The Relationship between Body Image and Sexual Functioning among Partnered Heterosexual Women

by

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ABSTRACT

THE RELATIONSHIP BETWEEN BODY IMAGE AND SEXUAL FUNCTIONING AMONG PARTNERED HETEROSEXUAL WOMEN

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The objective of this thesis was to determine whether evaluative body image, affective body image, and behavioural body image were predictive of women’s sexual desire, arousal and orgasm. Results are based on self-report and body composition data from 88 women (a subset of a larger data set including men) in heterosexual romantic relationships at the time of data collection. Hierarchical multiple regression indicated that poor evaluative, affective and behavioural body image were detrimental to women’s sexual functioning. Specifically, dissatisfaction with one’s body predicted decrements in desire ($\beta = -.31$, $p < .05$) and arousal ($\beta = -.35$, $p < .01$). Similarly, feeling that others evaluate one’s body negatively, predicted decrements in desire ($\beta = .22$, $p < .05$) and arousal ($\beta = .35$, $p < .01$). Feeling negatively about one’s appearance predicted decrements in arousal ($\beta = .26$, $p < .05$). Negative thoughts and feelings about one’s body that influence sexual behaviours (body image self-consciousness) predicted decrements in arousal ($\beta = -.37$, $p < .01$) and orgasm ($\beta = -.25$, $p < .05$). Implications for public health messages, treatment programs, sexual problem assessments and directions for future research are discussed.
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List of Abbreviations

BESAA .......................................................... Body Esteem Scale For Adolescents and Adults
BIAQ .......................................................... Body Image Avoidance Questionnaire
BISC .......................................................... Body Image Self Consciousness
BMI .................................................................. Body Mass Index
DSM .......................................................... Diagnostic and Stastical Manual of Mental Disorders
DXA .......................................................... Dual Energy X-Ray Absorptiometry
EDI .......................................................... Eating Disorders Inventory
FSFI .......................................................... Female Sexual Functioning Index
GMREL .................................................. Global Measure of Relationship Satisfaction
HSRC .......................................................... Human Sexual Response Cycle
MRT .......................................................... Medical Radiation Technologist
Rel Sat .......................................................... Relationship Satisfaction
Rel Length ...................................................... Relationship Length
STI .......................................................... Sexually Transmitted Infection
Chapter One: Literature Review

Introduction

Research has demonstrated that disruptions to sexual functioning are prevalent among men and women. Early ejaculation and erectile difficulties are examples of sexual problems frequently reported by men. In contrast, lack of interest in sex and inability to reach orgasm are examples of sexual problems or sexual dysfunctions commonly reported by women (Laumann et al., 2005; Laumann, Paik, & Rosen, 1999; Mercer et al., 2003). Current research suggests that sexual problems/sexual dysfunctions are not specific to one domain of sexual functioning, but, in fact, occur across domains. Further, research has identified that disrupted sexual functioning can lead to psychological distress and relationship problems (Mercer, et al., 2003; Shifren, Monz, Russo, Segreti, & Johannes, 2008).

Recent research has begun to focus on psychological factors in the etiology of disrupted or diminished sexual functioning. This research has revealed that affect and cognitions play an important role in the sexual functioning of both men and women (Dove & Wiederman, 2000; Meana & Nunnink, 2006; Purdon & Holdaway, 2006). In particular, body image has emerged as a cognition threatening to sexual functioning, especially among women (Sanchez & Kiefer, 2007; Weaver & Byers, 2006). However, research focusing on negative body image as a threat to sexual behaviours has largely emerged in the last decade, as such, conclusive evidence of the extent to which body image impacts women’s sexual functioning, and the mechanisms by which this occurs, is not yet available. Therefore, the purpose of the proposed research was to evaluate the extent to which body image impacts the sexual functioning among women above and
beyond relationship length, relationship satisfaction and percent body fat. Specifically, this study investigates the relationship between three different dimensions of body image (evaluative, affective and behavioural) and women’s experience of desire, arousal and orgasm.

Models of Sexual Response

Sexual functioning refers to a series of bodily responses and/or behaviours (Rosen et al., 2000). The bodily responses and/or behaviours that comprise sexual functioning are defined by sexual response models. Several sexual response models have set forth the components of sexual functioning (Basson et al., 2001; Kaplan, 1977; Masters & Johnson, 1966). To provide a framework for understanding sexual dysfunction, Masters and Johnson (1966) developed the Human Sexual Response Cycle (HSRC), in which sexual functioning was conceptualized as a linear process comprised of physiological stages. Excitement, defined by physiological preparedness to engage in sexual activity, was the initial phase in this model. The plateau phase followed and was characterized as the time between excitement and maximum pleasure. The plateau phase was followed by orgasm which was defined by the experience of extreme pleasure and satisfaction. Finally, the model concluded with a resolution stage in which an individual returned to a pre-aroused state. In 1977, Helen Zinger Kaplan challenged the purely physiological nature of the HSRC model. Kaplan argued that the model lacked consideration of interest in or desire for sex. As defined by Kaplan, sexual desire referred to an individual’s hunger, desire or interest in sexual activity. Kaplan proposed that interest in or desire for sex (sexual desire) initiated the sexual response cycle (Kaplan, 1977). In her model, she retained the HSRC concepts of excitement (renamed arousal), orgasm, and resolution,
and situated these following the desire component. Kaplan’s strong argument for the inclusion of sexual desire into sexual response has lead to a theoretical combination of the two models. Notably, the combined models are currently used as a framework for identifying sexual dysfunctions in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The Masters & Johnson/Kaplan model of sexual response begins with desire, followed by the experience of arousal, followed by orgasm and concludes with resolution (see Figure 1).

**Figure 1**

*The Human Sexual Response Cycle (Kaplan, 1977)*

Recently, clinical professor Rosemary Basson proposed a new sexual response model (Basson, 2000). This model conceptualizes sexual response as circular and interactional. The role of orgasm is deemphasized and eliminated is the prescriptive chronology of actions present in the two previous models. Basson’s changes were the result of her belief that sexual encounters are different within and between individuals and that they all begin and end differently (Basson, 2001). Basson originally developed her model to describe women’s sexual response (2000), however she subsequently
published an article entitled Human Sex-Response Cycles, indicating this model is also reflective of men’s sexual response (Basson, 2001). Sand and Fisher (2007) asked women between the ages of 29 and 69 to indicate which sexual response model (Masters and Johnson’s, Kaplan’s or Basson’s) was most reflective of their experience. An equal proportion of women endorsed each of the three models (Masters and Johnson, Kaplan and Basson). However, women with sexual difficulties were more likely to endorse the Basson model. Despite its intuitive appeal, Basson’s model does not have a body of empirical literature to support its use in delineating the components of sexual functioning or in making clinical diagnoses of sexual dysfunctions (Rosen, et al., 2000). Given this, the HSRC with Kaplan’s contribution of sexual desire was used in thesis to delineate the components of sexual response.

Components of Sexual Response

Desire. Although not identified in the original Masters and Johnson sexual response model, desire refers to a cognitive appetite for sex (Kaplan, 1977). The cognitive appetite for sex (desire) is believed to motivate an individual to initiate or become responsive to sexual stimuli (Kaplan, 1977; Rosen & Beck, 1988). Desire is considered a sexual response informed by physiological, psychological and cultural/sociological factors (Kaplan, 1977).

Arousal. Cognitive arousal theory states that sexual arousal, excitement in the Masters and Johnson/Kaplan model, is a sexual response which is the product of cognitive and physiological processes. Specifically, arousal requires the cognitive appraisal of a stimulus to be arousing which leads to a physiological response (i.e., vasocongestion) (Rosen & Beck, 1988). The concept of arousal is commonly understood
as the sum of subjective arousal and physiological arousal (Janssen, Everaerd, Spiering, & Janssen, 2000). Subjective arousal refers to the cognitive appraisal of a stimulus and physiological arousal is most often defined as vasocongestion (Rosen & Beck, 1988).

Predominant in the field of sexuality today is debate about a lack of distinction between women’s desire and subjective arousal (Brotto, 2010; Graham, 2010; Laan & Both, 2008; Laan & Janssen, 2007b). Although the field is pushing toward merging sexual arousal and sexual desire problems in the forthcoming DSM-V, there currently is not enough evidence to indicate sexual desire and arousal are not distinct constructs. Thus, for the purpose of this thesis, desire and arousal will be considered as separate experiences with an understanding that there is overlap between the two.

**Orgasm.** Orgasm was originally conceptualized by the Masters and Johnson/Kaplan model of sexual response as a psychophysiologic experience (Masters & Johnson, 1966). Psychologically, it is defined as the subjective perception of a sexual peak. Physiologically, it is defined as a release of sexual excitement that has escalated. Orgasm has been thought to occur in response to sexual stimuli and as a result of vasocongestion which is released via muscle contractions (Masters & Johnson, 1966). Orgasm has been identified as occurring at a maximum level of sexual tension. However, the duration of activity preceding orgasm varies, the duration of the orgasm varies and orgasm is experienced at different intensities, particularly for women. Consequently, it is believed that orgasm must be studied as a response comprised of interactions between physiological and psychosocial factors and responses (Masters & Johnson, 1966).
The Push-Pull Model of Incentive Motivation and Sexual Script Theory

The sexual response models identify sexual responses and characterize the cognitive and physiological processes associated with each response. Further, the models recognize that sexual functioning is a “psychosomatic” process, comprised of the interaction between physiological and psychological processes (Basson, et al., 2001). Despite this, the models do not make explicit the mechanisms whereby psychological and physiological processes interact to initiate, sustain and link sexual responses. However, these processes are described in the push-pull model of incentive motivation.

Push-Pull Model of Incentive Motivation (Laan & Both, 2008; Laan, Everaerd, Van Der Velde, & Geer, 1995; Laan & Janssen, 2007a) suggests that cognitive-affective processing of sexual cues result in sexual responses (both physiological and psychological). The model proposes that cognitive appraisal of a stimulus initiates the response cycle. Considering humans have limited attention capacity, the model posits that an individual must have available attention capacity to appraise the cue (Barlow, 1986). If attention capacity allows for a stimulus to be recognized as such, an emotional response is generated. The valence of the emotional response is largely influenced by previous experience with the sexual cue. For instance, a positive previous experience with a stimulus is likely to result in positive affect whereas a negative previous experience will likely result in negative affect. The emotional valence of a response to a sexual cue initiates one of two feedback loops (Barlow, 1986; Rosen & Beck, 1988).

