.044)	0.357	0.802 (0.020)	0.643
$ISOS_{10}$	0.691 (0.045)	0.519	0.694 (0.028)	0.481
$ISOS_{11}$	0.865 (0.045)	0.352	0.805 (0.020)	0.648
$ISOS_{12}$	0.457 (0.041)	0.709	0.539 (0.038)	0.291
$ISOS_{13}$	0.572 (0.050)	0.693	0.554 (0.037)	0.307
$ISOS_{14}$	0.482 (0.042)	0.696	0.552 (0.038	0.304
$ISOS_{15}$	0.658 (0.044)	0.540	0.678 (0.030)	0.460
Self-Objectification				
$OBCS\text{-}SSS_{1R}$	0.904 (0.075)	0.643	0.598 (0.038)	0.357
$OBCS\text{-}SSS_{2R}$	0.692 (0.086)	0.817	0.428 (0.047)	0.183
$OBCS\text{-}SSS_{3R}$	0.936 (0.074)	0.609	0.625 (0.037)	0.391
$OBCS\text{-}SSS_{4R}$	1.178 (0.084)	0.539	0.679 (0.033)	0.461
$OBCS\text{-}SSS_5$	0.874 (0.088)	0.737	0.512 (0.043)	0.263
$OBCS\text{-}SSS_6$	0.815 (0.084)	0.748	0.502 (0.044)	0.252
$OBCS\text{-}SSS_{7R}$	1.118 (0.081)	0.550	0.671 (0.034)	0.450
$OBCS\text{-}SSS_{8R}$	0.822 (0.072)	0.666	0.578 (0.040)	0.334
Body Appreciation				
BAS_1	0.422 (0.037)	0.714	0.534 (0.037)	0.286
BAS_2	0.743 (0.037)	0.323	0.823 (0.018)	0.677
BAS_3	0.845 (0.040)	0.272	0.853 (0.015)	0.728
BAS_4	0.878 (0.043)	0.292	0.841 (0.016)	0.708
BAS_5	0.605 (0.036)	0.466	0.731 (0.025)	0.534
BAS_6	0.887 (0.039)	0.204	0.892 (0.012)	0.796
BAS_7	0.445 (0.042)	0.747	0.503 (0.039)	0.253

BAS_8	0.383 (0.059)	0.892	0.328 (0.047)	0.108
BAS_9	0.475 (0.053)	0.813	0.433 (0.042)	0.187
BAS_{10}	0.887 (0.040)	0.235	0.875 (0.013)	0.765
BAS_{11}	0.468 (0.044)	0.742	0.508 (0.038)	0.258
BAS_{12}	0.552 (0.061)	0.804	0.443 (0.042)	0.196
BAS_{13}	0.875 (0.042)	0.284	0.846 (0.016)	0.716
Relationship Quality				
$RHI\text{-}P_1$	0.604 (0.037)	0.470	0.728 (0.026)	0.530
$RHI\text{-}P_2$	0.696 (0.037)	0.350	0.806 (0.020)	0.650
$RHI\text{-}P_3$	0.622 (0.035)	0.408	0.769 (0.023)	0.592
$RHI\text{-}P_4$	0.686 (0.040)	0.437	0.750 (0.024)	0.563
$RHI\text{-}P_5$	0.577 (0.034)	0.445	0.745 (0.024)	0.555
$RHI\text{-}P_6$	0.660 (0.043)	0.515	0.697 (0.028)	0.485
$RHI\text{-}P_{7R}$	0.678 (0.044)	0.520	0.693 (0.028)	0.480
$RHI\text{-}P_8$	0.693 (0.038)	0.382	0.786 (0.021)	0.618
$RHI\text{-}P_9$	0.587 (0.040)	0.557	0.666 (0.030)	0.443
$RHI\text{-}P_{10}$	0.669 (0.034)	0.331	0.818 (0.019)	0.669
$RHI\text{-}P_{11}$	0.229 (0.072)	0.973	0.165 (0.051)	0.027

R = Reverse Coded

Theoretical Model

This section provides details of how well the theoretical model in Figure 1 represented the data, as indicated by the results of an SEM analysis. Body mass index, race, and history of previous pregnancy were included as covariates. The first research question is: Does the proposed model—which describes the relationships among the variables sexual objectification, self-objectification, quality of monogamous sexual relationship, body appreciation, and preventative sexual health behavior—fit well enough to account for the observed correlations among these variables? To test whether the fit of the theoretical model was significantly different from the fit of a CFA model in which all correlations are freely estimated, rather than

fixing some to zero (as depicted by omitted regression paths in Figure 1), the difference in χ^2 values (i.e., a $\Delta\chi^2$ or "likelihood-ratio" test) was calculated.

A significance test of the original proposed model showed that fit was not perfect, $\chi^2(1205) = 3261.08$, $p < .001$, but the fit indices did not indicate that the degree of misfit was severe—i.e., fit was acceptable (SRMR = .068; RMSEA = .065; RMSEA 90% CI = [0.063, 0.068]). However, the theoretical model fit significantly worse than the CFA model, $\Delta\chi^2(5) = 15.84$, $p = .007$, so at least one regression path should not have been fixed to zero. Using theoretical literature and the CFA results as guides to identify which omitted relationships were the greatest in magnitude, a regression path from sexual objectification to body appreciation was allowed to be freely estimated. Although this path is not theorized by objectification theorists, this relationship is supported when viewed in the context of RCT. According to RCT, marginalization leads to disconnection (Jordan, 2008), including disconnection from self, which in this study is operationalized as lower levels of body appreciation. This final model also showed significant discrepancies from the observed data, $\chi^2(1204) = 3249.19$, $p < .001$, but the fit indices indicated acceptable model fit (SRMR = 0.064; RMSEA = 0.065; RMSEA 90% CI = [0.063, 0.068]), and the fit was not significantly worse than the CFA model, $\Delta\chi^2(4) = 3.95$, $p = .41$. Refer to Figure 2 for results from the final SEM regression model and to Table 6 for estimates of factor loadings, residual variances, and R^2 values for the final model.

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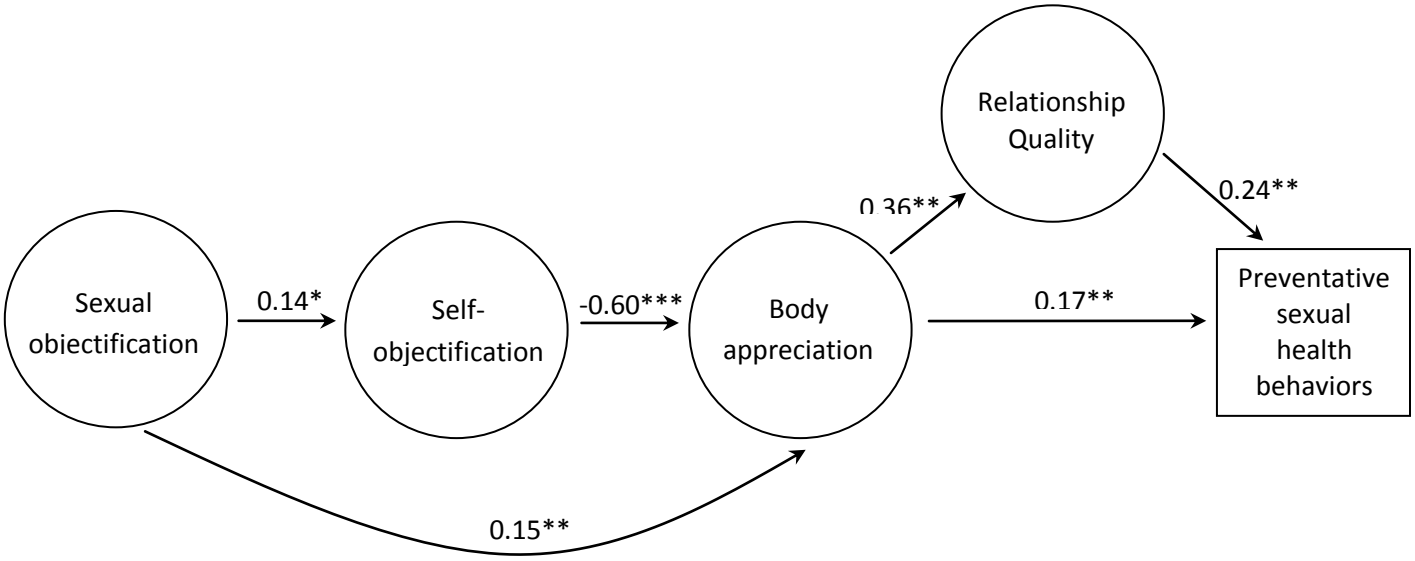
Figure 2: SEM Regression Model



Note: All parameter estimates are standardized.
*p < .05; **p < .01; ***p < .001

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Table 6: Regression Model Loadings, Residual Variances, and R^2 Values

