Chapter

Don't Objectify Me!: Sexual Self-Monitoring, Coping, and Psychological Maladjustment

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Abstract

Undergraduate college students (283 females, 127 males) completed surveys aimed at measuring positive sexual awareness vs. sexual self-monitoring, coping styles, and psychopathological symptoms. Positive sexual awareness significantly positively correlated with adaptive coping styles but did not otherwise correlate with psychopathological symptoms. Sexual self-monitoring was significantly positively correlated with somatization, depression-anxiety, and avoidant coping in women but not men. Bootstrapped mediation analyses indicated that the relationships between sexual self-monitoring and somatization, depression-anxiety, and eating disorder symptoms were significantly mediated by avoidant coping in women but not in men. These results were explained in terms of Objectification Theory, suggesting that women who experience sexual objectification are more likely to engage in avoidant coping, thus increasing their risk of developing psychopathology. Findings are discussed in terms of broader issues of the disempowering effects of objectification.

Keywords: gender, sexual monitoring, coping, psychological maladjustment, objectification theory

1. Introduction

While men and women do not significantly differ in prevalence for most major mental disorders, such as schizophrenia and bipolar disorder, women suffer from anxiety, depressive, and post-traumatic stress disorders at higher rates than men [1–3]. One possible reason for this disparity in mental illness between men and women may be attributed to the unique experiences of women in Western society. Though women have made great strides towards equality in our society, there are still fundamental differences in the ways in which men and women are treated. Women suffer higher rates of domestic violence, sexual assault, and sexual abuse than do men [4] and are often relegated to roles as caregivers or helping professionals in both their career options and their roles at home. Furthermore, media portrayals of women (such as in advertisements and popular film) tend to oversexualize women and focus on their relationships to men rather than give them agency and character in their own right. Such objectification of women by society may create experiences for women which contribute to higher rates of anxiety, depression, and PTSD in women.

One cannot study gender roles and the effects of society on these roles without discussing the intersecting role played by women's sexuality. Throughout history, sexuality has been used to control or define women. In her book The Purity Myth, Valenti [5] comments on the long history of judging women as virtuous based on their sexual "purity". Furthermore, sexual objectification has been used as a tool to strip women of their power by using sexuality and sexual appeal to define a woman's value and worth to others. In extreme cases, because women are treated as commodities to be consumed by men, sexual objectification has been used to justify violence against women, including sexual and intimate partner violence. However, if sexual objectification is used to subjugate women, sexual agency may be key to women's empowerment.

To be an agent is to have power over one's own body and actions. Agents are able to act on the world. To be an agent means to have the power to determine one's own identity and worth, rather than have them defined by someone else. To have sexual agency is to not only have control over one's body and sexual behavior, but also to have the confidence and awareness to use that control. Such power and control over one's sexuality has its benefits. In their commentary, Rosen and Bachmann [6] stated that the relationship between sexual satisfaction and well-being in women was an important and under-studied topic in health psychology.

Across studies, Rosen and Bachman [6] noticed a strong positive relationship between a woman's reported happiness and sexual satisfaction. This relationship has found continued support in the literature. Holmberg et al. [7] reported that sexual satisfaction was a predictor of well-being in women in both same-sex and mixed-sex relationships. Donaghue [8] found that a passionate/romantic sexual self-schema (one which indicated a greater interest and enjoyment of sex) was significantly associated with positive affect and greater life satisfaction. In one longitudinal study, sexual well-being was found to have not only a greater association with well-being in women over time, but also well-being from moment to moment [9]. Furthermore, this relationship has not only been found in America, but across countries. Carrobles et al. [10] found that, in a sample of Spanish women, greater sexual assertiveness, sexual confidence, and frequency of orgasm all predicted a greater sexual satisfaction, which in turn predicted a greater perception of well-being. In a survey of 13,882 women across 29 different countries, Laumann et al. [11] found a positive relationship between sexual satisfaction and psychological well-being across all countries. Interestingly, a study by Owen et al. [12] found that students who reported more depressive symptoms also reported improved well-being after engaging in casual sex, while students who reported fewer depressive symptoms reported decreased well-being after casual sex. This suggests that sex can be used as a tool for emotional regulation, lending further support to the relationship between sexuality and well-being. Across cultures and ages, sexual satisfaction has been found to have a strong relationship to psychological well-being.