Positive emotion is believed to initiate the positive feedback loop, facilitating an individual to consciously or unconsciously approach or pursue the sexual cue. Further, the positive affect allows for uninhibited attention focused on the sexual cue and the possible ensuing sexual encounter. Negative emotion initiates a negative feedback loop
which may potentially lead to a conscious or unconscious avoidance of that sexual cue (Heiman, 1980; Janssen, et al., 2000; Koukounas & McCabe, 2001; Laan, Everaerd, van Bellen, & Hanewald, 1994) (Figure 2). The negative affect may not directly facilitate an avoidance of the sexual cue; however it has the potential to occupy a significant portion of one’s attention, thus indirectly disrupting sexual response. In summary, the push-pull model of incentive motivation describes sexual response as the product of an interaction between sexual cues and cognitive-affective processing. Using the push-pull model of incentive motivation, sexual dysfunction or sexual problems can be caused by cognitive appraisal that inhibits sexual response (i.e., determination that the cue is not sexual) and/or negative feelings elicited in response to a cue that directly disrupts sexual response (i.e., make a sexual cue unappealing) or indirectly disrupts sexual response by diminishing attention capacity. Important to note, sexual problems can occur as a result of many other factors (e.g., physical illness, drug treatment side effect), the push-pull model of incentive motivation’s explanation of sexual problems is specific to cognitive appraisal of environmental, psychological and social stimuli.
Sexual scripts as defined by Simon and Gagnon (1986) are cognitive blueprints for what factors (i.e. environmental, social and psychological factors) initiate and facilitate sexual response and sexual behaviours. The content of scripts is informed by cultural norms, interpersonal interaction and intrapsychic elements (personal characteristics) (Simon & Gagnon, 1986). Sexual script theory and the push-pull model of incentive motivation can be used in conjunction to explain sexual behaviour and response. Sexual script theory explains what factors (e.g., psychological factors) are relevant to sexual response and the push-pull model of incentive motivation delineates how these factors can enhance or disrupt sexual response.

**Research on Sexual Functioning**

Debate around terminology for disrupted or diminished sexual functioning is prominent in sexuality literature. The term sexual dysfunction has been criticized for its
medicalization of sexuality and its implication that a ‘normal’ sexual standard exists (Tiefer, 2010). As a result, sexuality research is divided, with some studies using ‘sexual problems’ and others using ‘sexual dysfunction’ as the construct of interest. The term ‘sexual problem’ has been typically used to denote a sexual occurrence with which an individual is disturbed or unhappy (Laumann, et al., 2005; The Working Group of A New View of Women’s Sexual Problems, 2002). A sexual dysfunction is a term most often used to describe a clinical diagnosis using DSM-IV criteria that denotes ‘abnormal’ sexual functioning distressing to an individual (Basson, et al., 2001; Tiefer, 2010). Rather than adopting a position regarding which terminology is appropriate, this review of the literature will describe studies using the language used in each study (i.e., sexual dysfunction or sexual problems).

Studies documenting the prevalence and effects of sexual dysfunctions/sexual problems demonstrate the value in studying and understanding sexual functioning. Results of a U.S. study indicated that among adults aged 18-29, 16% to 32% of women and 7% to 30% of men reported experiencing trouble with at least one sexual function (Laumann, et al., 1999). For women, lack of interest in sex (32%) and sex not being pleasurable (27%) were the two most prevalent sexual dysfunctions. Performance anxiety (30%) and climaxing too early (19%) were the two most prevalent sexual dysfunctions for men. This study has been criticized for its usage of the term ‘sexual dysfunction’. In this study, sexual dysfunction was dichotomized as either experiencing difficulty with a sexual function or not. Sexual dysfunction was defined as difficulty with any of the sexual domains for more than one month (Mercer, et al., 2003). The authors acknowledge this criticism and note that the findings may not be reflective of a clinical diagnosis of
sexual dysfunction. Nonetheless, Laumann et al.’s (1999) findings do identify sexual disruptions as an important issue. In a more recent, multinational study of older adults, Laumann et al. (2005), using ‘sexual problem language, identified similar trends related to sexual problems. Between 18%-43% of women and between 12% -28% of men reported a sexual problem that persisted two months or longer. For women, lack of interest in sex (26%-43%) and inability to reach orgasm (18%-41%) were the two most prevalent sexual problems (Laumann, et al., 2005). For men, early ejaculation (12% -31%) and erectile difficulties (13%-38%) were the two most prevalent sexual problems (Laumann, et al., 2005). A similar study conducted in Britain indicated that, of sexually active adults, 53.8% of women and 34.8% of men experienced at least one sexual problem that lasted longer than one month (Mercer, et al., 2003). Lack of interest in sex and premature orgasm were the most prominent sexual problems reported by women and men respectively. These studies and similar others indicate that sexual problems are prevalent and that they have the potential to affect all of the components of sexual functioning (Laumann, et al., 2005; Mercer, et al., 2003; Shifren, et al., 2008).

Not only are sexual problems and sexual dysfunctions prevalent, they also have a profound impact on personal and relational aspects of life. Decreased self-esteem, decreased personal well-being and decreased happiness have been identified as consequences of sexual problems (Heiman, 2002). Similarly, sexual problems have been associated with stress, anxiety and depression (Shifren, et al., 2008). Relational issues such as marital strain and relationship instability have also been identified as correlates of sexual problems (Bartlik & Goldberg, 2000; Heiman, 2002; Morokoff, 1986; Morokoff & Gilliland, 1993; Pridal & LoPiccolo, 2000).
Due to the prevalence of sexual problems and the damaging effect they can have on personal and relational well-being, much research has focussed on examining the sources of these problems. These investigations have identified physical factors (cardiovascular disease, diabetes etc.) and psychological factors (sexual trauma) (Elliot & O'Donohue, 1997; Wallner, Sarma, & Kim, 2010). Sexuality literature is rich in information on sexual problems that result from physical illness, likely because the source of the problem can more easily be identified than if the source is psychological (Tiefer, 2010). Although some research has identified various psychological factors that impact sexuality, the current state of knowledge presents a limited picture of the range of these factors threatening to sexual functioning (Anderson & Cyranowski, 1995). This may be a result of the subtle, hidden or invisible nature of psychological disturbances to sexual functioning. Unlike the physical factors (i.e., diabetes) where consequences are visible in many situations, psychological factors, particularly cognitions and feelings, may only manifest in sexual situations, making them difficult to treat (Binik, Bergeron, & Khalife, 2007)

**Cognitive Disruptions to Sexual Functioning**

A variety of psychological factors (i.e., sexual trauma, anxiety, etc.) have been identified as sources of sexual problems and sexual dysfunctions (Elliot & O'Donohue, 1997; Masters & Johnson, 1970). Negative or troubling cognitions underlie many of the psychological issues that affect sexual functioning (Baker & de Silva, 1988; Barlow, 1986; Binik, et al., 2007; Petrak, 1996). For instance, in 1970, a behaviour termed “spectatoring” was identified as a psychological disruption to sexual functioning. Defined as inspecting and monitoring one’s self during sexual activity, spectatoring was identified
as a disruption to sexual functioning, particularly an inhibitor of arousal (Masters & Johnson, 1970). Underlying thoughts and concerns such as fear or anxiety over a partner’s appraisal of sexual performance result in being labelled a psychological hindrance of sexual functioning (Barlow, 1986). Interfering thoughts during a sexual encounter that result in spectatoring are the source of the disrupted sexual functioning (Barlow, 1986; Farkas, Sine, & Evans, 1979; Geer & Fuhr, 1976). Based on Barlow’s (1986) attentional processing model, spectatoring (which is a result of underlying thoughts about performance) consume much of the spectator’s attention during a sexual encounter. Consequently, the spectator’s capacity to pick up on erotic cues necessary for their sexual functioning diminishes. Spectatoring is characterized as a prominent cause of sexual problems and sexual dysfunctions (Dove & Wiederman, 2000; Masters & Johnson, 1970; Wiederman, 2001).

Cognitive distraction, a more recently proposed psychological hindrance to sexual functioning, refers to intrusive thoughts, notably self focus or self-consciousness during a sexual encounter that do not necessarily lead to spectatoring (although they can do so) but, nevertheless, disrupt sexual functioning (Wiederman, 2001). Identified in several empirical investigations, cognitive distraction is a common experience during sex (Dove & Wiederman, 2000; Purdon & Holdaway, 2006). For instance, an estimated 92% of an undergraduate student sample reported at least one distracting thought (i.e. guilt, fear of intrusion, fear of sexually transmitted infections, fear of pregnancy etc.) during a recent sexual encounter (Purdon & Holdaway, 2006). Further, cognitive distraction has been linked to lower sexual satisfaction, more sexual problems, more sexual concerns (Purdon & Holdaway, 2006), lower sexual self-esteem and less consistent orgasms (Dove &
In contrast to research on disrupted sexuality, research on optimal sexuality has also indicated that cognitions play a significant role in sexual functioning. For instance, uninhibited cognitive presence during a sexual encounter has been associated with ‘optimal sex’. As well, greater cognitive investment has been associated with ‘better sex’ (Kleinplatz et al., 2009).

In support of the push-pull model of incentive motivation, research has shown that emotions evoked from cognitive appraisal of stimuli are linked to sexual functioning. For instance, in discussion about factors that enhance their arousal, women indicated that positive thoughts, such as feeling accepted by their partner, could increase their arousal (Graham, Sanders, Milhausen, & McBride, 2004). In addition to affect associated with cognitive appraisal of sexual stimuli, mood has also been identified as a determinant of sexual response, such that positive emotional states are conducive to stronger or more frequent sexual response (Heiman, 1980; Laan, et al., 1995). Intensity of emotional response has also been implicated in influencing sexual functioning. In particular, thoughts with a strong negative valence are more likely to affect and/or have a more influential affect on sexuality than thoughts with a weaker negative valence (Trapnell, Meston, & Gorzalka, 1997).

Based on responses to a questionnaire on non-erotic thoughts, Purdon and Holdaway (2006) identified three groupings of cognitions with negative valences that affect sexual functioning. The first grouping was comprised of cognitions regarding external consequences of sex such as fear of pregnancy, sexually transmitted infections and being walked in on. The next group was comprised of cognitions regarding emotional consequences of sex, including morality, guilt and regret. Not classified under the
previous two categories, body image was the third category which was implicated in disrupting sexuality (Purdon & Holdaway, 2006). Purdon and Holdaway (2006) identified significant gender differences related to the content of the cognitive distraction experienced by participants. Foremost, women were more likely to have distracting thoughts about their bodies during sex. Furthermore, body image thoughts were more likely to elicit anxiety from women compared to men. In a similar study, thoughts about one’s body were more likely to occur during sex for women than men (Meana & Nunnink, 2006). These studies indicate that body image concerns are more common among women than men and may be more damaging to women’s sexual functioning than men’s. Other studies with female samples have demonstrated that body image concerns are a prominent distracting thought for women during sex. This research suggests that women’s body image concerns should be considered in the analysis of their sexual functioning (Anderson & LeGrand, 1991; Dove & Wiederman, 2000; Faith & Schare, 1993; Graham, et al., 2004).