Constructs and Indicators	Unstandardized Loading (*SE*)	Residual Variance	Standardized Loading	R^2
Sexual Objectification				
$ISOS_1$	0.565 (0.051)	0.662	0.571	0.326
$ISOS_2$	0.597 (0.048)	0.749	0.568	0.323
$ISOS_3$	0.489 (0.047)	0.542	0.553	0.306
$ISOS_4$	0.666 (0.045)	0.479	0.694	0.481
$ISOS_5$	0.696 (0.049)	0.540	0.688	0.473
$ISOS_6$	0.734 (0.045)	0.532	0.709	0.503
$ISOS_7$	0.615 (0.053)	0.743	0.581	0.337
$ISOS_8$	0.699 (0.046)	0.470	0.714	0.510
$ISOS_9$	0.830 (0.040)	0.382	0.802	0.643
$ISOS_{10}$	0.690 (0.043)	0.515	0.693	0.480
$ISOS_{11}$	0.865 (0.039)	0.405	0.805	0.649
$ISOS_{12}$	0.458 (0.048)	0.508	0.540	0.292
$ISOS_{13}$	0.574 (0.059)	0.735	0.556	0.309
$ISOS_{14}$	0.483 (0.053)	0.531	0.553	0.306
$ISOS_{15}$	0.659 (0.047)	0.508	0.679	0.461
Self-Objectification				
$OBCS\text{-}SSS_{1R}$	0.888 (0.078)	1.463	0.600	0.360
$OBCS\text{-}SSS_{2R}$	0.675 (0.099)	2.142	0.426	0.182
$OBCS\text{-}SSS_{3R}$	0.913 (0.086)	1.370	0.623	0.389
$OBCS\text{-}SSS_{4R}$	1.153 (0.081)	1.626	0.679	0.461
$OBCS\text{-}SSS_5$	0.854 (0.101)	2.145	0.512	0.262
$OBCS\text{-}SSS_6$	0.789 (0.087)	1.969	0.502	0.252
$OBCS\text{-}SSS_{7R}$	1.097 (0.082)	1.522	0.672	0.452
$OBCS\text{-}SSS_{8R}$	0.803 (0.084)	1.345	0.578	0.334
Body Appreciation				
BAS_1	0.312 (0.033)	0.446	0.535	0.286
BAS_2	0.550 (0.032)	0.264	0.823	0.677
BAS_3	0.625 (0.036)	0.267	0.853	0.728
BAS_4	0.650 (0.037)	0.319	0.841	0.708
BAS_5	0.448 (0.034)	0.320	0.731	0.534
BAS_6	0.656 (0.036)	0.202	0.892	0.795
BAS_7	0.329 (0.032)	0.585	0.503	0.253

BAS_8	0.283 (0.046)	1.214	0.328	0.108
BAS_9	0.351 (0.040)	0.978	0.433	0.188
BAS_{10}	0.656 (0.035)	0.242	0.874	0.765
BAS_{11}	0.346 (0.032)	0.630	0.508	0.258
BAS_{12}	0.408 (0.047)	1.247	0.443	0.196
BAS_{13}	0.647 (0.038)	0.303	0.846	0.716
Relationship Quality				
RHI-P_1	0.565 (0.044)	0.324	0.728	0.530
RHI-P_2	0.650 (0.038)	0.261	0.806	0.650
RHI-P_3	0.582 (0.048)	0.267	0.769	0.592
RHI-P_4	0.641 (0.044)	0.366	0.750	0.563
RHI-P_5	0.539 (0.055)	0.267	0.745	0.555
RHI-P_6	0.617 (0.043)	0.463	0.696	0.485
RHI-P_{7R}	0.634 (0.045)	0.498	0.693	0.480
RHI-P_8	0.648 (0.040)	0.297	0.786	0.618
RHI-P_9	0.548 (0.049)	0.433	0.665	0.443
RHI-P_{10}	0.625 (0.040)	0.222	0.818	0.669
RHI-P_{11}	0.215 (0.061)	1.880	0.165	0.027

R = Reverse Coded

Research Questions and Hypotheses for the Final Model

The final model was guided by one research question, five subquestions, and five hypotheses. The second subquestion was added when the model was modified by adding a path from sexual objectification to body appreciation, which was previously set to zero. This path is theoretically justified, as previously discussed. A value of $\alpha = .05$ was used as criterion for significance, and bootstrapped standard errors were used to calculate the Wald *z* test statistics and *p* values, which are not sensitive to the shape of the data. Bootstrapping was used to address the nonnormality of the data since no assumptions were made about the data (Rodgers, 1999). For a full list of questions and hypotheses for the final model, refer to Table 7. Significance tests are reported for unstandardized coefficients and standardized multiple regression coefficients are reported for effect sizes.

Table 7: Final Research Questions and Corresponding Hypotheses

Does the proposed model—which describes the relationships among the variables sexual objectification, self-objectification, quality of monogamous sexual relationship, body appreciation, and preventative sexual health behavior—fit well enough to account for the observed correlations among these variables?	
Sub-Question	**Corresponding Hypotheses**
SQ_1: What is the statistical effect of sexual objectification on self-objectification while controlling for BMI, race, and history of previous pregnancy?	H_1: Lower levels of sexual objectification will be related to lower levels of self-objectification.
SQ_2: What is the statistical effect of sexual objectification on body appreciation while controlling for BMI, race, and history of previous pregnancy?	H_2: Lower levels of sexual objectification would be related to higher levels of body appreciation.
SQ_3: What is the statistical effect of self-objectification on body appreciation while controlling for BMI, race, and history of previous pregnancy?	H_3: Lower levels of self-objectification will be related to higher levels of body appreciation.
SQ_4: Is there a statistical direct effect of body appreciation on preventative sexual health behavior while controlling for BMI, race, and history of previous pregnancy?	H_4: Higher levels of body appreciation will be related to more preventative sexual health behaviors.
SQ_5: Is there a statistical indirect effect of body appreciation on preventative sexual health behavior through quality of the monogamous sexual relationship while controlling for BMI, race, and history of previous pregnancy?	H_5: There will be a statistical indirect effect of body appreciation on preventative sexual health behaviors through quality of the monogamous sexual relationship with higher body appreciation being related to higher quality of the monogamous sexual relationship and higher quality of the monogamous sexual relationship being related to more preventative sexual health behaviors.

Covariates

Body mass index, race, and history of previous pregnancy were included as covariates. Body mass index was significantly related to body appreciation ($b = -0.07$, $\beta = -.22$, $p < .001$), self-objectification ($b = 0.04$, $\beta = .16$, $p = .008$), and preventative sexual health behaviors ($b = 0.09$, $\beta = .17$, $p = .003$). In other words, higher BMI was related to lower levels of body appreciation, higher levels of self-objectification, and more preventative sexual health behaviors, controlling for all other predictors. Race was significantly related to preventative sexual health

behaviors (b = 0.72, β = .13, p = .008). Put simply, White women were more likely to report more preventative sexual health behaviors than their non-White counterparts. However, all of the effect sizes (refer to the Beta statistics above) for the aforementioned covariate significant results were small (Cohen, 1988).

Hypothesis Testing

The first subquestion is: What is the statistical effect of sexual objectification on self-objectification while controlling for BMI, race, and history of previous pregnancy? Hypothesis 1 indicates that lower levels of sexual objectification would be related to lower levels of self-objectification. The model showed a significant relationship between sexual objectification and self-objectification (b = 0.14, β = .14, p = .015). Thus, Hypothesis 1 is supported, but the effect size is small (β = .14), and only 4 percent of the variance in self-objectification is explained by sexual objectification and the covariates (R^2 = .04).

The second subquestion is: What is the statistical effect of sexual objectification on body appreciation while controlling for BMI, race, and history of previous pregnancy? Hypothesis 2 suggests lower levels of sexual objectification would be related to higher levels of body appreciation. Sexual objectification was significantly related to body appreciation (b = 0.21, β = .15, p = .002), but the effect size is small (β = .15). Although the relationship was statistically significant, Hypothesis 2 is not supported, as higher sexual objectification was related to higher levels of body appreciation, the opposite of the hypothesized outcome.

The third subquestion is: What is the statistical effect of self-objectification on body appreciation while controlling for BMI, race, and history of previous pregnancy? Hypothesis 3 suggests that lower levels of self-objectification would be related to higher levels of body appreciation. The data show that self-objectification was significantly related to body

appreciation ($b = -0.79$, $\beta = -.60$, $p < .001$) with a medium effect size ($\beta = -.60$). This result provides support for Hypothesis 3. In addition to the covariates, sexual objectification and self-objectification explained approximately 45 percent of the variance in body appreciation ($R^2 = .45$).

The fourth subquestion is: Is there a statistical direct effect of body appreciation on preventative sexual health behavior while controlling for BMI, race, and history of previous pregnancy? Hypothesis 4 anticipated that higher levels of body appreciation would be related to more preventative sexual health behaviors. Body appreciation was significantly related to preventative sexual health behaviors ($b = 0.28$, $\beta = .17$, $p = .006$) among the current sample, though it produced a small effect size ($\beta = .17$).

Finally, the fifth subquestion is: Is there a statistical indirect effect of body appreciation on preventative sexual health behavior through quality of the monogamous sexual relationship while controlling for BMI, race, and history of previous pregnancy? Hypothesis 5 proposes an indirect effect of body appreciation on preventative sexual health behavior through quality of the monogamous sexual relationship, with higher body appreciation being related to higher quality of the monogamous sexual relationship and higher quality of the monogamous sexual relationship being related to more preventative sexual health behaviors. Results suggest that body appreciation was significantly related to quality of the relationship ($b = 0.28$, $\beta = .36$, $R^2 = .126$, $p < .001$) and approximately 13 percent of the variance in quality of the relationship was explained.