1.1 Sexual monitoring, objectification theory, and women's mental health

A negative aspect of sexual consciousness, however, is self-consciousness and monitoring of one's sexual desirability. In women, such sexual self-monitoring has been found to be associated with lower sexual assertiveness and sexual activities [13]. Sexual self-monitoring is an important aspect of the self-consciousness about one's body image. Sexual self-monitoring is much more prevalent in women than men and is predictive of a range of sexual problems and sexual dissatisfaction in women [14]. Sexual monitoring strips a woman of her sexual agency by making her self-worth dependent on the judgments of others, and this disempowerment may be associated with decreased well-being in women.

This phenomenon can be explained by Objectification Theory. Objectification Theory uses a feminist theoretical framework to understand how a woman's experience is influenced by a culture which objectifies the female body [15]. Objectification Theory posits that the experience of being treated as a "body" to be consumed by others (i.e., an object) results in a number of adverse psychological experiences for women [15]. Objectification occurs through the over-sexualization of women's bodies through obvious means, such as sexualization in the media, and also through more subtle means, such as the interactions between women and the men who engage in behaviors, such as catcalling and "elevator eyes" or the "objectifying gaze" [15]. In contrast to sexual agency, men who objectify women are more likely to report pressuring/coercing women for sex, while women who feel objectified are more likely to report being pressured/coerced for sex [16].

Because women are often treated as consumable objects, they are evaluated by their attractiveness to others, rather than their inherent dignity and worth as a person. Through self-objectification, women internalize objectifying messages from society, thus diminishing the worth of their personal attributes and focusing heavily on their physical attributes. As a result, women often feel ashamed of their bodies and engage in unhealthy behaviors, such as disordered eating, in an attempt to improve their attractiveness to others [17, 18]. Even in girls as young as 6 years old, self-objectification has been found to affect eating habits and body anxiety [19].

Increasing evidence has shown that self-objectification negatively affects a woman's mental health [20, 21]. In their comprehensive review of objectification theory, Tiggeman and Williams [21] found that self-objectification strongly predicted depressed mood and disordered eating in young women, as well as, though less strongly, predicting sexual dysfunction. Self-objectification has also been found to significantly predict the development of disordered eating in both adolescent girls and young women [18, 20]. The body shame and appearance anxiety caused by self-objectification have been shown to increase depressed mood [22]. Furthermore, Carr et al. [23] argue that objectification of women's bodies can also exacerbate serious mental illnesses, such as schizophrenia and borderline personality disorder, by further marginalizing women whose mental illness has already marginalized them.

1.2 Objectification theory, objectification, and coping

Objectification Theory can provide insight into the link between objectification and mental illness in women. It may be that objectification interferes with a woman's ability to cope with stressors, resulting in a higher likelihood of developing mental illness. Coping styles often predict how well a person is able to overcome stressors [24]. Avoidant coping, or emotion-focused coping, is a more passive coping style, which has been shown to result in higher symptoms of depression and anxiety [24, 25]. In contrast, active, or problem-focused, coping has been shown to increase psychological well-being in the face of stressors [25–27]. Figueroa et al. [28] found that psychological well-being in the face of stressors, such as poverty, was predicted by use of problem-focused coping rather than emotion-focused coping.

Despite well-documented positive effects of problem-focused coping, women tend to engage more in avoidant, or emotion-focused, coping styles. This can often lead to higher psychological distress in women [29], though adult women are not the only ones who engage in emotion-focused coping. In their study of adolescent girls, Broderick and Korteland [30] found that girls engaged more often in emotion-focused coping than did boys and thus were more likely to develop depressive symptoms. This finding indicates that emotion-focused coping in women may be cultivated from a young age.

Few studies have explored why these gender differences exist in coping styles, though there is evidence that links gender differences in coping styles to gendered beliefs. Broderick and Koreland [30] found that the more adolescent girls believed in traditional gender roles, the more likely they were to engage in passive coping styles. In their analysis of coping and gender, Banyard and Graham-Bermann [31] argued that societal factors, such as power differences between men and women, affected the way in which women cope with stress. Gendered beliefs and power differences are not inherent in women; they are developed through the way society treats women. From a feminist theoretical perspective, one can see how gendered beliefs and a sense of powerlessness promote passive coping styles in women. In the context of Objectification Theory, it is possible to attribute this to the objectification of women. When women are objectified, their identity and worth are defined by others [15], stripping women of their most basic power, the ability to define one's own identity and worth. It is possible that, through this process (the loss of basic power and agency), women learn to become passive and thus engage more frequently in passive coping.