**Body Image**

Originally, the term body image referred to an individual’s cognitive appraisal of their body. This unidimensional conceptualization of body image has evolved over time to incorporate additional dimensions (Banfield & McCabe, 2002). Banfield and McCabe (2002) have proposed body image is comprised of three dimensions, perceptual/evaluative body image, affective body image and behavioural body image. *Perceptual or evaluative* image refers to an individual’s evaluation or appraisal of their body. Feelings and emotions about one’s body are classified as *affective* body image. *Behavioural* body image refers to the degree to which one’s behaviours are affected by
their thoughts and feelings about their body (Banfield & McCabe, 2002). Recent research on the association between body image and sex has identified a need for a body image dimension specific to sex. According to Weaver and Byers (2006), body image concerns are most salient in situations where the body is the central focus of the event. Wiederman (2000) conceived of body image self-consciousness to account for the otherwise missing dimension specific to sex, and developed a measure to assess this construct (Body Image Self Consciousness, BISC; Wiederman, 2000). Body image self-consciousness refers to an individual’s behaviours during sexual intimacy that are influenced by body image concerns (Wiederman, 2000). Body image self-consciousness may be classified as a sub-component of behavioural body image due to its assessment of sexual behaviours dictated by body image.

**Socialization Theory and Body Image**

A number of theories have been used in the body image literature to explain why body image concerns can be distracting and damaging thoughts for women. Socialization theory refers to transference of societal/cultural rules, regulations, norms and expectations across the lifespan among people in a culture (Maccoby, 2007). According to socialization theory, socializing agents drive the transference of cultural norms, rules, regulations and expectations. Parents, peers and media are identified as the most influential socializing agents (Maccoby, 2007). Research has demonstrated that cultural body size and shape ideals are frequently conveyed by parents, peers and the media to girls and women in Western culture. Mothers who are always dieting, peer conversations about clothes and attractiveness, and models/actresses with flawless appearances are all examples of parents, peers and the media conveying messages about cultural body shape.
and appearance ideals (Jones, 2004; Karraker, Vogel, & Lake, 1995; McCabe et al., 2007; Paxton, Eisenberg, & Neumark-Sztainer, 2006; Shakin, Shakin, & Sternglanz, 1985). Studies show that these socializing agents do have an impact on girls and women. For instance, girls ranging from 4-11 years old have reported being dissatisfied with their bodies and desiring a thinner body (McCabe, et al., 2007). Additionally, girls this age believe it is important for women to be thin and believe an attractive appearance is directly associated with a woman’s power and success (Kalof, 1993; Ricciardelli & McCabe, 2003; Shapiro, Newcomb, & Loeb, 1997). Older girls and women have reported feeling pressure to meet cultural standards for body weight and appearance and have implemented weight loss strategies in response to this perceived pressure (McCabe, Ricciardelli, & Ridge, 2006; Ricciardelli & McCabe, 2003). In a study of over 3000 women between 14-74 years of age, 60.2% of the women reported being dissatisfied with their bodies (Ackard, Kearney-Cooke, & Peterson, 2000). In addition to explaining why women have body image concerns, socialization theory has also been used to argue that women are more likely to have body image concerns than men. For instance, women are socialized to believe that the extent to which women measure up to cultural ideals of thinness and beauty is directly related to their desirability in the eyes of men (Kalof, 1993). Although there is pressure for men to meet ideals of body size, men are socialized to believe other characteristics (i.e., sensitivity) also carry substantial weight in a woman’s judgment of their desirability (McCabe, et al., 2007).

Theories Linking Body Image and Sexuality

Social comparison and objectification theories have also been used to explain why women have body image concerns. Using his social comparison theory, Festinger (1954)
argued women are conditioned to evaluate themselves for validation of personal attributes. The need to self-evaluate is easily fulfilled by comparing oneself to another individual. Women often compare their body shapes and sizes to models and actresses, images of which they are bombarded by in daily life. These comparisons likely lead women to feel as though they have inferior body shapes or sizes. If they feel vulnerable about their bodies during sexual situations this could impact how they function sexually (Festinger, 1954; Weaver & Byers, 2006). Sociocultural norms are a critical element of objectification theory, as in socialization theory. For instance, objectification theory also purports women are socialized to believe culture holds ideals regarding body size and appearance which are communicated through parents, peers and the media. However, objectification theory goes further to argue that, because of these cultural ideals, women objectify others and themselves (Fredrickson & Roberts, 1997). This self-objectification leads to individuals viewing themselves from an observer’s perspective and focussing on their own appearance. This appearance-focussed view of oneself leads to self-evaluation and comparison to cultural ideals. Self-evaluation, in many cases, can lead to body image becoming a prominent concern for many individuals (Steer & Tiggemann, 2008).

In 2008, Steer and Tiggemann found that self-objectification was associated with appearance anxiety and body shame in women. Furthermore, appearance anxiety and body shame were associated with self-consciousness during sexual activity and, in some cases, decreased sexual activity. Steer and Tiggeman (2008) have suggested a mechanism whereby body image impacts sexual functioning. They suggested sexual activity requires and involves another individual focussing on one’s body. Thus, negative feelings about one’s body and the likelihood of self-objectifying are amplified in sexual situations.
Researchers have argued that due to the appearance-focussed socialization of young girls and women, women are more likely to self-objectify than men (Weaver & Byers, 2006). Altogether, the combination of high and well-known cultural standards for body shape and appearance, the exposure of one’s body during sex and the likelihood of women to self-objectify, suggest interconnectedness between body image and sexual functioning among women. Further, considering women are socialized to believe their physical appearance is important to attract men, and sexual scripts are informed by cultural norms (Simon & Gagnon, 1986), it is likely that women’s sexual scripts require a level of comfort or appreciation with their body to want, to expose it and to enjoy, exposing it to a male partner.

**Research Linking Body Image and Sexuality**

Based on the abundant evidence suggesting body image concerns are prevalent and the anecdotal evidence suggesting body image concerns have the potential to impact women’s sexual behaviours, several studies have empirically examined this. Anderson and LeGrand (1991) found an association between body image and interest in engaging in sexual activity. Similarly, research has shown body image concerns predict sexually avoidant behaviours in women (Faith & Schare, 1993; Trapnell, et al., 1997) and positive body image predicts initiation of sex (Ackard et al., 2000). Trapnell et al. (1997) identified body image as a predictor of sexual frequency for both men and women. Men and women who had more positive body image engaged in sex more frequently. Body image concerns were associated with less sexual experience. In 2006, Meana and Nunnink found women frequently experienced appearance-based thoughts (i.e., worrying about how one’s body appeared to a partner) during sexual intimacy. Additionally, appearance-
based thoughts during sexual intimacy were predicted by negative body image. Purdon and Telford (1999) found that arousal and enjoyment were hindered by feelings of self-consciousness of bodily features in women. In particular, inhibited arousal and inhibited enjoyment predicted sexual problems in women (Purdon & Telford, 1999 as cited in Purdon & Holloway, 2006).

From this research, several variables can be identified as influencing the relationship between body image and sexuality or sexual functioning. Two of these are relationship status and relationship length. Meana and Nunnink (2006) identified that women in relationships and relationship duration were negatively associated with appearance-based cognitive distraction. In a study by Wiederman and Hurst (1998), individuals in self-reported exclusive relationships had significantly higher ratings of personal perceived attractiveness relative to individuals not in a relationship. Similarly, Sanchez and Kiefer (2007) also found that women in relationships had fewer body image concerns relative to individuals not in relationships. In a review of desire literature Klusmann (2002) concluded that for women, desire declines as length of relationship increases. Relationship satisfaction has also been associated with sexual functioning. In a study by Steer and Tiggemann (2008), relationship satisfaction was the strongest predictor of sexual functioning among partnered participants. This research highlights the importance of considering (e.g., controlling for) relationship variables in the assessment of the impact body image has on sexual functioning.

In previous research, body weight has also been shown to relate to body image and sexuality individually, though limited research has considered these constructs concomitantly. Sexually avoidant behaviours, sexual inexperience and less frequent
desire, arousal and orgasm have all been associated with increasing body weight (Bajos, Wellings, Laborde, & Moreau, 2010; Castellini et al., 2010; Esposito et al., 2007; Kolotkin et al., 2006; Wiederman & Hurst, 1998; Wiederman, 2000). Studies also show that higher body weight is associated with body dissatisfaction (Jagstaidt, Golay, & Pasini, 1997; Stice & Whitenton, 2002). Also important to note, research has indicated that women of normal body weight often report being overweight (Cash & Hicks, 1990). Inaccurate perceptions of body weight illustrate why body weight and body image should be considered separate concepts. Thus, when body image and sexual functioning are examined, body weight should be included or controlled for. While these data support inclusion of body weight in sexuality studies, body weight and Body Mass Index (BMI, kg/m$^2$) can be considered, at best, gross indicators of body composition. Sexuality literature has yet to incorporate a more biologically relevant measurement of body composition, such as body fat, however a rich body of literature in human nutrition has demonstrated that this is worthwhile (Albanese, Diessel, & Genant, 2003; Vega et al., 2006). Therefore, future studies examining the relationship between body image and sexual functioning should use body fat as the indicator of body composition (Albanese, et al., 2003).

Research has also shown that age is associated with sexual functioning. In particular, sexual problems and difficulties become more prevalent with age (Laumann, et al., 2005). Sanchez and Kiefer (2007) indicated age is also associated with more orgasm difficulties. Research on body image has also demonstrated that body image satisfaction, social physique anxiety, body concealment and appearance comparisons all differ with age. Specifically, Davison and McCabe (2005) found significant differences
between 18-29 year olds and 30-40 year olds on assessments of body image satisfaction, social physique anxiety, body concealment and appearance comparisons. This research suggests that assessments of body image and sexual functioning should take age into consideration. In particular, in empirical investigations of these relationships, age ranges should be small to minimize variability in sexual functioning due to age or samples should be large enough to test for differences between age groups.