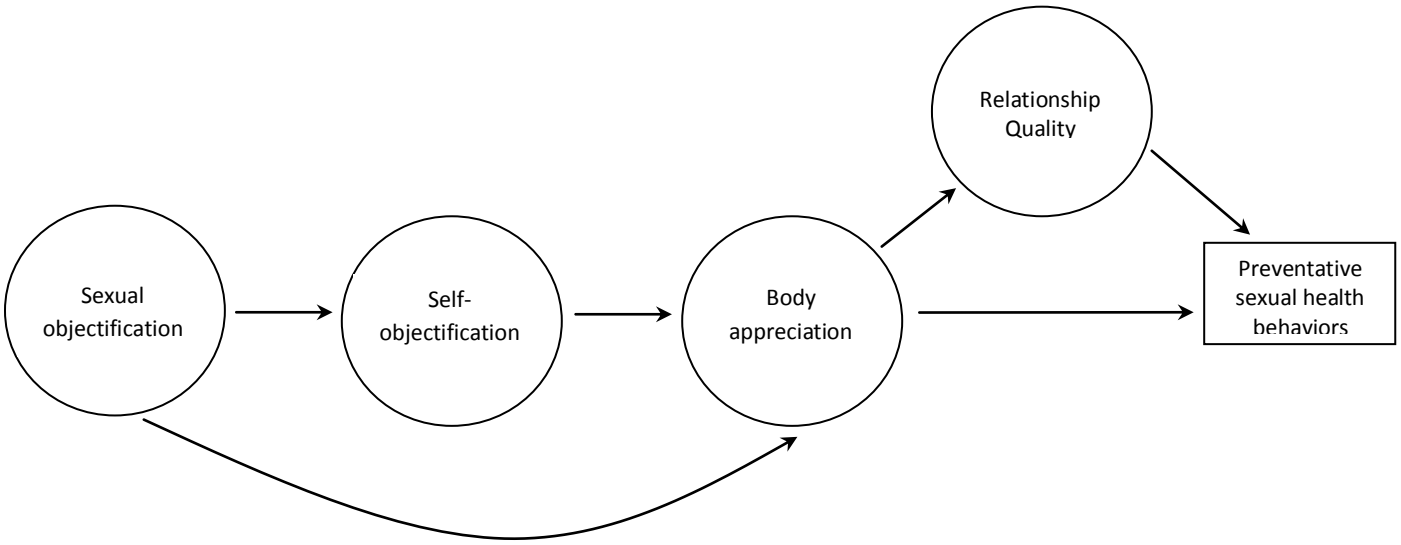
Quality of the relationship was significantly related to more preventative sexual health behaviors ($b = 0.51$, $\beta = .24$, $p < .001$) with a small effect size ($\beta = .24$). The statistical indirect effect using bootstrapped standard errors from body appreciation to preventative sexual health

behavior was statistically significant (b = 0.15, 95% CI for b = [0.07, 0.27], β = .09, 95% CI for β = [.03, .14], p = .002). In sum, the results related to the fifth subquestion supported Hypothesis 5. The total standardized statistical effect of body appreciation on preventative sexual health behaviors was 0.26; thus, an increase in BAS by 1 standard deviation will result in an increase in 0.26 standard deviations of PSHBI for this sample of women. Additionally, body appreciation, quality of the relationship, and the covariates explained approximately 13 percent of the variance in preventative sexual health behavior (R^2 = .128).

Chapter 5: Discussion

In this study, which explored relationships between sexual objectification, self-objectification, body appreciation, quality of the monogamous sexual relationship, and preventative sexual health behaviors among a sample of emerging adult women, support was found for a model that married objectification (Fredrickson & Roberts, 1997) and relational-cultural theories (Miller, 1976). See Figure 3 for the theoretical model.

Figure 3: Theoretical Model



From Pathology to Strengths

The conceptual approach in the design of this study represents a shift away from a focus on pathology to one on strengths and so provides a unique contribution to the literature. The inverse relationships of the ones in existing research (e.g., relationship between body appreciation and preventative sexual health behavior vs. body dissatisfaction and risky sexual health behavior) need to be studied because the absence of pathology does not necessarily equate

to health. In other words, a woman with low body dissatisfaction may not necessarily have high body appreciation just as a woman without cancerous cells may not have healthy cells.

This is also congruent with the strengths perspective in social work, which proposes to help clients at any level (e.g., individual, family) see and utilize their strengths, abilities, and capacities while still recognizing the barriers to doing so, in order to improve their well-being (Saleebey, 2000). As such, body image scholarship cannot ignore pathology. Sexual objectification is real and should not be minimized, but scholars must also explore positive constructs in order to highlight women's ability to reject objectification. According to Saleebey (1996), "…in the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem" (p. 297). Thus, by exploring the problem, i.e., objectification, and positive constructs such as body appreciation, this study suggests that positive bodily regard may lead to good relationship and sexual health behaviors and outcomes, all of which may improve women's lives.

The Importance of Human Relationships

The mediating relationship between body appreciation, relationship quality, and preventative sexual health behaviors is this study's most distinctive finding and its largest contribution to the area of scholarship in body image and sexual health, as it may have significant implications for women's relational and sexual health. The context of the sexual relationship was embedded in the study sample by limiting the sample to women who are in monogamous sexual relationships, including a measure of relationship quality in the theoretical model, and accounting for the gender of the woman's partner. By doing this, the current study sheds light on how these relationships work together. As hypothesized, there were significant direct and indirect relationships between body appreciation and preventative sexual health behaviors, through quality of the relationship. Higher body appreciation was significantly

related to more preventative sexual health behaviors directly and indirectly through quality of the monogamous sexual relationship. In other words, higher body appreciation was also significantly related to higher quality of the monogamous sexual relationship, which was, in turn, significantly related to more preventative sexual health behaviors. Thus, this study suggests that if an intervention increases body appreciation, it may also improve both the quality of the individual's sexual relationship and increase the number of preventative sexual health behaviors. This is important because interventions that lead to improvements in body appreciation may also improve women's physical, mental, sexual, and relational health.

Many preventative sexual health behaviors require the consent of the romantic partner. For example, male condom use is an interpersonal behavior that requires consent. However, much of the existing body image and sexual health research fails to account for the interpersonal relationship. The relationship between body appreciation and quality of the sexual relationship suggests that when a woman experiences intrapersonal connection with herself, i.e., higher body appreciation, she may be more likely to experience higher quality interpersonal connection with her romantic partner. Further, the results suggest that if a relationship experiences a growth-fostering connection through mutuality, as advanced in RCT (Miller, 1976), engaging in interpersonal preventative sexual health behaviors may be more likely. Consequently, scholarship in this area needs to specifically address the relationship context, particularly when sexual health is the outcome of interest. This will yield a more complete understanding of the relationship between body image and sexual health. Furthermore, interventions designed in the context of this theoretical framework have the potential to have a larger impact on women's well-being than those that exclude the relationship context.

Finally, a model of objectification, body image, and sexual health that accounts for the sexual relationship is congruent with social work values. According to the Code of Ethics of the National Association of Social Workers,

> Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (NASW, 2008).

The model and results of the current study align with this core social work value, as an increase in body appreciation is related to better quality in the sexual relationship, which is, in turn, related to more preventative sexual health behaviors. Thus, incorporating human relationships into body image and sexual health literature and practice may contribute to the well-being of social work clients. Of course, to know this in practice necessitates the social worker's willingness, knowledge, and ability to engage in discussions about objectification, body image and sexual health. Recommended strategies for doing so are discussed in the implications section of this dissertation.

Objectification Theory

This study lends support for a model that marries objectification and relational-cultural theories. There was a significant inverse relationship between self-objectification and body appreciation. This relationship also provides support for relational-cultural theory, as it suggests that marginalization does, in fact, lead to disconnection from self (Jordan, 2008). It is important to note the strength of this relationship, as it has the largest effect size in the model ($\beta = -.60$),

suggesting that the relationship is both statistically and clinically significant. In other words, a decrease of self-objectification by 1 standard deviation was related to an increase in body appreciation by .60 standard deviations in this sample of women. This relationship is important because it suggests that if self-objectification can be prevented, body appreciation may be impacted in a positive way, which has implications for women's physical, mental, sexual, and relational health. The strength of the relationship between self-objectification and body appreciation makes it an especially exciting finding because this is an area that is ripe for intervention.

The relationship between sexual objectification and self-objectification, informed by objectification theory, is supported by the findings of the research undertaken here. Sexual objectification was significantly related to self-objectification, with higher sexual objectification related to higher self-objectification. Although this relationship has a small effect size ($\beta = .14$), this finding provides further evidence for the assertion of objectification theorists that cultural sexual objectification leads women to view their own bodies as objects for others' sexual pleasure (Fredrickson & Roberts, 1997). In doing so, this finding adds an important contribution to the growing body of objectification literature (Moradi & Huang, 2008).

While the findings here in part support the objectification theory model originally proposed by Fredrickson and Roberts (1997), importantly, the results of this study also suggest these relationships are more complex than originally theorized. Higher sexual objectification was related to higher levels of body appreciation among the current sample of women. This finding has a small effect size ($\beta = .15$) and is counter to Hypothesis 2, which rests on both objectification and relational-cultural theories. Although surprising, this finding is a promising one because though we ultimately want to eliminate sexual objectification altogether, this is

unlikely. If we can increase the number of women who experience heightened body appreciation as a result of sexual objectification, this may decrease the negative effects of sexual objectification on women's health and mental health.