1.3 Hypotheses

The present study examined the relationships between positive sexual awareness, sexual self-monitoring, coping, and psychopathological symptoms in a college student sample. Using the Sexual Awareness Questionnaire [32], we hypothesized that positive sexual awareness would be positively related to adaptive coping and negatively related to symptoms of psychopathology, while sexual self-monitoring, indicative of being objectified, would be positively related to avoidant, passive coping and symptoms of psychopathology. Analyses also tested whether the relationships between sexual self-monitoring and symptoms of psychopathology were mediated by avoidant coping. Given the greater salience of objectification for women than men, it was also hypothesized that the above relationships would be stronger for women than for men.

2. Methods

2.1 Participants

Four hundred thirteen undergraduate psychology students (283 female, 127 male, 1 other, 2 not reported) at a large southwestern state university completed an anonymous online survey for research participation credit. The majority of the participants identified as straight (90.1%), followed by bisexual (5.8%), gay or lesbian (2.7%), and other (1.2%). The mean age of the sample was 19.4 years (SD = 2.7) for women and 20.0 years (SD = 3.0) for men. The race/ethnicity of the sample was 38.0% Caucasian/White, 26.6% Hispanic/Latino, 20.1% Asian/Pacific Islander, 11.1% African American/Black, and 3.6% other. Almost half of the participants (45.4%) defined themselves as not currently dating, followed by steady or exclusive daters at 38.3%, occasionally dating at 10.9%, married 2.4%, and engaged 2.7%.

2.2 Measures

Reported Cronbach's alphas are based on the present sample.

Somatization was measured by the Patient Health Questionnaire PHQ-15 Somatic Symptom Severity scale [33, 34] ($\alpha = 0.77$), which consists of 15 questions asking about how often one has been bothered by somatization symptoms, such as

"stomach pain" and "dizziness," in the past 2 weeks. Responses are coded 0 = "Not Bothered," 1 = "Bothered A Little," and 2 = "Bothered A Lot." Scores are the sum of the responses across the 15 items.

Depression was measured by the Patient Health Questionnaire PHQ-9 Depression scale [35] (α = 0.85), which consists of 9 questions asking about the frequency of depressive symptoms one has experienced in the past 2 weeks, with items such as "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless." Responses are coded 0 = "Not at all," 1 = "Several days," 2 = "More than half the days," and 3 = "Nearly every day." Scores are the sum of the responses across the 9 items.

Anxiety was measured by the Patient Health Questionnaire GAD-7 Anxiety scale [36] (α = 0.82), which consists of 7 questions asking about the frequency of anxiety symptoms one has experienced in the past 4 weeks, with items such as "Feeling nervous, anxious, on edge, or worrying a lot about different things." Responses are coded 0 = "Not at all," 1 = "Several days," 2 = "More than half the days," and 3 = "Nearly every day." Scores are the sum of the responses across the 7 items. Since the depression and anxiety scales were highly correlated (r = 0.78), they were combined (averaged) to form a composite depression-anxiety scale.

Eating disorder symptoms were measured by the Patient Health Questionnaire PHQ-ED Eating Disorder scale [34] (α = 0.70), which consists of 8 yes-no questions asking about the occurrence of behaviors indicative of a binge eating disorder. An example item is "Do you often feel that you can't control what or how much you eat?" Scores are the number of yes responses across the 8 items.

Sexual awareness was measured by the Sexual Awareness Questionnaire [32], a 36-item self-report measure designed to measure four personality traits associated with sexual awareness and assertiveness: sexual consciousness (the tendency to think about one's own sexuality; "I am very aware of my sexual feelings"; α = 0.85), sexual monitoring (the awareness one has of the impression one's sexuality makes on others; "I'm concerned about the sexual appearance of my body"; α = 0.76), sexual assertiveness (the tendency to be assertive in one's sexual desires; "I'm assertive about the sexual aspects of my life"; α = 0.80), and sex appeal consciousness ("I am quick to sense whether others think I'm sexy"; α = 0.93). Participants are asked to indicate, on a scale of zero to four, how characteristic of him/her each statement is. Subscale scores are the sum of the responses on the relevant items. Sexual consciousness correlated 0.64 with sexual assertiveness in the present sample, so these 2 scales were combined (averaged) to form a positive sexual awareness scale, in contrast to the sexual self-monitoring scale, which may reflect one's acceptance of being sexually objectified. The 3-item sex appeal consciousness subscale was not used in the present analyses. The Sexual Awareness Questionnaire has been validated on a population of undergraduate students.