**Research Linking Body Image and Sexual Functioning**

Presently, research on body image and sexual functioning demonstrates that body image concerns influence sexual behaviours, attitudes, and cognitions. However, this research does not make explicit which elements of sexual response (defined by the HSRC) are vulnerable to body image concerns. Only a few studies have examined the relationship between body image and some of the phases of sexual response in the HSRC. Graham et al. (2004) examined factors that enhance and inhibit women’s sexual arousal. In this qualitative study, women reported that their sexual arousal was frequently influenced by feelings about their own body and whether they felt desired or accepted by a sexual partner. For instance, one woman described her arousal being contingent on her comfort level with her body. Specifically, this particular woman described arousal deficiencies when she was not feeling good about herself or her body (Graham, et al., 2004).

Seal, Bradford and Meston (2009) assessed the association between body esteem and sexual desire within college aged women. In their sample of 85 women they found that higher body esteem was positively correlated with both self-reported sexual desire with a partner and sexual desire in response to erotic stimuli in a laboratory setting. Seal
et al., (2009) failed to confirm their hypothesis that body esteem would be associated with self-reported arousal with a partner and self-reported arousal in response to erotic stimuli. These results highlighted that women’s sexual desire is susceptible to negative body image. Sanchez and Kiefer (2007) specifically assessed the impact body shame and sexual self-conscious had on sexual arousability, orgasm and sexual pleasure among both men and women aged 17-71 years. Greater body concerns for men and women were associated with less arousability and orgasm difficulty. For men and women, there was no direct relationship between body shame and sexual pleasure. However, for men and women, body shame predicted sexual self-consciousness. Further, women reported higher levels of both body shame and sexual self-consciousness. Additionally, women’s body shame was a stronger predictor of sexual self-consciousness. Body image self-consciousness mediated the relationship between body shame and arousability for both men and women. Specifically, body shame likely resulted in an individual’s behaviour during a sexual encounter being influenced by their negative thoughts about their body. Consequently, their ability to become aroused from the sexual situation was hindered. These results highlight the important role body image self-consciousness plays in sexual functioning, particularly the sexual functioning of women.

In 2006, Weaver and Byers conducted a similar study with only female participants. Weaver and Byers (2006) assessed body image dissatisfaction (an evaluative body image assessment), body image avoidance (a behavioural body image assessment) and body image dysphoria (an affective body image assessment). Sexual assertiveness, sexual arousability, sexual esteem, sexual problems and sexual satisfaction were included as sexual outcomes. Informed by canonical correlation coefficients, Weaver and Byers
(2006) combined body dissatisfaction and body image dysphoria. Similarly, sexual arousability, sexual assertiveness, sexual esteem and sexual problems were all combined to comprise sexual functioning. In this study, better body image was associated better sexual functioning. Weaver and Byers (2006) concluded that women with poorer situational body image reported more sexual problems, lower sexual esteem, lower sexual assertiveness and higher sexual anxiety. Further, these results were maintained while controlling for actual body weight. The results from these four studies indicate women’s sexual desire, arousal and orgasm are all influenced to an extent by concerns about one’s body.

**Rationale for Current Study**

Although the aforementioned research suggests a link between body image and sexual functioning, methodological shortcomings limit our understanding of this relationship. Foremost amongst these is the manner in which sexual functioning has been operationalized. As previously noted, sexual functioning is comprised of the experience of desire, arousal and orgasm. Yet most studies fail to incorporate any or all of these functions in their inquiries. For instance, Weaver and Byers (2006) referred to a combination of sexual assertiveness, sexual arousability, sexual self esteem and sexual problems as sexual functioning. Sanchez and Kiefer (2007) examined sexual arousability, orgasm and pleasure. Other researchers have inaccurately stated they have examined sexual functioning when they have more generally studied sexual behaviours or sexual experiences (Davison & McCabe, 2005; Dove & Wiederman, 2000). Research should include all of the sexual functions (sexual desire, sexual arousal and experience of orgasm) and assess them independently. Accurate and comprehensive definitions of
sexual functioning will allow for findings which illustrate which aspects of sexual functioning are most vulnerable to body image concerns.

There are similar misunderstandings/inconsistent definitions/uses of body image in the literature. Despite developments demonstrating body image as a multidimensional concept (Banfield & McCabe, 2002) studies continue to utilize limited conceptualizations of this construct. For instance, Weaver and Byers (2006) incorporated affective, evaluative and behavioural body image. However, body image self-consciousness, or body image concerns specific to the sexual interaction, was missing from this study. Seal et al. (2009) only assessed body esteem which assessed feelings related to specific body parts, thus evaluative and behavioural body image were not included. Research on the relationship between body image and sexual behaviours has conceptualized body image narrowly. For instance, Faith and Schare (1993) defined body image as positive and negative conceptualizations of one’s body. Studies conceptualizing body image as multidimensional, and assessing it as such, will aid in determining which types of body image concerns are relevant to sexual functioning.

Body composition is a variable relevant to the relationship between body image and sexual functioning (Bajos, Wellings, Laborde, & Moreau, 2010; Castellini et al., 2010; Esposito et al., 2007; Kolotkin et al., 2006; Wiederman & Hurst, 1998; Wiederman, 2000); however, this variable has largely not been included in research to date. Sanchez and Kiefer (2007) and Steer and Tiggemann (2008) failed to acknowledge body weight as a relevant variable in the assessment of body image and sexual functioning. Seal et al. (2009) did include BMI in their study, however they did not control for it in their analyses. Weaver and Byers (2006) included body weight in their
assessment of body image and sexual functioning. However, they used self-reported body weight which is fraught with inaccuracies. In particular, it has been well documented that there is discordance between self-report and actual body weight, such that women often underreport body weight (Cash & Hicks, 1990; Gorber, Tremblay, Moher, & Gorber, 2007; Larsen, Ouwens, Engels, Eisinga, & van Strien, 2008). Body weight and BMI have also been shown to inaccurately estimate fat mass (Mascie-Taylor & Goto, 2007). Further, body weight is a proxy measure for body fat, the body compartment of interest to numerous health outcomes (Albanese, et al., 2003). Therefore incorporating body fat (i.e. percent body fat) into the analysis allows for conclusions about the relationship between body image and sexual functioning independent of actual body composition.

Finally, as indicated by sexuality literature, relationship satisfaction and relationship duration are important to consider when evaluating the effect body image has on sexual functioning (Meana & Nunnink, 2006; Wiederman & Hurst, 1998). However, Weaver and Byers (2006), Seal et al. (2009) and Sanchez and Kiefer (2007) failed to include these important relationship variables in their analyses.

The studies to date that have specifically examined the role body image plays in sexual functioning are limited in terms of external validity because of sampling issues. Weaver and Byers (2006), Seal et al. (2009) and Steer and Tiggemann (2008) all sampled participants from an introductory psychology class, and, as such their results are only generalizable to that population. Although Sanchez and Kiefer (2007) reported participants ranged in age from 17 to 71 years of age, the distribution of age was not provided. Without this information it is unclear if results are generalizable across this wide age range or if the results are driven by a particular subset of that age range (i.e., 17-
25 year olds). Also, very little information is provided with respect to how participants were recruited. This also calls into question the generalizability of the findings and renders the study difficult to replicate. Similarly, although ethnicity information was collected from participants, it was not included as a variable in the analysis. Thus, the impact ethnicity had on the relationship between body image and sexual functioning is unclear.

The current study rectifies these limitations examining sexual desire, sexual arousal and the experience of orgasm, elements of sexual response defined by Masters and Johnson’s and Kaplan’s models. Similarly, this study incorporated all three dimensions of body image (evaluative, affective, and behavioural). Percent body fat, a biologically accurate measurement of body composition was included. The sample was homogenous in terms of age and ethnicity. The impact of relationship satisfaction on body image and sexual functioning was accounted for. Lastly, based on research indicating body image concerns are more salient among women than men, the current study focussed on the extent to which body impacts women’s sexual functioning.

Objectives

The purpose of the proposed study was to investigate the relationship between multiple dimensions of body image and aspects of sexual functioning among women. The study is guided by the following research questions:

1. Is evaluative body image (i.e. body dissatisfaction) predictive of decrements in women’s sexual desire, sexual arousal and experience of orgasm while controlling for relationship satisfaction, relationship length and percent body fat?
2. Is affective body image (i.e. negative feelings about one’s appearance and feeling that others evaluate one’s body negatively) predictive of decrements in women’s sexual desire, sexual arousal and experience of orgasm while statistically controlling for relationship satisfaction, relationship length and percent body fat?

3. Is behavioural body image (i.e. the extent to which thoughts and feelings about one’s body influence behaviour) predictive of decrements in women’s sexual desire, sexual arousal and experience of orgasm while statistically controlling for relationship duration, relationship satisfaction and percent body fat?

**Chapter Two: Methods**

**Participants**

A cross-section of 167 self-identified heterosexual white men (N = 79) and women (N = 91) between the ages of 18-25 participated in a larger study on body image, body composition and sexual functioning entitled SEX, HEALTH and YOU (SHAY) conducted at the University of Guelph Campus in South-western, Ontario. The sample for this thesis was limited to Caucasian women (N = 88) between 18-25 years (M = 20.8, SD = 1.8 ) based on theories and research indicating that body image is a more salient concern for women than men (Fredrickson & Roberts, 1997; Meana & Nunnink, 2006; Purdon & Holdaway, 2006). Considering body image and sexual functioning varies as a function of age a narrow age range was selected. Eighteen to twenty-five year olds were selected based on research indicating body image concerns may be most relevant to this age group (Davison & McCabe, 2005). Participants had to identify as Caucasian based on research suggesting body image differs based on ethnicity (Ard, Greene, Malpede, & Jefferson, 2007). The Female Sexual Functioning Index (Rosen, et al., 2000) requires that
participants report on sexual activities within the month prior to participating (Graham & Bancroft, 2005). Therefore, this sample was limited to women in self-reported committed relationships who had intercourse (penile-vaginal intercourse) at least once in the month prior. Due to research suggesting body image concerns for women are often the result of perceived pressure to ‘look good’ for men, participants had to self-identify as heterosexual (Conner, Johnson, & Grogan, 2004; Fredrickson & Roberts, 1997; Siever, 1994). Research has shown antidepressants reduce sexual functioning therefore, participants were excluded from the study if they were currently taking antidepressants (Rothschild, 2000). Participants classified as underweight based on BMI calculated from self-report height and weight were excluded to avoid distorted body images and disordered eating. Additionally pregnant women were excluded to avoid exposing a fetus to radiation emitted during the dual energy x-ray absorptiometry (DXA) scan.