Existing research helps contextualize this complexity, in that it is possible that when women reject the cultural ideals for women's appearance and do not internalize cultural objectification, they instead experience a sense of empowerment from sexual objectification, resulting in an increase in their body appreciation. Scholars posit that a feminist identity may serve as a protective factor against self-objectification (e.g., Hurt et al., 2007) and lead to better body image (Murnen & Smolak, 2009). Feminist identity may give women the tools to articulate the negative consequences of objectification and contextualize sexual objectification when they experience sexual objectification, which, according to Calogero and Tylka (2014), may make them less likely to self-objectify. Thus, increasing feminist identity may support a decrease in self-objectification and an increase in body appreciation.

It is also possible that some women find enjoyment in the sexual objectification they experience, which would help explain the relationship between sexual objectification and body appreciation in this study. For example, a woman may feel better about her body after being whistled at while crossing the street. Women who report enjoying the sexualization of their bodies have more traditional and sexist beliefs (Erchull & Liss, 2013; Liss, Erchull, & Ramsey, 2010), but nonetheless some women experience empowerment through objectification (Erchull & Liss, 2014). Although scholars argue that the sense of empowerment through sexualization and objectification does not lead to long-term benefits (Erchull & Liss, 2013, 2014), it is possible it leads to better body image in the short-term. In sum, the relationship between higher levels of sexual objectification and higher levels of body appreciation may be explained by framing

feminist identity as a protective factor and/or it could be the result of feeling empowered through cultural sexual objectification.

Limitations and Implications for Future Research

Limitations. There are several limitations to the study, most notably the cross-sectional design. As observed in the critique of existing literature, most research in this area of scholarship is cross-sectional, which limits the generalizability of current evidence. The sampling strategy and inclusion criteria also limit generalizability. Thus, the conclusions drawn from the current study cannot be generalized beyond the sample. Additionally, the cross-sectional, non-experimental study design does not meet the criteria for determining cause and effect among the variables in the study.

The sample in the current study is more diverse than that detailed in existing literature in some ways, but lacks diversity in other ways. The sample was limited to women currently in a monogamous sexual relationship with a man. Thus, the research focused solely on women engaged in heterosexual relationships. The required sample size for each race group (n = 175), based on a priori power analysis, limited the researcher's ability to include race as a moderating variable, but race is included as a control variable. However, the sample is much more diverse by race/ethnicity than many other existing studies and is also diverse with regard to socioeconomic status. It is possible this diversity is a result of recruiting students from community colleges (Pokhrel, Little, & Herzog, 2013) as well as four-year universities. In sum, the sample of the current study addresses some of the diversity limitations of existing scholarship in this area, but not all.

Previous research findings suggest that the relationship between sexual objectification and self-objectification may be moderated by body size. Body mass index is often used as a

measure of body size, though it has been critiqued for its inability to assess body shape, inability to accurately assess health, and its lack of applicability to women and people of color (e.g., Satinsky & Ingraham, 2014). However, BMI is the most widely used measure of body size and despite the aforementioned critique; it is arguably the best existing measure. In the study reported here, sample size requirements to use multiple group SEM resulted in including BMI as a control variable rather than a moderating variable. The current study also relied on self-reported data, including height and weight to calculate BMI. Although overweight and obese women often underreport their weight, the discrepancies between self-reported and actual weight are small (Elgar & Stewart, 2008). Consequently, it is possible that body size is underestimated in the current study, but if so, this likely would not have had a significant impact on the results.

Implications for future research. The findings of current study highlight possible areas for intervention and opens up this area of scholarship for further exploration. More evidence is needed to support a theoretical model of objectification, body image, relational health, and preventative sexual health among women. Future research should replicate this study longitudinally in order to understand if and how these relationships change over time and to establish temporal precedence and directionality. Additionally, future research should be conducted with representative samples of women to better understand if and how this relational model applies to the larger population of women in the U.S. To accomplish this, scholars should also seek to recruit more diverse samples by including women of color, women with different levels of ability, women who are not exclusively heterosexual, and women who are in non-monogamous relationships. To continue moving this area of scholarship toward a strengths-focus, future research should also include the relationship context and use positive, multidimensional measures of body image. This might include the revised body appreciation

scale (Tylka & Wood-Barcalow, 2015), which needs to be tested for reliability and validity with diverse groups of women, and measures of preventative or protective sexual health behaviors. There is also a need to develop a scale that measures the inverse of self-objectification, which would allow for a more strengths-based model and hopefully lead to a better understanding of women who do not self-objectify.

Additionally, we need to better understand relationships between sexual objectification, self-objectification, and body appreciation. To do this, scholars should investigate the contexts of the relationship between sexual objectification and body appreciation and how this relationship changes over time. Additionally, future research should explore feminist identity and other possible protective factors against self-objectification, factors that might include the knowledge and skills to reject misogynistic, sexually objectifying images and experiences. With a better understanding of the relationships in the model tested in the current study, scholars and practitioners will have the knowledge they need to test interventions that aim to improve women's body image, thereby mitigating the negative consequences associated with poor body image.

Looking Ahead: Implications for Social Work Practice and Public Policy

The social work profession works from the person-in-environment perspective in order to address the needs and wants of clients. When we fail to address the body and body image in social work practice, we fail to address the whole person's needs. Further, we fail to address some of the restorative and healing properties of the person, i.e., some of her strengths (Saleebey, 1992). Thus, embodying social work practice is necessary for the person-in-environment perspective. This section will discuss the implications of this study on practice with women, practice with men, health education, and policy.

Practice with women. This study revealed that higher levels of body appreciation were related to better quality of the sexual relationship, which was, in turn, related to more preventative sexual health behaviors among the current sample. The relationships between objectification, body image, relational health, and sexual behaviors found in this study have implications for social work practice with women. In accordance with NASW's policy statements (NASW, 2012), social work practitioners must strive to provide services and programs for women that are relevant and empower women, leading them to "develop the power and sense of entitlement that fuels self-advocacy" (p. 367). This involves social workers using their skills and education to screen female clients for poor body image and address topics concerning women's bodies, teach women to critically analyze misogynist representations of the female body, and empower women to resist gender stereotypes (NASW, 2012). According to Saleebey (1992), it is:

> The social worker's obligation to help clients regard and experience the body as an instrument of effective action and to give clients permission to take control of their body sense, image, and energy…in some cases, social workers must help to raise consciousness about how clients' body experiences have been subjugated (pp. 115-116).

Thus, social work practitioners have an obligation to address sexual objectification and body image with female clients, which, consistent with the findings of this study, may improve the clients' relational health and increase their preventative sexual health behaviors. This movement starts in social work education where students learn the assessment strategies that include exploration of these important areas having to do with the body, which will be explored later in the section on implications for social work education.

Practice with men. New explorations in social work practice with men are also suggested by the findings presented here. The movement to involve men in preventing violence against women (Berkowitz, 2004), much of which is focused on achieving gender equality (Flood, 2011), rests on the premise that the achievement of gender equality will reduce violence against women. In addition, equality between genders will also likely reduce objectification of women. Thus, social workers should work to engage men to reduce objectification in ways similar to how men are engaged in the gender-based violence prevention movement. Flood (2011) applied the six levels of intervention from the Spectrum of Prevention (Cohen & Swift, 1999) to engaging men in violence prevention, which can further be adapted to reducing sexual objectification of women. These levels include: 1) strengthening individual knowledge and skills; 2) promoting community education; 3) educating providers (and other professionals); 4) engaging, strengthening, and mobilizing communities; 5) changing organizational practices; and 6) influencing policies and legislation. These six levels can be adapted in social work practitioners' work with men to address sexual objectification of women and improve body image.

Social workers who work with men, but do so outside of violence prevention (e.g., case management) can still participate in several of Flood's (2011) levels of prevention. For example, a social work practitioner doing family reunification can work with fathers to "support positive parenting and encourage shared power and decision making" (p. 363) (level one). A social worker in a community mental health agency could work with male colleagues and agency administrators to assess the culture and climate of the agency in terms of objectifying images, policies, and language in the workplace (level five). This would lead to a safer, healthier work environment for female employees, but also a safer, healthier space for female clients to seek and

receive services. In sum, engaging men in reducing the objectification of women has the potential to support improvements in women's body image and quality of relationships, and increase women's preventative sexual health behaviors. This work should not be left solely to those social workers in violence prevention agencies, but can instead be undertaken by social workers who work with men in any subfield of the profession.

Health education. This study also has implications for social workers and other practitioners working in public health, especially those practitioners who provide human sexuality education to collegiate women. To reduce the negative consequences associated with poor body image and risky sexual behaviors, comprehensive sexuality education provided in courses and by campus health centers, for example, needs to be embodied by including components on sexual objectification, body image, and relational health in addition to contraception, anatomy, reproduction, STIs, pregnancy, and more. This is in accordance with a model of human sexuality developed by social work scholar Dr. Dennis Dailey, which accounts for the intersections between systems (e.g., family), culture, attitudes, feelings, values, and sexuality issues, including sexualization, sexual health and reproduction, sexual identity, intimacy, and sensuality (Dailey, 1981). Taking a comprehensive approach to human sexuality education has the potential to reduce sexual objectification, thereby possibly increasing the positive consequences associated with higher levels of body appreciation, better quality of relationships, and more preventative sexual behaviors.

Implications for policy. Regardless of practice area (e.g., child welfare) or the type of client (e.g., individual) a social worker engages with, social workers have an ethical obligation to engage in advocacy on behalf of their clients in pursuit of social justice, one of social work's

core values (NASW, 2008). This section explores the implications of this study on two areas of policy advocacy, comprehensive sexuality education and advertising standards.