Coping was measured by the Brief COPE [37], which consists of 14 two-item subscales that measure different coping responses. For the present study, participants were asked to report on their coping behaviors in the past year (indicative of a "coping style") using a 4-point response scale ranging from 1 = "I haven't been doing this at all" to 4 = "I've been doing this a lot." Six of the subscales (active coping, emotional support, instrumental support, positive reframing, planning, acceptance) were combined (averaged) to form an adaptive coping scale (α = 0.82). Three of the subscales (denial, substance use, behavioral disengagement) were combined to form an avoidant coping scale (α = 0.73). While Carver [37] states that the separate COPE subscales are not meant to be combined into necessarily adaptive vs. maladaptive avoidant coping, the above schema made sense in terms of the idea of agency discussed above, and the alphas for the composite scales indicate that the separate COPE subscales did cluster within the composite scales.

3. Results

Independent sample t-tests compared sex differences in somatization, depression-anxiety, eating disorder symptoms, positive sexual awareness, sexual self-monitoring, and adaptive and avoidant coping (**Table 1**). Women scored significantly higher than men on somatization and depression-anxiety, while men scored higher than women on both sexual consciousness/assertiveness and sexual monitoring.

Table 2 presents the correlations among somatization, depression-anxiety, eating disorder symptoms, sexual consciousness/assertiveness, sexual self-monitoring, and adaptive and avoidant coping separately by gender. For both women and men, somatization, depression-anxiety, and eating disorder symptoms were significantly positively correlated with each other. Contrary to hypotheses, however, these disorders were not significantly negatively correlated with positive sexual awareness (consciousness + assertiveness). These disorder symptoms were, on the other hand, positively correlated

	Gender		*t*
	Female	Male	
	M (*SD*)	*M* (*SD*)	
Somatization	6.37 (3.94)	3.88 (3.55)	−5.71**
Depression-anxiety	6.29 (4.22)	5.37 (3.87)	−2.02*
Eating disorder	0.89 (1.40)	0.87 (1.33)	−0.14
Positive sexual awareness	13.78 (5.47)	15.22 (4.88)	2.34*
Sexual monitoring	17.50 (7.25)	19.26 (6.28)	2.26*
Adaptive coping	2.83 (0.62)	2.74 (0.67)	2.34*
Avoidant coping	1.55 (0.63)	1.60 (0.74)	2.56*

*$p < 0.05$.
**$p < 0.001$.

Table 1.
Means and standard deviations by gender.

	Som.	Dep.-anx.	ED	Pos. sex. aware.	Sex. mon.	Adapt. coping	Avoid. coping
Somatization		0.53***	0.19**	0.04	0.14*	0.04	0.31***
Depression-anxiety	0.60***		0.28***	0.00	0.17**	−0.02	0.41***
Eating disorder	0.30**	0.31***		0.02	0.12	−0.03	0.37***
Positive sexual awareness	0.05	−0.07	0.01		0.20***	0.15*	−0.01
Sexual monitoring	0.17	0.05	0.13	0.33***		0.08	0.19**
Adaptive coping	0.20*	0.08	−0.03	0.32***	0.17		0.14*
Avoidant coping	0.18	0.14	0.28**	0.04	0.13	0.38***	

[a]*Women above the diagonal and men below the diagonal.*
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

Table 2.
Correlations among variables[a].

with sexual self-monitoring for men and women, with these correlations reaching statistical significance for women. As expected, for both women and men, positive sexual awareness was significantly positively correlated with adaptive coping, while sexual self-monitoring was significantly positively correlated with avoidant coping for women. The one notable gender difference in the correlations was the higher correlations of avoidant coping with somatization, depression-anxiety, and eating disorder symptoms for women than for men, with this difference reaching statistical significance for depression-anxiety (Fisher's z-test = −2.73, $p < 0.01$).