The sample consisted of primarily university students (95.6%) (see Table 1). On average, participants were: 20.8 years of age ($SD = 1.8$), in relationships for 25.70 months ($SD = 18.1$), had 31.30 ($SD = 7.5$) percent body fat and had a BMI of 24.99 ($SD = 5.0$).
Table 1

*Participant Characteristics*

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal weight (BMI 18.5 -24.9)</td>
<td>47 (53.4)</td>
</tr>
<tr>
<td>Overweight (BMI 25 – 29.9)</td>
<td>28 (31.8)</td>
</tr>
<tr>
<td>Obese (BMI ≥ 30)</td>
<td>13 (14.8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>University student</td>
<td>80 (95.6)</td>
</tr>
<tr>
<td>College student</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Working</td>
<td>5 (5.7)</td>
</tr>
<tr>
<td>Not working</td>
<td>2 (2.3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriously dating one person</td>
<td>68 (77.3)</td>
</tr>
<tr>
<td>Living with partner (not married)</td>
<td>14 (15.9)</td>
</tr>
<tr>
<td>Married</td>
<td>4 (4.5)</td>
</tr>
<tr>
<td>Casually dating one or more partners</td>
<td>2 (2.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of Sexual Activity with Partner</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3 times a month</td>
<td>6 (6.8)</td>
</tr>
<tr>
<td>At least once a week</td>
<td>33 (37.5)</td>
</tr>
<tr>
<td>Several times a week</td>
<td>45 (51.1)</td>
</tr>
<tr>
<td>At least once a day</td>
<td>3 (3.4)</td>
</tr>
</tbody>
</table>

This convenience sample was recruited using print advertisements posted around the University of Guelph campus (lecture halls, libraries, departmental offices, athletic centre, bookstore etc.). Print advertisements were also posted in community locations.
such as athletic centres, grocery stores etc (Appendix A-F). Participants were also recruited from in-class visits where researchers attended large lectures and had any interested individuals provide contact information. Additionally, online advertisements posted on Kijiji and snowball sampling were utilized. A goal of this study was to obtain a proportionate sample of healthy weight, overweight and obese women. Therefore, purposive recruitment strategies, such as print advertisements posted at weight-loss clinics in Guelph were used to recruit obese women. The study was approved by the University of Guelph Research Ethics Board (Appendix G). Participants provided informed consent prior to being enrolled, and were given a $10 gift card on completion of the study visit. Recruitment and data collection took place from January to June 2009 and September 2009 to April 2010.

**Procedure**

Individuals interested in participating were contacted by the research assistant. The research assistant screened participants using a screening questionnaire administered via email (Appendix H). If the participant met all of the inclusion criteria they were invited for a two hour appointment at the Body Composition and Metabolism Laboratory on the University of Guelph campus ([www.uoguelph.ca/bodycomp](http://www.uoguelph.ca/bodycomp)). For the appointment, participants were instructed to wear metal-free clothing and to avoid wearing jewellery with metal (metal confounds the measurement of body composition by the dual energy x-ray absorptiometry). Participants were sent an email 48 hours prior to their appointment to remind them to wear light clothing and to remove all jewellery. Also, participants were instructed to know the date of their last menstrual period and were reminded that they could not be pregnant and participate. Upon arrival, the research
assistants introduced themselves and welcomed the participants. Participants were offered refreshments (juice and granola bars) and informed to help themselves to refreshments at any time during their visit to the lab. Participants were then led to a private conference room. In the conference room, participants sat at a station equipped with either a laptop to complete the questionnaires online using Survey Monkey or a paper and pencil version of the questionnaires. At this time participants were issued their participant identification number. There were two data collection periods, January to June 2009 and September 2009 to April 2010. Participants in the first half of the study completed a paper and pencil version of the questionnaires and those in the second half completed questionnaires using Survey Monkey. The data from the paper and pencil questionnaires were later inputted into Survey Monkey by study personnel. The research assistant directed the participant’s attention to the informed consent and asked them to read carefully through the instructions and to provide their signed consent to participate (Appendix I). The participant was also instructed to provide signed consent to have a DXA scan in which they would be exposed to 0.025 millisieverts radiation dose via one whole body DXA scan, one pelvis scan and one lumbar spine scan. The research assistant left the room and allowed the participant to complete questionnaires assessing demographic information, overall health, relationship satisfaction, body image and sexuality. Participants were instructed to notify the research assistant when they had finished the questionnaires. Subsequently, the participant’s height was measured by the research assistant using a wall-mounted stadiometer. Participants were required to empty their pockets and remove their shoes. They were instructed to stand with their backs, heels, buttocks, shoulder blades and head flush against the wall. The research assistant then lowered the headboard
to touch the top of the participant’s head and height was measured to the nearest millimetre.

Participants were then asked by the Medical Radiation Technologist (MRT) to remove any metal on their clothing in order for their body composition to be assessed accurately by DXA scan. Participants entered a small lead-shielded room where the instrument was located. Participants were instructed to lie still on the scanning bed for 7-10 minutes. While the participant was lying still, the instrument emitted x-rays from below the participant, and measured the x-rays above the participant by a moving “arm.” The software then quantified whole body fat (kg and %), regional fat (kg and %) and bone mineral density. The same MRT conducted all of the DXA scans. The coefficient of variation for repeated %FM by this MRT was 0.76±0.57%. The instrument was calibrated on the morning of each study day using a standard calibration block of thermoplastic acrylic resin, per manufacturer’s instructions. The order of the procedure was also reversed (body composition assessed first and questionnaires completed second) in situations when several participants had overlapping appointments. All of the participants completed the questionnaires independently and only participated once in the study.

Materials

Descriptive variables. A demographic and sexual history questionnaire was used to collect information such as work status, highest level of education obtained, ethnicity,
relationship duration, sexual history and health history (i.e., health conditions, prescribed medications) in order to describe the sample. Forced choice and open-ended questions were used to collect this information.

Control variables. The demographic and sexual history questionnaire also collected information specifically related to age and relationship duration. This information was gathered through the use of open-ended questions (Appendix J).

Relationship satisfaction was assessed using the Global Measure of Relationship Satisfaction (GMREL; Byers & Lawrence, 1998). The GMREL is a six-item self report questionnaire assessing satisfaction with overall relationship with current partner (refer to Appendix B to view questionnaire). Participants were asked “In general, how would you describe your overall relationship with your partner?” Participants were required to answer on a seven-point Likert-type scale that ranges from 7 (very good) to 1 (very bad) (Appendix K). Higher scores indicate greater relationship satisfaction. For each participant, all six questions were summed to produce an overall GMREL score. This measure was selected because it has demonstrated strong reliability and validity and has been used in previous research in this area. Specifically, the GMREL has shown high internal consistency with a Cronbach’s alpha of .95. The GMREL has also shown strong test-retest reliability and good validity (Byers, 2005). The GMREL was also used by Weaver and Byers (2006) to assess relationship satisfaction in their investigation of the relationship between body image and sexual functioning. The GMREL was also selected based on its assessment of satisfaction with various aspects of a relationship.

Body composition was measured by DXA (Hologic Discovery WI, Bedford, MA). Measurements of, whole body fat (kg and %) were provided by DXA. Research has
shown DXA is a reliable and valid tool to assess body composition (Albanese, Diessel, & Genant, 2003).

**Outcome variables.** Female sexual functioning was assessed by the Female Sexual Functioning Index (FSFI; Rosen et al., 2000). The FSFI is a 19-item self-report questionnaire assessing 6 domains (factors) of sexual functioning: sexual desire (2 items), sexual arousal (4 items), lubrication (4 items), orgasm (3 items), satisfaction (3 items) and pain (3 items). For this thesis only the sexual desire, sexual arousal and orgasm domains were used as outcome variables in the analyses. Participants were required to respond to the questions based on their experience in the previous four weeks. For instance respondents were asked, “Over the past 4 weeks, how often did you feel sexual desire or interest?” and were required to answer on a five or six-point Likert-type scale ranging from 0 (no sexual activity) or 1 (almost never or never), to 5 (almost always or always). A higher score on each domain was indicative of a higher level of sexual functioning (Appendix L). For each participant, domain scores were based on a summation of the questions in each domain multiplied by the domain factor (see Rosen et al., 2000). In previous research, the domain scores have demonstrated good test-retest reliability. Also, a high degree of internal consistency has been reported (Cronbach’s alpha were 0.82 and higher) (Rosen, et al., 2000). The FSFI has also successfully distinguished between clinical and non-clinical samples, demonstrating strong discriminant validity (Rosen, et al., 2000). The scale also has good divergent validity evidenced by a comparison to a marital satisfaction survey (Rosen, et al., 2000).

**Predictor variables.** Four body image questionnaires were selected in order to assess the dimensions of body image (evaluative body image, affective body image, and
behavioural body image). Evaluative body image was measured by the Body
Dissatisfaction subscale of the Eating Disorders Inventory – 2 (EDI; Garner, Olmstead, &
Polivy, 1983). The Body dissatisfaction subscale assesses an individual’s evaluation of
various body parts (i.e., stomach). For instance respondents were asked to respond to
statements such as, “I think my stomach is too big”. They were required to answer on a
five-point Likert-type scale ranging from 1 (never) to 5 (always). The body
dissatisfaction subscale produces an overall summation score which higher scores
indicate greater body dissatisfaction (Appendix M). The Body Dissatisfaction subscale
was selected based on its brief but comprehensive assessment of an individual’s
evaluation of their body parts. The Body Dissatisfaction subscale has shown good
convergent and discriminant validity with other scales on the EDI. Also, it has good
internal consistency with a Cronbach’s alpha of .90 (Garner, et al., 1983). The EDI has
been used by numerous studies over the years to assess evaluative body image (McCabe,
Ricciardelli, & Karantzas, 2010; Meller, McCabe, Riccardelli, & Ball, 2004). Weaver and
Byers (2006) also used the EDI to assess the relationship between body image and sexual
functioning.