Comprehensive sexuality education. This discussion of the implications of this study would be incomplete without mention of the ways sexuality education and messages related to developing body appreciation are delivered. Although the current study utilizes a sample of college women, the implications for policy can extend to adolescent sexuality education, since young adolescent girls experience many body changes (Levine & Smolak, 2002) and poor body image peaks and remains high during adolescent and young adult years (Cash et al., 1985). Educational strategies that promote health and prevent negative consequences associated with risky sexual behaviors should be driven by evidence and theory (Schaalma, Abraham, Gillmore, & Kok, 2004). According to the current study, these educational strategies would be well served by including body image, sexualization, sexual objectification, and healthy relationships in the content, in addition to other topics.

Empirically and theoretically-driven prevention programming is only as good as the educators who provide it. Teachers need to be trained to provide quality sexuality education with fidelity. This training should include material that addresses complex issues related to gender and teach educators skills for providing gender-inclusive sexuality education that includes the aforementioned topics. Additionally, new health and physical education teachers should graduate from college prepared to provide comprehensive sexuality education. This may require changes in college-level curricula. According to the results of this study, educators providing high quality, embodied, prevention curricula have the potential to increase girls' body appreciation, increase quality of relationships, and decrease negative consequences of risky sexual behavior, including unplanned pregnancy and sexually transmitted infections.

Advertising standards. Given the relationship between objectifying media images and body dissatisfaction (Levine, 2012), advertising standards and practices in the U.S. need to be addressed. Using marketing strategies that incorporate realistic images of women is not a new idea. In fact, it was proposed for fitness centers, an industry that almost exclusively uses unrealistic, thin images of women to attract customers, almost 13 years ago (Vogel, 2002). In her article, Vogel asserts "For many people—especially women, who have been targets of perfect-body advertising for decades—ads that advocate acceptance at any shape and size do strike an emotional cord" (n.p.). Vogel concludes by offering a checklist of positive body image marketing, including items such as avoiding before and after photos and providing rewards for achievements other than weight loss. Although these recommendations have not been widely adopted by fitness centers, similar proposals may gain more traction if they are created and promoted by stakeholders.

In 2009, the Australian Government appointed a National Advisory Group on Body Image. This group came together to create the Voluntary Industry Code of Conduct (Australian Policy Online, 2010). Learning from them, advertising experts, body image activists, social workers, and other stakeholders should come together to convene a workgroup with government buy-in that aims to influence advertising standards. A voluntary code of conduct sanctioned by influential agencies and individuals may be able to create an embodied media culture that sends girls and women realistic and healthy messages regarding women's bodies. Doing so has the potential to improve women's relationships with the beauty industry, the products they purchase, and the people in their lives, thereby improving women's body image and their physical, sexual, and mental health.

Implications for Social Work Education

It is unfair to expect social work practitioners to embody their social work practice in a way that honors women's experiences if their education has not prepared them to do so. Although content on women was mandated for inclusion in social work education curriculum in 1979 (as cited in Figueira-McDonough, 1998), the Council on Social Work Education (CSWE) established the Council on the Role and Status of Women in Social Work Education, and social work scholars have called for gender-integrated knowledge (Figueira-McDonough, 1998), social work education appears to continue its androcentrist ways despite the challenge for change issued by Grise-Owens (2002). To prepare social workers to address body image, sexual objectification, and other issues relevant to women, social work curricula need to be updated and inclusive.

To equitably incorporate gender into social work curricula, it is not sufficient to unsystematically add content on women to courses and/or to offer one course on social work with women. Instead, content on gender, including issues of body image and sexual health, should be purposefully integrated throughout coursework. Further, McPhail (2008) notes that gender is more complex than just women and men, and so social work curricula must address issues and topics related to women, feminism, men, masculinities, and transgender individuals. Integrating a new, comprehensive understanding of gender would allow students to develop a more critical awareness of gender. In sum, "re-gendering the social work curriculum" with a comprehensive understanding of gender, as suggested by McPhail (2008), requires integrating content on gender throughout human behavior in the social environment, policy, practice, diversity, research, administration, community practice, and psychopathology courses (Figueira-McDonough, 1998) in addition to teaching students about the construction of gender using a

critical gendered analysis. One way this could be addressed would be too revise master syllabi and include gender and issues related to gender in the educational outcomes of each course. These proposed curricular changes are likely to result in a more comprehensive, body-conscious social work education that addresses topics such as sexual objectification and women's body image and sexual health; thus, preparing social work students for practice with clients across the gender spectrum.

Implications for Social Justice

If interventions that are informed by this study can successfully improve women's body image, this study suggests there may also be important implications for social justice. McKinley (2002) suggests that the time women spend addressing body dissatisfaction and sexual objectification takes away from the time they could otherwise spend elsewhere, including time spent pursuing an education, time working toward career advancement, and time with family. Thus, if interventions can be devised that improve women's body image, women may be able to achieve more equity in work, pay, politics, and elsewhere. McKinley (2002) points out that viewing objectification and body image as a social justice issue for women will require changing social systems, not just improving individual women's body image. With a larger group of embodied, empowered women however, there may be fewer barriers to systemic change. Thus, simultaneously working toward individual and social change may be mutually beneficial and positively impact social justice issues related to body image.

Conclusion

This study provides evidence for a relational model of sexual objectification, self-objectification, body appreciation, quality of the sexual relationship, and preventative sexual behaviors among a sample of emerging adult women. This knowledge highlights the need for

the social work profession to become embodied by paying intentional attention to the thoughts, feelings, and experiences associated with women's bodies and the relational context in which these occur. As a profession that explicitly values the importance of relationships, we must acknowledge the impact relationships have on women's experiences. As such, our interventions and future research should account for the relational context of body image and sexual behavior. According to Saleebey (1992), "People should not become, as helpers, part of the mechanics and metaphors of oppression through the denial of bodiliness" (p. 115). Working from a relational strengths perspective will allow social work practitioners to work with women and men to make changes at the individual, family, community, organizational, and policy levels to improve the lives of women and reduce negative consequences associated with poor body image.

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Appendices

Appendix A: University of Kansas Human Subjects Application

Submission for Initial Review

University of Kansas
Human Subjects Committee - Lawrence

KU RESEARCH & GRADUATE STUDIES
The University of Kansas

Human Subjects Committee - Lawrence

Submission for Initial Review

For Use with eCompliance Only

Project Title:	The Effects of Sexual Objectification, Self-Objectification, Body Appreciation, and Quality of the Sexual Relationship on Preventative Sexual Health Behaviors among a Sample of Emerging Adult Women
Investigator Name:	Virginia Ramseyer Winter
Faculty Supervisor:	**Dr. Margaret Severson**

This form must be used when submitting an application through the eCompliance system.
No other methods of submission will be accepted.

You may access the system here: http://research.ku.edu/ecompliance

Students and faculty supervisors: Please note an ancillary review process will be required to obtain faculty supervisor approval within the system. Please see the IRB Study Submission Guide for more information.

For faster processing, ensure all study staff have completed all required training through https://rgs.drupal.ku.edu/human_subjects_compliance_training

Contact hscl@ku.edu with questions!

rev 6/7/13

Submission for Initial Review

University of Kansas
Human Subjects Committee - Lawrence

1. Subject Information

1.1 Number of Subjects: 350

1.2 Subject Age *(Check all that Apply)*

- ☐ 0-7
- ☐ 8-17
- ☒ 18-65
- ☐ 65+

1.3 Special Populations *(Check all that apply)*

- ☐ Minors
- ☐ Non-English speaking
- ☐ Mentally or developmentally disabled individuals
- ☐ Pregnant women
- ☐ Prisoners
- ☐ Individuals with diminished capacity for consent
- ☐ Individuals with a Legally Authorized Representative
- ☐ Other vulnerable population (describe below)

1.4 Describe any specific populations targeted for inclusion or exclusion:

To qualify for the study, participants must: 1) identify as a woman; 2) be between 18-25 years old; 3) be in a monogamous sexual relationship with a male partner for at least the last 3 months; 4) currently be sexually active with monogamous partner; and 5) not be pregnant.

1.5 Describe target demographics of proposed subjects; explain how you will ensure that selection is equitable and that all relevant ethnic groups, genders, and populations have access to the study.

Racially- and ethnically-diverse women will be recruited for the study. However, all women who fits the criteria for the study will be encouraged to participate. The researcher will recruit participants through Kansas City-metro community colleges and 4-year universities.

2. Recruitment

2.1 Describe the recruitment process for the study. Explain how you will gain access to and recruit the subjects for participation in this project.

Purposive sampling from community colleges and 4-year universities with high minority enrollment will be used so as to include racially- and ethnically-diverse women from the Kansas City metro area. The researcher will contact instructors and student group leaders at the community colleges and 4-year schools via email and/or phone to request permission to provide students with information about the study during a class session. When class time is not a possibility, the researcher will send a recruitment email to instructors and ask them to forward it to their students. Additionally, fliers will be posted on billboards at the community colleges advertising the study. Participants will be directed to an online survey.

2.2 Identify any cooperating institutions by name.

2.3 Where will the research activities take place? List all off campus locations.

The researcher will recruit participants from Metropolitan Community Colleges and 4-year universities in Missouri and Kansas City Kansas Community College. The surveys, however, will be completed online.