The patterns of correlations suggested that avoidant coping might be significantly mediating the relationships between sexual monitoring and psychopathology particularly in women. To test this, a path analysis (**Figures 1** and **2**) was conducted that modeled positive sexual awareness and sexual self-monitoring as exogenous variables predicting adaptive and avoidant coping that, in turn, were tested as predictors of somatization, depression-anxiety, and eating disorder symptoms. Combined and separate analyses were also run for sex, with a difference chi-square calculated for the combined analyses to test for the equivalence of the estimated paths for the male versus female matrices. Mediation effects were tested using the

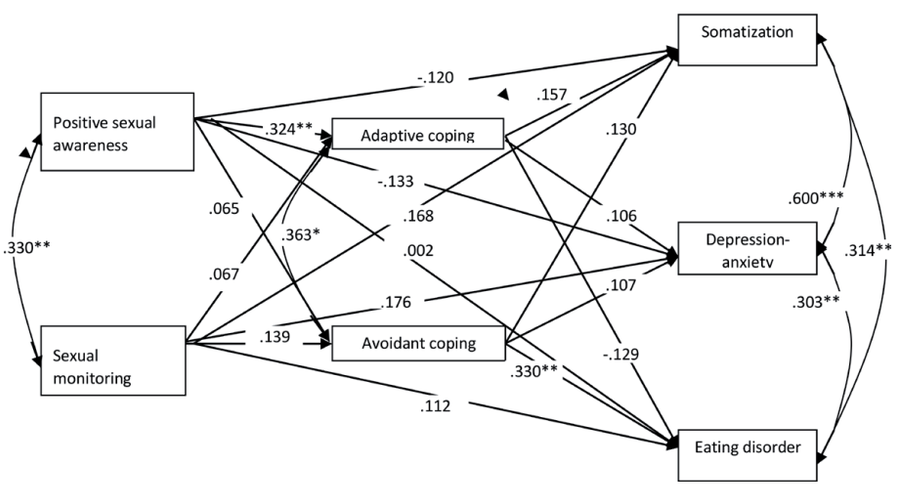

Figure 1.
Path diagram showing standardized estimates for the model testing direct and indirect pathways between positive sexual awareness, sexual monitoring, coping, and psychological maladjustment: Men. $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

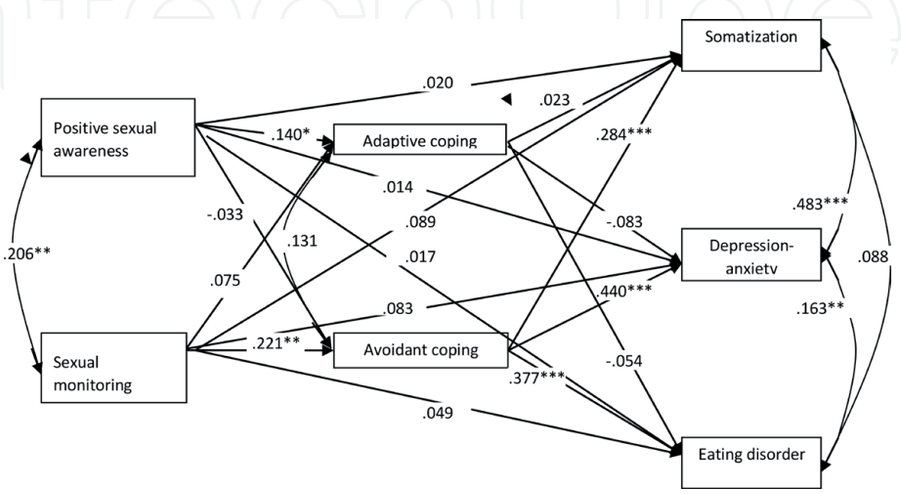

Figure 2.
Path diagram showing standardized estimates for the model testing direct and indirect pathways between positive sexual awareness, sexual monitoring, coping, and psychological maladjustment: Women. $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

bias corrected bootstrapping of confidence intervals option in Mplus version 5.21 [38] with maximum likelihood estimation using the covariance matrix. Missing data were handled using full information maximum likelihood.