Affective body image was assessed by the Body Esteem Scale for Adolescents
and Adults (BESAA; Mendelson, Mendelson, & White, 2001). The BESAA is a 23-item
self report questionnaire that assesses feelings about appearance (10 items), weight (8
items) and evaluations attributed to others about one’s body and appearance (attribution)
(5 items) (Appendix N). Participants were required to answer questions on a five-point
Likert-type scale ranging from 1 (never) to 5 (always). The BESAA is comprised of three
subscales, for this thesis, the appearance (“I like what I look like in pictures) and
attribution (“People my own age like my looks”) subscales were used. Each subscale score is the mean of the responses that comprise that subscale. Higher scores on the subscales are indicative of more positive affective body image, therefore all negative questions were reversed scored. In previous research the BESAA has shown good internal consistency with Cronbach’s alphas ranging from .75-.91. Additionally, the BESAA has shown strong test-retest reliability (Mendelson, et al., 2001). Mendelson et al. (2000) have also demonstrated that the BESAA has strong convergent and discriminant validity. The BESAA was selected for its strong psychometric properties, its comprehensive assessment of feelings about appearance, weight and attribution, and based on its previous usage in studies of women’s body image (Buchholz, Mack, McVey, Feder, & Barrowmen, 2008; Forbes & Jung, 2008; Snapp, 2009).

Behavioural body image was assessed by two questionnaires. The Body Image Avoidance Questionnaire (BIAQ; Rosen, Srebnik, Saltzberg, & Wendt, 1991) assessed the degree or extent to which behaviours were affected by feelings about one’s body. Participants were required to respond to statements such as, “I wear baggy clothes” on a six-point Likert-type scale ranging from 1 (never) to 6 (always). The BIAQ produced an overall score which higher scores were indicative of more body image avoidance (Appendix O). The BIAQ has shown good internal consistency with Cronbach’s alpha of .89. Also it has demonstrated strong test-retest reliability and concurrent validity (Rosen, et al., 1991). The BIAQ has also been widely used in research on disordered eating (Collings, Saules, & Saad, 2008; Latner, 2008; Tissot & Crowther, 2008). It has also been used in a previous study which examined the relationship between body image and sexual
functioning (Weaver & Byers, 2006). The BIAQ was selected for its history as a strong assessment of behavioural dimension of body image.

Behavioural body image specific to sexual encounters was measured by the Body Image Self-Consciousness scale (BISC; Wiederman, 2000). The BISC is a 15-item self-report questionnaire that assess the degree or extent to which a woman’s sexual behaviours are affected by thoughts about her body. Participants were required to respond to statements such as, “While having sex I am (would be) concerned that my hips and thighs would flatten out and appear larger than they actually are” on a six-point Likert-type scale ranging from 1 (never) to 6 (always). The BISC produces an overall body image self-consciousness score which is a summation of all of the questions. Higher scores are indicative of greater body image-self consciousness (Appendix P). The BISC has shown strong internal consistency with a Cronbach’s alpha of .93. The BISC has also shown strong discriminant and convergent with validity (Wiederman, 2000). The BISC was developed specifically for women and has been used in previous research studying the impact body image has on sexual functioning and sexual behaviours (Aubrey, 2006; Sanchez & Kiefer, 2007; Wiederman, 2000). The BISC was selected based on its strong psychometric properties and its relevance to studying the relationship between body image and sexual functioning.

**Data Analysis**

The Statistical Package for Social Sciences (PASW version 18.0, Chicago, IL, USA) was used for all of the analyses.

*Assumptions.* To assess the assumption of normality for multiple regression an examination of the *Kolmogorov-Smirnoff* (KS) statistics and skewness/kurtosis values of
the outcome variables was undertaken (Field, 2009). Statistically significant (p<.05) KS statistics and/or skewness and kurtosis values that are two or more times greater than the standard error indicate a violation of the normality assumptions (Field, 2009). Bivariate correlations were computed between the control variables and the predictor variables to assess for multicollinearity. Correlation coefficients among predictor and/or control greater than .80 are considered problematic (Field, 2009). Additionally, to test for multicollinearity among predictor variables in the model, Tolerance values were considered. Tolerance values that range from .6-.1 are acceptable, values less than .40 are considered problematic (Field, 2009).

*Internal Consistency.* Cronbach’s alpha was used to evaluate the internal consistency of the scales used. Values greater than .70 are acceptable (Field, 2009).

*Inferential statistics.* Hierarchical multiple regression models were used to determine the degree to which body image concerns could predict decrements in sexual functioning. Fifteen models were computed, in each model, relationship satisfaction, relationship length and percent total fat were entered into step one to control for the amount of variance they accounted for in the sexual functioning domains. In step two, one of the three body image dimensions were entered independently. This process was repeated to produce fifteen models in which each body image dimension predicted each sexual functioning outcome.

To evaluate the amount of variance accounted for in the outcome variable by the model, adjusted $R^2$ values were reported. To estimate the proportion of variance accounted by the predictor variable of interest (body image variable) the $R^2$ change value was reported. The *Significant $F$ change value* indicated whether the proportion of
variance accounted for uniquely by the predictor variable of interest was significant \( (p < .05) \). Standardized regression weights \((\beta)\) and their corresponding significance levels were reported to identify significant predictors in the model. Unstandardized regression coefficients were reported to specifically describe the relationship between each body image dimension and the outcome.

**Diagnostic statistics.** To evaluate how well the regression model fit the data, several diagnostic statistics were utilised. Durbin Watson statistics were selected to determine if the independent errors assumption of regression was met. Values less than 1 or greater than 3 indicate a violation (Durbin & Watson, 1951). To evaluate the fit of the model, standardized residuals were referred to. Standardized residuals greater than 3.30, indicate poor fit (Field, 2009). Partial regression plots were used to assess for the assumptions of heteroscedasticity and linearity. Variance of residuals that remain constant at each level of the predictor variable indicate that the assumption of homoscedasticity is met (Field, 2009). Cook’s distance values were used to identify potential influential observed values on predicted values. This value is a measure of the overall influence a case has on the regression equation and predicted values (Cook & Weisberg, 1982 as cited in Field, 2009). Values greater than 1 indicate cause for concern (Field, 2009).

**Chapter Three: Results**

**Data Screening**
To ensure all of the participants included in the analysis met the eligibility criteria the data from the 91 female participants were screened. This process revealed that two women were ineligible because of BMI’s indicating that they were underweight (BMI < 18.5). Additionally, one woman indicated she was Hispanic, thus making her ineligible. The exclusion of these three cases resulted in a data set with 88 women.

**Normality and Multiple Regression Assumptions**

All of the outcome variables (FSFI score, desire score, arousal score, orgasm score) were continuous variables, thus meeting the assumption of continuous outcome variables. There was a discrepancy between the KS statistic and the Skewness and Kurtosis values for the desire and arousal domains. For both domains, the KS test was significant, however the skewness and kurtosis values were not twice the size of the standard error (indicating that the scores were neither skewed nor kurtotic). The histograms of both suggest a slight negative skew indicating that more women in the sample experienced less difficulty with desire and arousal relative to more difficulty. Indicated by a significant KS test and a skewness value that was twice its standard error, the distribution of the orgasm domain was negatively skewed (Table 2). This negative skew indicated that a large portion of the sample experienced little difficulty with orgasm. Due to the violation of the normality assumption caution was taken in making generalizations beyond the current sample (Field, 2009). The non-zero variance assumption was also met as all of the predictor variables had variation in value (Table 3 &4).
Table 2

*Outcome Variables: Normality & Descriptive Statistics (N = 88)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td>1.2-6</td>
<td>1.8-6.0</td>
<td>4.49 (1.0)</td>
<td>-0.19</td>
<td>0.26</td>
<td>-0.59</td>
<td>0.52</td>
<td>(85) .13**</td>
</tr>
<tr>
<td>Arousal</td>
<td>0-6</td>
<td>3.0-6.0</td>
<td>5.03(0.7)</td>
<td>-0.22</td>
<td>0.26</td>
<td>-0.79</td>
<td>0.52</td>
<td>(85) .11**</td>
</tr>
<tr>
<td>Orgasm</td>
<td>0-6</td>
<td>1.2-6.0</td>
<td>4.25(1.6)</td>
<td>-0.73</td>
<td>0.26</td>
<td>-0.77</td>
<td>0.52</td>
<td>(85) .17***</td>
</tr>
</tbody>
</table>

*Note.* p < .05*, **p < .01, *** p < .001, KS = Kolmogorov - Smirnov test of normality
Table 3

*Predictor Variables: Normality & Descriptive Statistics (N = 88)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td>0-40</td>
<td>0-24</td>
<td>8.75(6.3)</td>
<td>.59</td>
<td>0.26</td>
<td>-0.6</td>
<td>0.52</td>
<td>(84) .12**</td>
</tr>
<tr>
<td>BESAA Appearance</td>
<td>0-4</td>
<td>.10-3.8</td>
<td>2.48(0.8)</td>
<td>-0.68</td>
<td>0.26</td>
<td>0.09</td>
<td>0.52</td>
<td>(83).10</td>
</tr>
<tr>
<td>BESAA Attribution</td>
<td>0-4</td>
<td>.80-3.6</td>
<td>2.27(0.64)</td>
<td>-0.39</td>
<td>0.26</td>
<td>-0.31</td>
<td>0.52</td>
<td>(83).11**</td>
</tr>
<tr>
<td>BIAQ</td>
<td>0-95</td>
<td>12-57</td>
<td>24.02(8.5)</td>
<td>1.29</td>
<td>026</td>
<td>2.25</td>
<td>0.52</td>
<td>(83).11*</td>
</tr>
<tr>
<td>BISC</td>
<td>0-75</td>
<td>0-72</td>
<td>14.21(15.8)</td>
<td>1.1</td>
<td>0.26</td>
<td>3.66</td>
<td>.52</td>
<td>(83).23***</td>
</tr>
</tbody>
</table>

*Note.* p < .05*, **p < .01, *** p < .001, KS = Kolmogorov - Smirnov test of normality
Table 4

**Control Variables: Normality & Descriptive Statistics (N = 88)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Scale Range</th>
<th>Sample Range</th>
<th>M (SD)</th>
<th>Skew Stat</th>
<th>Skew SE</th>
<th>Kurtosis Stat</th>
<th>Kurtosis SE</th>
<th>KS Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMREL</td>
<td>6 - 42</td>
<td>13 – 35</td>
<td>29.73 (5.3)</td>
<td>-1.34</td>
<td>0.26</td>
<td>1.29</td>
<td>0.52</td>
<td>(84) .17***</td>
</tr>
<tr>
<td>Rel. Length</td>
<td>-</td>
<td>1 – 84</td>
<td>25.14 (16.7)</td>
<td>1.08</td>
<td>0.26</td>
<td>1.7</td>
<td>0.52</td>
<td>(84) .09</td>
</tr>
<tr>
<td>Body fat (%)</td>
<td>-</td>
<td>17.9 - 47.7</td>
<td>31.44 (7.6)</td>
<td>0.11</td>
<td>0.26</td>
<td>-0.79</td>
<td>0.52</td>
<td>(84) .60</td>
</tr>
</tbody>
</table>