2.4 Identify all applicable recruitment methods. *(Please provide copies of materials)*

- ☒ Flyers
- ☐ Letter
- ☐ Telephone
- ☐ Newspaper
- ☐ Poster
- ☐ Departmental Communication
- ☐ Internet
- ☒ E-mail
- ☐ Amazon MTurk
- ☐ Social Media
- ☐ SONA
- ☐ Third Party (Professional or Charitable Organization
- ☐ Purchased Sample List
- ☐ Personal or Professional Contacts
- ☐ Other

2.5 Are you recruiting students from a class you teach or for which you have responsibility? No

2.6 Are you recruiting employees who directly or indirectly report to you? No

2.7 If yes to 2.5 or 2.6, please explain why this population is necessary and describe what precautions have been taken to minimize potential undue influence or coercion.

3. Compensation

Drawings and raffles may not be permitted for payment or recruiting; see HSCL website for detailed guidance.

☐ **Participants will not receive compensation**

☐ **Students will receive extra credit or course credit**

☒ **Subjects will receive monetary compensation**

Describe the compensation or credit, including amount, scheduling and method. Explain what will happen if participants withdraw from the study.

Participants will be offered a small incentive, in the form of $10 on a Mastercard® debit card through the KU Center for Research, for their completion the survey (participants can "complete" the survey even if they skip questions they feel uncomfortable or unwilling to discuss). Participants will be asked at the end of the survey if they want to provide an email address in order to receive their compensation. They can choose to provide an email address in order to receive the incentive or choose from 1 or 2 organizations that focus on sexual health to receive what would have been their compensation. Once they have completed the survey, the participants who provided an email address

will receive an email with a link to a separate REDCap survey where they will enter their contact information in order to receive the incentive. The researcher will enter the participant's contact information into the Greenphire ClinCard system. The payment will then be mailed to the participant by the researcher. Email addresses will be permanently deleted from all data files upon completion of data collection. The researcher will not be able to match the data entered in the survey with that entered for the incentive; thus, the anonymity of the survey will not be compromised.

Submission for Initial Review

University of Kansas
Human Subjects Committee - Lawrence

4. Project Information

4.1 Expected Study period from: Apr 1, 2014 **To:** Aug 31, 2014

4.2 Describe the purpose of the research. Include purpose, aims, and objectives. State the hypothesis to be tested.

This dissertation research is guided by the following objectives:
1. To better understand college age women's experiences with sexual objectification, self-objectification, positive body image, and sexual health, to more fully inform preventive interventions designed to increase positive sexual health outcomes.
2. To determine how these relationships differ among racially-diverse women.

The following hypotheses are proposed:
- H1: Race will moderate the relationship between sexual objectification and self-objectification.
- H2: Lower levels of self-objectification will predict higher levels of body appreciation.
- H3: Lower levels of self-objectification will predict better quality in the sexual relationship.
- H4: Higher body appreciation will predict a higher level of preventative sexual health behavior
- H5: Better quality in the sexual relationship will predict a higher level of preventative sexual health behavior.
- H6: The relationship between self-objectification and preventative sexual health behaviors will be mediated by body appreciation and quality of the sexual relationship.

4.3 Background; describe prior relevant experience and gaps in current knowledge. Provide a brief scientific or scholarly background.

Research on the relationship between women's body image and sexual health has the potential to inform the design of efficacious interventions, yet existing studies have significant conceptual and methodological limitations. The majority of existing research is presented within a pathology frame. While much can be learned from the study of negatively-focused constructs, a strengths-based perspective is also important to incorporate into research initiatives. Further, given that sexual behavior occurs in the context of a relationship, the lack of research on the type of relationship, type of partner (new vs. ongoing), gender of the partner, and how the quality of the romantic relationship impacts body image and sexual behavior, are significant gaps in this area of inquiry. Finally, most existing research relies on predominantly White, heterosexual, collegiate samples of women to test these relationships. This is an important methodological limitation, as experiences with body image vary by body size (Schwartz & Brownell, 2004), race/ethnicity (Grabe & Shibley Hyde, 2006), age (Levine & Smolak, 2002; Tiggemann, 2004), and sexual orientation (Morrison, Morrison, & Sager, 2004). The proposed study addresses some of these limitations and will provide a unique contribution to existing literature.

5. Risks & Benefits

5.1 Does this study involve any of the following? *(Check all that apply)*

- ☐ Deception
- ☐ Omission
- ☐ Misleading information/False feedback
- ☐ Physical or mental stress
- ☐ Collection of fluids or tissue
- ☐ Genetic information
- ☐ Substances taken internally or applied externally
- ☐ Mechanical or electrical device applied to subjects
- ☐ Information pertaining to illegal activity
- ☐ Information pertaining to substance use
- ☒ Information relating to sexual attitudes, orientation or practice
- ☐ Private identifiable information
- ☒ Personal or sensitive information
- ☐ Private records (academic or medical)
- ☐ Social or economic burden to particpants
- ☐ Exposure to hazardous materials
- ☐ Information that if released could damage an individual's financial standing, employability, reputation; or cause social stigmatization or discrimination
- ☐ Other
- ☐ **None of these**

5.2 Describe the nature and degree of the risk or harm checked above. If using deception, include a justification for the deception.

The study seeks to explore relationships between sexual objectification, self-objectification, body image, quality of the sexual relationship, and preventative sexual health behaviors. Therefore, the very nature of some of the questions is sensitive because they relate to a persons' body image and sexual behaviors. It is possible that recalling this information could raise some difficult experiences and cause mental distress for some participants. The only personally identifiable information that will be collected is an email address if the participant wants to receive the incentive and this will be permanently deleted from all files at the completion of data collection. Thus, risks are minimal to participants.

5.3 What steps will be taken to minimize the risks or harm and to protect the subject's welfare (when risk is greater than minimal)?

The researcher does not expect risks to be greater than minimal. However, the researcher will provide web links to mental health and sexual health resources and local community resources at the end of the survey and in the information statement. Participants may, at any time, drop out of the study without penalty. In addition, they can complete the study while skipping any questions if they feel uncomfortable or unwilling to discuss the topic.

5.4 Describe the anticipated benefits of the research for individual subjects.

Participants will be given the opportunity to think about how they feel about their bodies and their sexuality, and may be given new insight into the connections between their body image and their sexual health. Additional benefits for the individuals include the opportunity to participate in innovative research that has the potential to inform prevention interventions in the future. The participants will also receive a small monetary benefit for participating.

5.5 Describe the anticipated benefits of the research for society or science, and explain how the benefits outweigh the risks.

The relationship between body image and sexual behaviors is not well understood. This study will add uniquely to the literature by combining two theoretical perspectives, testing the relationships among racially- and ethnically-diverse women, and exploring preventative sexual health and positive body image (rather than pathology-focused constructs). Therefore, this study has the potential to inform future interventions that may improve women's body image and increase preventative sexual health behaviors.

6. Data Collection & Security

6.1 Data collection methods *(Check all that apply)*

- ☐ Observation
- ☐ Interviews
- ☐ Focus groups
- ☒ Surveys/Questionnaires
- ☐ Psychological tests
- ☐ Educational tests
- ☒ Internet based methods
- ☐ Blood draw, saliva swab, or other biological sampling
- ☐ Tissue biopsies
- ☐ Audio recording
- ☐ Video recording
- ☐ Previously collected data (no individual identifiers)
- ☐ Previously collected data (with individual identifiers)
- ☐ Other

6.2 Procedures *(Describe the setting and tasks subjects will be asked to perform. Describe the frequency and duration of procedures, tests, and experiments. Include a time line or step by step listing.)*

Subjects will be provided with a link to the online survey, which will be collected and stored using REDCap. REDcap was chosen due to the sensitive nature of the information that will be collected and its ability to provide HIPAA-level protection of data. Protected health information will not be collected, but using REDCap will provide an additional layer of data protection. Researchers expect the survey to take less than 20 minutes to complete online.

Once subjects go to the survey link, they will be asked questions to determine if they meet the qualifications for the survey. A skip pattern will be used to take them to a page that either 1) thanks them for their time, but informs them that they do not meet the qualifications of the study or 2) begins the study.

Subjects that do not qualify for the study will not take any further steps. Those that do qualify and complete the online survey will take another REDCap survey where they will provide their name, address, and date of birth in order to receive the $10 incentive. The researcher will mail the incentives to the participants. While the researcher will have access to the participants' identifying information, she will not be able to connect it to their survey data.

6.3 Sharing results with Subjects *(Indicate if results like tests or incidental findings will be shared with the subject or others and if so, indicate how it will be shared.)*

Information will not be shared with participants.

6.4 Withdrawal of Subjects *(Describe the procedures to be followed when subjects withdraw from research or under what circumstances subjects may be withdrawn without their consent.)*

Participants may withdraw their consent to participate in this study at any time.

6.5 Protected data to be collected (Check all that apply)

- ☐ Protected health information
- ☐ Unique ID number (e.g. employee id, driver's license number)
- ☐ Academic records
- ☐ Social security number
- ☐ Other personally identifiable information

6.6 Describe the steps that will be taken to secure the data during storage, use, and transmission. How and where will the data be stored, for how long will it be kept, what safeguards are in place for data with identifying information. Include a description of physical and electronic security.

Steps will be taken to secure the data that is collected, including keeping all files in a locked cabinet and password securing all computer files.

6.7 Identify any direct identifiers like name, unique identifier, address, e-mail, etc. that will kept with the records. Explain why it is necessary to record the identifiers and describe the coding system to be used.

A unique identifier will be assigned to each participant. These will start with 1 and will be assigned in order of completed surveys.

6.8 If retaining a link between study code numbers and direct identifiers after data collection is complete, please explain why this is necessary, how long the link will be kept, and how it will be stored.