Results of the path analyses are presented separately for the male and female estimates, as the difference chi-square for this model approached significance (χ^2 = 30.267, 21 df, p = 0.087, CFI = 0.967, RMSEA = 0.047), and there was a theoretical reason for expecting gender differences in the pathways. It is notable, that while positive sexual awareness was significantly positively predictive of adaptive coping for men and women, sexual self-monitoring was only significantly predictive of avoidant coping in women. Controlling for sexual monitoring, avoidant coping was a significant predictor of somatization, depression-anxiety, and eating disorder symptoms for women and of eating disorder symptoms in men. The direct paths from sexual self-monitoring to psychopathology were not significant for women or men. Bootstrapped mediation analyses indicated that for men the relationships between sexual self-monitoring and psychopathology were not significantly mediated by avoidant coping (95% confidence interval: −0.010, 0.063 for somatization; −0.008, 0.060 for depression-anxiety; −0.004, 0.033 for eating disorders). In contrast, all of these mediated pathways were significant for women at the 0.01 significance level (99% confidence interval, 0.004, 0.085 for somatization; 0.011, 0.134 for depression-anxiety; 0.004, 0.037 for eating disorders). None of the indirect paths involving positive sexual awareness or adaptive coping were significant.

4. Discussion

This is the first study to differentiate the effects of positive vs. negative aspects of sexual awareness/consciousness on coping and psychological functioning. While men scored higher than women on both positive sexual awareness (sexual consciousness and sexual assertiveness) and sexual self-monitoring, the patterns of correlations and path analysis results suggest that sexual self-monitoring has different meanings and implications for men vs. women. A study by Gillen et al. [39], in fact, suggests that such sexual self-consciousness may reinforce traditional gender beliefs about sexuality. As expected, positive sexual awareness was associated with greater adaptive coping in men and women, but sexual self-monitoring was more associated with avoidant coping in women than men. In support of Objectification Theory, sexual self-monitoring and avoidant coping were more predictive of psychopathological symptoms in women than men, and the relationships between sexual self-monitoring and psychopathological symptoms were significantly mediated by avoidant coping only in women. These results indicate that women who score high in sexual self-monitoring tend to engage in avoidant coping styles, which in turn contributes to higher rates of reported symptoms of depression, anxiety, somatization, and disordered eating. In contrast, women who scored high on sexual consciousness/assertiveness were found to engage in more active coping styles, although no mediation relationship was found between this and symptoms of mental illness. In the context of Objectification Theory, these results are to be expected. Sexual self-monitoring, which indicates a person's fixation on his/her attractiveness to others, can serve as an indicator of sexual objectification, as women who experience objectification often become fixated on their body and attractiveness to others [19].

The implications for this study are two-fold. First, this study supports the idea that the sexual objectification of women contributes to poor mental health outcomes by taking away their sense of agency. Second, this study suggests that therapeutic interventions which incorporate agency may be beneficial for work with women, including perhaps those who have suffered some form of sexual violence.

4.1 Limitations and future directions

While the sample was recruited from an ethnically diverse population, all participants were college students from a university in a particular region of the U.S., which limits generalizability. The cross-sectional nature of the research also limits causal inference. Future research should focus on how experiences of objectification, especially in women, lead to maladaptive coping behaviors and increased risk of psychopathology. In addition to positive and negative sexual awareness, future studies should directly measure self-perceived self-objectification [40]. Research on therapeutic practices with women should consider ways in which sexual and gender empowerment may produce salutary effects through increasing adaptive coping behaviors.

Future studies of objectification should also focus on the other forms objectification takes, such as treating a person as a servant or otherwise denying their humanity [41]. This is prevalent in cases of domestic violence, where an abusive partner abuses in order to maintain power and control over his partner, so that he/she remains focused on meeting the abuser's needs [42]. This study also calls for an exploration of objectification and its effects on coping and psychological maladjustment in other populations. Members of racial/ethnic minorities in the U.S. often experience the objectification of their bodies [43], and children who suffer childhood abuse may also have parents who view them as objects [44].

Respect for the autonomy of others is at the core of many moral philosophies. Martin Buber [45] explicitly distinguishes between I-thou relationships between autonomous conscious beings versus I-it relationships between such beings and inanimate objects. I-thou relationships require a moral consciousness, while treating a person as if they were an object is inherently immoral. Meanwhile, psychologists [46] have recognized the role of autonomy in enabling moral consciousness and behavior. The present study shows how the objectification of women in the context of their sexuality not only strips women of their autonomy, with consequent deleterious effects on their psychological functioning, but is also inherently immoral. Beyond working to achieve political and economic gender equality, public policies and educational practices should also work to encourage women to be empowered in their sexuality rather than objects in a male-controlled world.

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