*Note.* p < .05*, **p < .01, ***p < .001, KS = Kolmogorov - Smirnov test of normality
Displayed in Table 5, the correlation coefficients amongst predictor variables and control variables were all below the recommended .80 (Field, 2009). Bivariate correlations were computed between all of the body image domains and the sexual functioning domains (Table 6). BESAA appearance was positively correlated with arousal, BESAA attribution was positively correlated with desire and arousal. Scores on the EDI were negatively correlated with arousal and orgasm. Scores on the BISC were negatively correlated with arousal and orgasm. There were no significant coefficients between the BIAQ and scores on desire, arousal or orgasm ($p > .05$).
Table 5

Bivariate Correlations among Predictor & Control Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>EDI</th>
<th>BESAA: appearance</th>
<th>BESAA: attribution</th>
<th>BIAQ</th>
<th>BISCS</th>
<th>GMREL</th>
<th>Rel. Length</th>
<th>Per. Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BESAA:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>appearance</td>
<td>-.79***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BESAA:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attribution</td>
<td>-.59***</td>
<td>.58***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIAQ</td>
<td>.55***</td>
<td>-.69***</td>
<td>-.35**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BISCS</td>
<td></td>
<td>.69**</td>
<td>-.40***</td>
<td>.53***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMREL</td>
<td>-.014</td>
<td>.28**</td>
<td>.12</td>
<td>-.19</td>
<td>-.23*</td>
<td>-.12</td>
<td>.08</td>
<td>1</td>
</tr>
<tr>
<td>Rel. Length</td>
<td>.10</td>
<td>-.14</td>
<td>-.08</td>
<td>.03</td>
<td>-.12</td>
<td>.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>.53***</td>
<td>-.43***</td>
<td>-.35**</td>
<td>.35**</td>
<td>-.23*</td>
<td>.02</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note. * p < .05, **p < .01, *** p < .001
Rel Length = Relationship Length, Per. Total = Percent total body fat
### Table 6

**Bivariate Correlations among Predictor & Outcome Variables**

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Desire</th>
<th>Arousal</th>
<th>Orgasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td>-.20</td>
<td>-.24*</td>
<td>-.24*</td>
</tr>
<tr>
<td>BESAA appearance</td>
<td>.15</td>
<td>.23*</td>
<td>.19</td>
</tr>
<tr>
<td>BESAA attribution</td>
<td>.25*</td>
<td>.38***</td>
<td>.17</td>
</tr>
<tr>
<td>BIAQ</td>
<td>-.06</td>
<td>-.16</td>
<td>-.11</td>
</tr>
<tr>
<td>BISC</td>
<td>-.04</td>
<td>-.23*</td>
<td>-.27*</td>
</tr>
</tbody>
</table>

* p < .05, **p < .01, *** p < .001
Reliability Analysis

To determine the reliability of the scales used in the current sample, Cronbach’s alpha values were calculated for scales involved in the regression analysis. The alphas for all of the scales used were all acceptable (Field, 2009) and ranged from .75-.96 (Table 7).

Table 7

<table>
<thead>
<tr>
<th>Scale</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMREL</td>
<td>0.96</td>
</tr>
<tr>
<td>EDI</td>
<td>0.89</td>
</tr>
<tr>
<td>BESAA - Appearance</td>
<td>0.94</td>
</tr>
<tr>
<td>BESAA - Attribution</td>
<td>0.75</td>
</tr>
<tr>
<td>BIAQ</td>
<td>0.78</td>
</tr>
<tr>
<td>BISCs</td>
<td>0.96</td>
</tr>
<tr>
<td>FSFI desire</td>
<td>0.83</td>
</tr>
<tr>
<td>FSFI arousal</td>
<td>0.81</td>
</tr>
<tr>
<td>FSFI orgasm</td>
<td>0.95</td>
</tr>
</tbody>
</table>

Evaluative Body Image

All of the models with EDI as the predictor were statistically significant ($p < .05$) (Tables 8-10). Relationship satisfaction, relationship duration, percent total body fat and EDI accounted 17% of variance in desire, 11% in arousal and 13% in orgasm. Also, EDI accounted for a significant amount of variance in desire (6%) and arousal (8%) over and above the control variables (Table 8 & 9). EDI did not significantly account for variance in orgasm over and above the control variables (Table 10).
### Table 8

*Hierarchical Regression Model: EDI (Body Dissatisfaction) Predicting Desire*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. $R^2$</th>
<th>$R^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.11</td>
<td></td>
<td>4.27**</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-.34**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.01</td>
<td>0.02</td>
<td>-.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.17</td>
<td></td>
<td>4.95***</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-.33**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.01</td>
<td>0.02</td>
<td>.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDI</td>
<td>-0.05</td>
<td>0.02</td>
<td>-.31*</td>
<td>.06*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p < .01, ***p < .001*
Table 9

Hierarchical Regression Model: EDI (Body Dissatisfaction) Predicting Arousal

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.04</td>
<td></td>
<td>2.04</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.01</td>
<td>0.01</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>0.11</td>
<td></td>
<td>3.46*</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.01</td>
<td>0.01</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDI</td>
<td>-0.04</td>
<td>0.02</td>
<td>-.35**</td>
<td>.08**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. * p < .05, **p <.01, *** p < .001
Table 10

**Hierarchical Regression Model: EDI (Body Dissatisfaction) Predicting Orgasm**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. $R^2$</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rel Sat.</td>
<td>0.05</td>
<td>0.03</td>
<td>.16</td>
<td></td>
<td></td>
<td>3.81*</td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.03</td>
<td>0.01</td>
<td>.28</td>
<td></td>
<td></td>
<td>3.83**</td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.03</td>
<td>0.02</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDI</td>
<td>-0.06</td>
<td>0.03</td>
<td>-.24</td>
<td></td>
<td>.04</td>
<td></td>
</tr>
</tbody>
</table>

Note. * p < .05, **p <.01, *** p < .001

The unstandardized regression weights (B) indicate that, as scores on the body dissatisfaction subscale of the EDI (scale range, 0 - 24) increase by one unit (i.e., more body dissatisfaction), scores on desire (scale range, 1.8 - 6) and arousal (scale range, 3 - 6) decrease by .05 and .04 of a point respectively. Relationship length was a significant predictor of desire and orgasm, such that, as relationship length increased by one month desire decreased by .02 of a point and orgasm (scale range, 1.2 - 6) increased by .03 of a point.
Affective Body Image

All of the models with BESAA appearance as a predictor were statistically significant ($p < .05$) (Table 11-13). Relationship satisfaction, relationship duration, percent total body fat and BESAA appearance accounted for 11% of variance in desire, 7% in arousal and 9% in orgasm. Also, BESAA appearance accounted for a significant amount of variance in arousal (5%) over and above the control variables (Table 12).

BESAA appearance did not significantly account for variance in desire or orgasm over and above control variables (Table 11 & 13).

Table 11

Hierarchical Regression Model: BESAA Appearance Predicting Desire

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj $R^2$</th>
<th>R$^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.1</td>
<td></td>
<td>4.17**</td>
</tr>
<tr>
<td></td>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.02</td>
<td>.02</td>
<td>.10</td>
</tr>
<tr>
<td></td>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-.35**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.02</td>
<td>-.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td>0.11</td>
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<td>3.70**</td>
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<tr>
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<td>0.02</td>
<td>0.02</td>
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<td></td>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-.33**</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Per. Total</td>
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<td>0.02</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appearance</td>
<td>0.22</td>
<td>0.16</td>
<td>.17</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

Note. * $p < .05$, **$p < .01$, *** $p < .001$
Table 12

*Hierarchical Regression Model: BESAA Appearance Predicting Arousal*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
<td>.16</td>
<td></td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.01</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.07</td>
<td>2.6*</td>
<td></td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.00</td>
<td>0.01</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>0.24</td>
<td>0.11</td>
<td>.26*</td>
<td></td>
<td>.05*</td>
<td></td>
</tr>
</tbody>
</table>

*Note. * p < .05, **p < .01, *** p < .001
Table 13

**Hierarchical Regression Model: BESAA Appearance Predicting Orgasm**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. ( R^2 )</th>
<th>( R^2 ) change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.05</td>
<td>0.03</td>
<td>.15</td>
<td></td>
<td></td>
<td>3.5*</td>
</tr>
<tr>
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<td>0.01</td>
<td>.26*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.03</td>
<td>0.02</td>
<td>-.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.04</td>
<td>0.03</td>
<td>.12</td>
<td></td>
<td></td>
<td>3.1*</td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.03</td>
<td>0.01</td>
<td>.28*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.02</td>
<td>0.02</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>0.32</td>
<td>0.24</td>
<td>.16</td>
<td></td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

*Note. * p < .05, **p < .01, *** p < .001

Indicated by the unstandardized regression weights (B), one unit increases on BESAA appearance (scale range, 0.10 - 3.8) resulted in arousal scores (scale range, 3 - 6) increasing by .24 of a point. Similar to the other models, relationship length was a significant predictor of desire and orgasm, such that, as relationship length increased by one month desire (scale range, 1.8 - 6) decreased by .01 of a point and orgasm (scale range, 1.2 - 6) increased by .03 of a point.

All of the models with attribution as the predictor were statistically significant (Table 14 -16). Relationship satisfaction, relationship duration, percent total body fat and attribution accounted for 14% of variance in desire, 13% in arousal and 9% in orgasm.
Attribution accounted for a significant amount of variance in desire (4%) and arousal (11%) over and above the control variables (Table 14 & 15). Attribution did not account for a significant amount of unique variance in orgasm (Table 16).