N/A

6.9 If using audio and video recording, describe how the recordings will be used, how confidentiality will be maintained, and how and when the recordings will be destroyed.

N/A

6.10 As part of the study will you:
1. Collect protected health information (PHI) from subjects in the course of providing experimental care, or
2. Have access to PHI in the subject's records?
If yes, please describe how you will satisfy the HIPAA requirements for authorization to use PHI in research below.
(Submit the Statement on Use of Protected Health Information (PHI) form)

N/A

7. Informed Consent

7.1 Specify the type of informed consent you will use with this research project.

☐ **Signed Consent**

Consent forms included with this submission:

☐ Adult ☐ Assent Script/Procedures

☐ Parent/Guardian ☐ Foreign Language version

☐ **Oral Consent** (Waiver of documentation of consent, include script with application)

☐ A signed consent form would be the only record linking the subject to the research, and the principal risk of signing a consent form would be potential harm resulting from a breach of confidentiality.

☐ The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside the research context.

☒ **Information Statement**

☐ **Debriefing Statement**

7.2 Describe any potential concerns with obtaining informed consent (Foreign language, minimizing possibility of coercion, etc.)

7.3 Describe the process you will follow to obtain consent and/or assent. Include names of individuals on the research team who will obtain consent, where and when the process will take place and how you will ensure the subject's understanding.

When participants go to the study website, they will be required to read through the information statement prior to starting the study. An information statement will be used since the data are to be collected online.

Appendix B: University of Kansas Human Subjects Approval Letter

KU RESEARCH & GRADUATE STUDIES
The University of Kansas

APPROVAL OF PROTOCOL

March 20, 2014

Virginia Ramseyer Winter
ginnywinter@ku.edu

Dear Virginia Ramseyer Winter:

On 3/20/2014, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title of Study:	The Effects of Sexual Objectification, Self-Objectification, Body Appreciation, and Quality of the Sexual Relationship on Preventative Sexual Health Behaviors among a Sample of Emerging Adult Women
Investigator:	Virginia Ramseyer Winter
IRB ID:	STUDY00000993

The IRB approved the study on 3/20/2014.

1. Any significant change to the protocol requires a modification approval prior to altering the project.
2. Notify HSCL about any new investigators not named in original application. Note that new investigators must take the online tutorial at https://rgs.drupal.ku.edu/human_subjects_compliance_training.
3. Any injury to a subject because of the research procedure must be reported immediately.
4. When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity.

Please note university data security and handling requirements for your project:
https://documents.ku.edu/policies/IT/DataClassificationandHandlingProceduresGuide.htm

You must use the final, watermarked version of the consent form, available under the "Documents" tab in eCompliance.

Sincerely,
Stephanie Dyson Elms, MPA
IRB Administrator, KU Lawrence Campus

Human Subjects Committee Lawrence
Youngberg Hall I 2385 Irving Hill Road I Lawrence, KS 66045 I (785) 864-7429 I HSCL@ku.edu I research.ku.edu

Appendix C: Information Statement

The School of Social Welfare at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

We are conducting this study to better understand relationships between sexual objectification, body image, and sexual behaviors among women who are in a committed sexual relationship. This will entail your completion of an anonymous online survey. Your participation is expected to take approximately 20 minutes. The content of the survey should cause no more discomfort than you would experience in your everyday life. Should you experience any discomfort, you may skip any questions you wish not to answer or you may stop taking the survey at any time by closing your browser. If you experience concerns related to your body image, mental health, or sexual health, and seek additional information or assistance, the following resources are available:

- Bert Nash Community Mental Health Center at 785-843-9192 or http://www.bertnash.com (for Douglas County, KS residents)
- Compass Behavioral Health Center at 620-276-7689 or http://compassbh.org (for Garden City, Kansas residents)
- Comprehensive Mental Health Services at 816-524-3652 or http://www.thecmhs.com/ (for Jackson County, MO residents)
- Garden City Community College Counseling and Advising at http://www.gcccks.edu/student/counselingadvising/ (for GCCC students)
- https://www.nami.org/
- http://www.plannedparenthood.org/health-topics/
- Johnson County Mental Health Center at 913-826-4200 or http://www.jocogov.org/dept/mental-health/home (for Johnson County, KS residents)
- Johnson County Community College Counseling and Advising Services at 913-469-3809 or http://www.jccc.edu/counseling/ (for JCCC students)
- Pathways Community Behavioral Healthcare, Inc. at 888-403-1071 or http://www.compasshealthhome.org/pathways-community-health (for Warrensburg residents)
- Rose Brooks Center (domestic violence center) at 816-861-6100 (crisis line) or http://www.rosebrooks.org
- University of Central Missouri Counseling Center at 660-543-4060 or http://www.ucmo.edu/cc/ (for UCM students)
- University of Kansas Counseling and Psychological Services at 785-864-2277 or http://www.caps.ku.edu/ (for KU students)
- University of Missouri-Kansas City Counseling Center at 816-235-1000 or http://www.umkc.edu/counselingcenter/ (for UMKC students)
- Valeo Behavioral Health Care at 785-233-1730 or http://www.valeotopeka.org/ (for Topeka residents)
- Washburn Counseling Services at 785-670-3100 or http://www.washburn.edu/current-students/services/counseling/ (for Washburn students)
- Willow Domestic Violence Center at 1-800-770-3030 (available 24/7) or http://www.willowdvcenter.org

- Wyandot Center at 913-233-3300 or http://www.wyandotcenter.org/ (for Wyandotte County, KS residents)

Although your participation in this research may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of how interventions that improve body image may impact sexual behaviors as well. Your participation is solicited, although strictly voluntary. Your name will not be associated in any way with the research findings. Your identifiable information will only be collected for the purposes of providing you with the incentive and will not be connected back to your survey data. Therefore, the information you provide is anonymous.

**It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response.*

***You will be paid $10.00 for your completion of the survey (though you may skip questions and still finish the survey if the questions cause you any discomfort). In order to receive your $10 compensation, you must provide an email address. If you do so, you will receive an email with the link to a survey where you will provide your contact information so the compensation can be mailed to you. If you don't provide an email address, you will have the option to choose between two sexual health-related organizations that will receive what would have been your $10 compensation. All email addresses will be permanently deleted once data collection is complete. Email addresses will not be shared with any one or any group. Your identifiable information will not be linked with the study, so your anonymity will not be compromised.*

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail.

Completion of the survey indicates your willingness to take part in this study and that you are at least 18 years old. If you have any additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email irb@ku.edu.

Sincerely,

Virginia Ramseyer Winter, MSW
Principal Investigator
School of Social Welfare
Twente Hall
The University of Kansas
Lawrence, KS 66045
(785) 864- 6492
ginnywinter@ku.edu

Margaret Severson, J.D., M.S.W.
Professor and Faculty Supervisor
School of Social Welfare
120 Twente Hall
The University of Kansas
Lawrence, KS 66045
(785) 864-8952
mseverson@ku.edu

Appendix D: Recruitment Flier

Are you a woman currently in a monogamous relationship with a male partner? If you are an adult female ages 18-25, you may be eligible to participate.

This study hopes to shed light on the experiences of women's body image and sexual behaviors. We welcome your participation. The online survey will take approximately 20 minutes to complete. Topics discussed will include: Body image, sexual behaviors, and experiences with sexual objectification.

If you are eligible and you complete the survey, you will receive $10.

Go to http://j.mp/1lKGSQE to determine your eligibility and participate in the study! Enter the web address just as it appears here or it won't work.

KU THE UNIVERSITY OF KANSAS search project of the KU School of Social Welfare.

Appendix E: Recruitment Email

From:
Date:
To:
Subject: Body image and sexual health study--participate today and earn $10!

Are you a woman currently in a monogamous relationship with a male partner?

If you are an adult female, ages 18-25, you may be eligible to participate!

This study hopes to shed light on the experiences of women's body image and sexual behaviors. We welcome your participation.
The online survey will take approximately 15-20 minutes to complete.
Topics discussed will include: Body image, sexual behaviors, and experiences with sexual objectification.

If you are eligible and you complete the survey, you will receive $10.

Click on https://redcap.ittc.ku.edu/surveys/?s=87ZYE9 to determine your eligibility and participate in the study!

Appendix F: Survey

Study Qualifiers

1. Do you identify as a woman?
   Yes No
2. Are you between 18-25 years old?
   Yes No
3. Are you currently pregnant?
   Yes No
4. Are you in a monogamous (neither one of you is seeing someone else) sexual relationship (you are having penile-vaginal intercourse) with a male partner for at least the last 3 months?
   Yes No

The following questions are related to how you feel about and view your body.

Body Appreciation Scale (Avalos et al, 2005) (Scale is reprinted with permission from Elsevier)
Next to each statement, please indicate the number that best reflects your feelings toward your body.

	1 Never	**2 Seldom**	**3 Sometimes**	**4 Often**	**5 Always**
I respect my body.	**1**	**2**	**3**	**4**	**5**
I feel good about my body.	**1**	**2**	**3**	**4**	**5**
On the whole, I am satisfied with my body.	**1**	**2**	**3**	**4**	**5**
Despite its flaws, I accept my body for what it is.	**1**	**2**	**3**	**4**	**5**
I feel that my body has at least some good qualities.	**1**	**2**	**3**	**4**	**5**
I take a positive attitude toward my body.	**1**	**2**	**3**	**4**	**5**
I am attentive to my body's needs.	**1**	**2**	**3**	**4**	**5**
My self-worth is independent of my body shape or weight.	**1**	**2**	**3**	**4**	**5**
I do not focus a lot of energy being concerned with my body shape or weight.	**1**	**2**	**3**	**4**	**5**
My feelings toward my body are positive, for the most part.	**1**	**2**	**3**	**4**	**5**
I engage in healthy behaviors to take care of my body.	**1**	**2**	**3**	**4**	**5**
I do not allow unrealistically thin images of women presented in the media to affect my attitudes toward my body.	**1**	**2**	**3**	**4**	**5**
Despite its imperfections, I still like my body.	**1**	**2**	**3**	**4**	**5**

Objectified Body Consciousness Scale-Self-Surveillance Subscale (McKinley & Hyde, 2006)
(Reprinted with permission from Sage Publications, Inc.)

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

	1 Strongly Disagree	**2**	**3**	**4 Neither Agree nor Disagree**	**5**	**6**	**7 Strongly Agree**
I rarely think about how I look.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I think it is more important that my clothes are comfortable than whether they look good on me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I think more about how my body feels than how my body looks.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I rarely compare how I look with how other people look.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
During the day, I think about how I look many times.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I often worry about whether the clothes I am wearing make me look good.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I rarely worry about how I look to other people.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I am more concerned with what my body can do than how it looks.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

These questions relate to your experiences how others treat you and your body.

Interpersonal Sexual Objectification Scale (Kozee, et al., 2007) (Reprinted with permission from Sage Publications, Inc.

Next to each statement, please indicate how often each has occurred in the past year.

	1 Never	**2 Rarely**	**3 Occasionally**	**4 Frequently**	**5 Almost Always**
How often have you been whistled at while walking down a street?	**1**	**2**	**3**	**4**	**5**

How often have you noticed someone staring at your breasts when you are talking to them?	**1**	**2**	**3**	**4**	**5**
How often have you felt like or known that someone was evaluating your physical appearance?	**1**	**2**	**3**	**4**	**5**
How often have you felt that someone was staring at your body?	**1**	**2**	**3**	**4**	**5**
How often have you noticed someone leering at your body?	**1**	**2**	**3**	**4**	**5**
How often have you heard a rude, sexual remark made about your body?	**1**	**2**	**3**	**4**	**5**
How often have you been honked at when you were walking down the street?	**1**	**2**	**3**	**4**	**5**
How often have you seen someone stare at one or more of your body parts?	**1**	**2**	**3**	**4**	**5**
How often have you overheard inappropriate sexual comments made about your body?	**1**	**2**	**3**	**4**	**5**
How often have you noticed that someone was not listening to what you were saying, but instead gazing at your body or a body part?	**1**	**2**	**3**	**4**	**5**
How often have you heard someone make sexual comments or innuendos when noticing your body?	**1**	**2**	**3**	**4**	**5**
How often have you been touched or fondled against your will?	**1**	**2**	**3**	**4**	**5**
How often have you experienced sexual harassment (on the job, in school, etc.)?	**1**	**2**	**3**	**4**	**5**
How often has someone grabbed or pinched one of your private body areas against your will?	**1**	**2**	**3**	**4**	**5**
How often has someone made a degrading sexual gesture towards you?	**1**	**2**	**3**	**4**	**5**

This section will ask you questions about your relationship with your current sexual partner.

1. How long have you been with your current sexual partner?
    a. 3-6 months
    b. 6-9 months
    c. 9-12 months
    d. 1-2 years
    e. 2-3 years
    f. 4+ years
2. How long have you and your current sexual partner been sexually active with one another?
    a. Less than 3 months
    b. 3-6 months
    c. 6-9 months
    d. 9-12 months
    e. 1-2 years
    f. 2-3 years
    g. 4+ years
3. Do you live with your current sexual partner?
    a. Yes
    b. No
4. How old is your current partner (in years)? _____

Relational Health Indices Peer Subscale, modified (Liang et al, 2002) (Reprinted with permission from Sage Publications, Inc.)

Next to each statement below, please indicate the number that best applies to your relationship with your current sexual partner.

	1 Never	**2 Seldom**	**3 Sometimes**	**4 Often**	**5 Always**
Even when I have difficult things to share, I can be honest and real with my partner.	**1**	**2**	**3**	**4**	**5**
After a conversation with my partner, I feel uplifted.	**1**	**2**	**3**	**4**	**5**
The more time I spend with my partner, the closer I feel to him.	**1**	**2**	**3**	**4**	**5**
I feel understood by my partner.	**1**	**2**	**3**	**4**	**5**
It is important to us to make our relationship grow.	**1**	**2**	**3**	**4**	**5**
I can talk to my partner about our disagreements without feeling judged.	**1**	**2**	**3**	**4**	**5**
I am uncomfortable sharing my deepest feelings and thoughts with my partner. **(R)**	**1**	**2**	**3**	**4**	**5**

I have a greater sense of self-worth through my relationship with my partner.	**1**	**2**	**3**	**4**	**5**
I feel positively changed by my partner.	**1**	**2**	**3**	**4**	**5**
I can tell my partner when he has hurt my feelings.	**1**	**2**	**3**	**4**	**5**
My relationship causes me to grow in important ways.	**1**	**2**	**3**	**4**	**5**

These questions are about your sexual health and sexual activity to which you consented.

Preventative Sexual Health Behavior Inventory

1. Have you and your partner talked about preventing pregnancy?
    a. Yes
    b. No. But, I do NOT want to get pregnant
    c. No. But, I DO want to get pregnant
2. Do you and your partner agree on your plan to prevent pregnancy?
    a. Yes
    b. No
    c. I don't know
    d. Does not apply
3. Do you take precautions to prevent pregnancy every time you engage in penile-vaginal intercourse?
    a. Yes
    b. No
4. In those times when you did not take precautions to prevent pregnancy, what were the reasons? _____ N/A
5. My current sexual partner told me about his complete history of protected and unprotected sex.
    a. Yes, he told me about his complete history
    b. Yes, he told me about some of his history
    c. He hasn't told me about any of his history
    d. I don't know if he has told me his complete history
6. I was tested for sexually transmitted diseases/infections in the time between being sexual with my last sexual partner and being sexual with my current sexual partner.
    a. Yes
    b. No
    c. I don't know
    d. Does not apply because my current sexual partner is my first sexual partner
7. I know my current partner was tested for sexually transmitted diseases/infections in the time between being sexual with his last sexual partner and being sexual with me.
    a. Yes
    b. No
    c. I don't know
    d. Does not apply because I am his first sexual partner

8. My current sexual partner has used IV drugs (putting a needle in one's arm or other body part to inject drugs).
    a. Yes
    b. No
    c. I don't know
9. My current sexual partner and I have talked about how we will prevent transmitting sexually transmitted infections/diseases.
    a. Yes
    b. No
    c. Does not apply
10. Do you take precautions to prevent sexually transmitted diseases/infections every time you engage in sexual behavior?
    a. Yes
    b. No
    c. Does not apply (We have both been tested, we have talked about our previous sexual history)
11. The vaccines to prevent HPV (Gardasil® or Cervarix®) require three shots. In regard to getting the vaccine:
    a. I have had all 3 shots
    b. I am in the process of getting the shots (I have had at least 1)
    c. I have not had any of the 3 shots
    d. I don't know
12. Have you had a Pap smear (exam done by a medical provider to detect cervical cancer) in the past 3 years?
    a. Yes
    b. No
    c. I don't know
13. Have you had a breast exam by a medical provider in the last 12 months?
    a. Yes
    b. No
    c. I don't know
14. Are you currently taking a daily vitamin with Folic Acid for your sexual well-being?
    a. Yes
    b. No
    c. I don't know

Please answer the following demographic questions.

1. How old are you (in years)? _____
2. What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.
    a. Less than high school graduate
    b. High school graduate—high school diploma or the equivalent (for example: GED)
    c. Some college
    d. Associate degree (for example: AA, AS)

    e. Bachelor's degree (for example: BA, AB, BS)
    f. Post-Bachelor's degree
3. Where are you currently enrolled in college?
    a. 2-year community college
    b. 4-year university
    c. Other
    d. I am not currently enrolled in college
4. Taking all of the income sources available to you into account, how would you describe your current economic class? (This question is informed by Satinsky, 2010)
    a. Poor
    b. Working class
    c. Lower middle class
    d. Middle class
    e. Upper middle class
    f. Upper class/wealthy
5. What is your race/ethnicity (select one):
    a. White/Caucasian
    b. Black/African American
    c. Hispanic/Latina
    d. American Indian or Alaska Native
    e. Asian
    f. Native Hawaiian or Other Pacific Islander
    g. Multiracial
    h. Other (please specify: _____)
6. Which of the following best describes the religion with which you identify, if any?
    a. Catholic
    b. Hindu
    c. Jehovah's Witness
    d. Jewish
    e. Mormon/Latter Day Saints
    f. Muslim/Islam
    g. Pagan
    h. Protestant (Baptist, Lutheran, Presbyterian, Episcopalian, Methodist)
    i. I don't identify with any specific religion
    j. Other, please specify _____
7. Which of the following best describes your sexual orientation (select one):
    a. Heterosexual
    b. Lesbian
    c. Homosexual
    d. Queer
    e. Bisexual
    f. Pansexual
    g. Asexual
    h. Other (please describe: _____)
8. Do you believe that men and women should have equal rights and opportunities?
    a. Yes

   b. No
   c. Unsure
9. What is your marital status?
   a. Married
   b. Divorced
   c. Widowed
   d. Never Married