Table 14

Hierarchical Regression Model: BESAA Attribution Predicting Desire

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Adjusted R²</th>
<th>R² Change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rel Sat.</td>
<td>0.10</td>
<td>0.02</td>
<td>0.11</td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.35**</td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.04</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2</th>
<th>Adjusted R²</th>
<th>R² Change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rel Sat.</td>
<td>0.14</td>
<td>0.03</td>
<td>0.12</td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.03</td>
<td>0.01</td>
<td>-0.34**</td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.02</td>
<td>0.02</td>
<td>-0.03</td>
</tr>
<tr>
<td>Attribution</td>
<td>0.35</td>
<td>0.18</td>
<td>0.22*</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01, *** p < .001
Table 15

*Hierarchical Regression Model: BESAA Attribution Predicting Arousal*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. $R^2$</th>
<th>$R^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.03</td>
<td></td>
<td></td>
<td>0.16</td>
<td></td>
<td>1.78*</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.13</td>
<td></td>
<td></td>
<td>0.35**</td>
<td>.11**</td>
<td>4.10**</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>0.004</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>0.01</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attribution</td>
<td>0.39</td>
<td>0.12</td>
<td>.35**</td>
<td></td>
<td>.11**</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p <.01, *** p < .001
### Table 16

**Hierarchical Regression Model: BESAA Attribution Predicting Orgasm**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.09</td>
<td></td>
<td>3.5*</td>
</tr>
<tr>
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<td>0.05</td>
<td>0.03</td>
<td>.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.02</td>
<td>0.01</td>
<td>.26*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.03</td>
<td>0.02</td>
<td>-.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>0.34</td>
<td>0.09</td>
<td>3.0*</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.04</td>
<td>0.03</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.03</td>
<td>0.01</td>
<td>.26*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.02</td>
<td>0.02</td>
<td>-.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attribution</td>
<td>0.34</td>
<td>0.28</td>
<td>.14</td>
<td></td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p < .01, *** p < .001

The unstandardized regression weights (B) indicate that, as scores on attribution (scale range, .8 - 3.6) increase by one unit, scores on desire (scale range, 1.8 - 6) and arousal (scale range, 3 - 6) increased by .35 and .39 of a point respectively. Relationship length was a significant predictor of desire and orgasm, such that, as relationship length increased by one month desire decreased by .02 of a point and orgasm (scale range, 1.2 - 6) increased by .03 of a point.

**Behavioural Body Image**

The models with BIAQ as a predictor were significant in predicting desire and orgasm but not arousal (Table 17 -19). Relationship satisfaction, relationship duration,
percent total body fat and BIAQ accounted for 9% of variance in desire, 4% in arousal and 9.6% in orgasm. BIAQ did not account for significant amount of variance in any of the outcome variables.

Table 17

Hierarchical Regression Model: BIAQ Predicting Desire

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>( \beta )</th>
<th>Adj. ( R^2 )</th>
<th>( R^2 ) change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
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<td></td>
<td></td>
<td>0.08</td>
<td></td>
<td>3.3 *</td>
</tr>
<tr>
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<td>0.02</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.33**</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.00</td>
<td>0.02</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td>0.09</td>
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<td>2.8*</td>
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<tr>
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<td>0.02</td>
<td>0.00</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.33**</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>0.01</td>
<td>0.02</td>
<td>0.00</td>
<td>0.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIAQ</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.14</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. * \( p < .05 \), ** \( p < .01 \), *** \( p < .001 \)
Table 18

Hierarchical Regression Model: BIAQ Predicting Arousal

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td></td>
<td>0.02</td>
<td>.14</td>
<td>1.20</td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.00</td>
<td>0.01</td>
<td>-0.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIAQ</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.22</td>
<td>0.04</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 2

<table>
<thead>
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<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td></td>
<td>0.02</td>
<td>.15</td>
<td>1.81</td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.00</td>
<td>0.01</td>
<td>-0.09**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.00</td>
<td>0.01</td>
<td>-0.02</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. * p < .05, **p <.01, *** p < .001
Table 19

Hierarchical Regression Model: BIAQ Predicting Orgasm

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. $R^2$</th>
<th>$R^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.05</td>
<td></td>
<td>1.20</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.04</td>
<td>0.03</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
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<td>0.01</td>
<td>.31**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.03</td>
<td>0.02</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td></td>
<td>0.09</td>
<td></td>
<td>1.81</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.04</td>
<td>0.03</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
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<td>0.03</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIAQ</td>
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<td>0.02</td>
<td>-.05</td>
<td></td>
<td></td>
<td>0.04</td>
</tr>
</tbody>
</table>

Note. * p < .05, **p < .01, *** p < .001

Relationship length was a significant predictor of desire and orgasm, such that, as relationship length increased by one month desire (scale range, 1.8 - 6) decreased by .02 of a point and orgasm (scale range, 1.2 - 6) increased by .03 of a point.

All of the models with BISC as the predictor were statistically significant (Table 20 - 22). Relationship satisfaction, relationship duration, percent total body fat and BISC accounted for 13% of variance in desire, 15% in arousal and 14% in orgasm. Also, BISC accounted for a significant amount of variance in arousal (13%) and orgasm (6%) over and above the control variables (Table 21 & 22). BISC did not account for a significant amount of unique variance in desire (Table 22).
Table 20

Hierarchical Regression Model: BISC Predicting Desire

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. $R^2$</th>
<th>$R^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>0</td>
<td>0.11</td>
<td>4.26**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Sat.</td>
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<td>0.02</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.36**</td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.38***</td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.001</td>
<td>0.02</td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>BISC</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.19</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Note. * p < .05, ** p < .01, *** p < .001
Table 21

*Hierarchical Regression Model: BISC Predicting Arousal*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Adj. R²</th>
<th>R² change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
<td></td>
<td>1.76</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.01</td>
<td>0.01</td>
<td>-.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>0.15</td>
<td></td>
<td>4.60**</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.02</td>
<td>0.02</td>
<td>.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>-0.01</td>
<td>0.004</td>
<td>-.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.003</td>
<td>0.01</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BISC</td>
<td>-0.02</td>
<td>0.01</td>
<td>-.37**</td>
<td>.13**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p < .01, ***p < .001
Table 22

Hierarchical Regression Model: BISC Predicting Orgasm

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>Adj. $R^2$</th>
<th>$R^2$ change</th>
<th>F Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>0.09</td>
<td></td>
<td>3.58*</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.05</td>
<td>0.03</td>
<td>.05</td>
<td>.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.03</td>
<td>0.01</td>
<td>.03</td>
<td>.26*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.02</td>
<td>0.02</td>
<td>-0.02</td>
<td>.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>0.14</td>
<td></td>
<td>4.18**</td>
</tr>
<tr>
<td>Rel Sat.</td>
<td>0.04</td>
<td>0.03</td>
<td>.04</td>
<td>.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rel Length</td>
<td>0.02</td>
<td>0.01</td>
<td>.02</td>
<td>.23*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per. Total</td>
<td>-0.02</td>
<td>0.02</td>
<td>-0.02</td>
<td>.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BISC</td>
<td>-0.03</td>
<td>0.01</td>
<td>-0.03</td>
<td>.25*</td>
<td></td>
<td>.06*</td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p < .01, ***p < .001

Indicated by the unstandardized regression weights (B) in Table 21 - 22, as scores on BISC (scale range, 0-72) increase by one unit, scores on arousal (scale range, 3 - 8) and orgasm (scale range, 1.2 - 6) decreased by .02 and .03 of a point respectively.

Similar to the other models, relationship length was a significant predictor of desire and orgasm, such that, as relationship length increased by one month desire (scale range, 1.8 - 6) decreased by .02 of a point and orgasm increased by .02 of a point. Summarized in Table 23, body dissatisfaction as measured by the EDI, attribution and appearance as measured by the BESAA, BISC and relationship length were the only significant predictors in any of the fifteen models.
Table 23

*Summary of Significant Predictors*

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Desire</th>
<th>Arousal</th>
<th>Orgasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Attribution</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>BIAQ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BISC</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Relationship Satisfaction</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Relationship Length</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Total Fat</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* X indicates the variable was a significant predictor.

**Diagnostics**

For all fifteen models the Durbin Watson statistic was approximately 2 indicating that the assumption of independent errors was met (Table 24). Tolerance values were all within the acceptable range of between .6 -.9 for all of the models indicating that the assumption of multicollinearity was met (Field, 2009).
Table 24

*Diagnostics: Evaluative and Affective Body Image Predictors*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Step 2 Predictor</th>
<th>Tolerance range</th>
<th>Durbin-Watson</th>
<th>St. Residual Range</th>
<th>Cook's distance range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td>EDI</td>
<td>.65 - .98</td>
<td>2.00</td>
<td>-2.5 – 1.9</td>
<td>0 - .53</td>
</tr>
<tr>
<td>Arousal</td>
<td>EDI</td>
<td>.65 - .98</td>
<td>2.20</td>
<td>-2.4 - 1.8</td>
<td>0 - .20</td>
</tr>
<tr>
<td>Orgasm</td>
<td>EDI</td>
<td>.66 - .98</td>
<td>2.30</td>
<td>-2.1 - 1.5</td>
<td>0 - .11</td>
</tr>
<tr>
<td>Desire</td>
<td>Attribution</td>
<td>.87 - .98</td>
<td>2.03</td>
<td>-3.2 - 2.6</td>
<td>0 - .56</td>
</tr>
<tr>
<td>Arousal</td>
<td>Attribution</td>
<td>.84 - .98</td>
<td>2.20</td>
<td>-2.4 - 1.9</td>
<td>0 - .30</td>
</tr>
<tr>
<td>Orgasm</td>
<td>Attribution</td>
<td>.84 - .98</td>
<td>2.10</td>
<td>-2.0 - 1.5</td>
<td>0 - .08</td>
</tr>
<tr>
<td>Desire</td>
<td>Appearance</td>
<td>.77 - .97</td>
<td>1.90</td>
<td>-2.8 – 2.3</td>
<td>0 - .48</td>
</tr>
<tr>
<td>Arousal</td>
<td>Appearance</td>
<td>.77 - .97</td>
<td>2.10</td>
<td>-2.8 – 1.7</td>
<td>0 - .18</td>
</tr>
<tr>
<td>Orgasm</td>
<td>Appearance</td>
<td>.77 - .97</td>
<td>2.10</td>
<td>-2.1 – 1.5</td>
<td>0 - .08</td>
</tr>
<tr>
<td>Outcome</td>
<td>Step 2 Predictor</td>
<td>Tolerance range</td>
<td>Durbin-Watson</td>
<td>St. Residual Range</td>
<td>Cook's distance range</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Desire</td>
<td>BIAQ</td>
<td>.82 - .98</td>
<td>1.95</td>
<td>-2.7 – 2.2</td>
<td>0- .50</td>
</tr>
<tr>
<td>Arousal</td>
<td>BIAQ</td>
<td>.82 - .98</td>
<td>2.14</td>
<td>-2.6 – 1.9</td>
<td>0-.16</td>
</tr>
<tr>
<td>Orgasm</td>
<td>BIAQ</td>
<td>.82 - .98</td>
<td>2.17</td>
<td>-2.1 – 1.5</td>
<td>0 - .05</td>
</tr>
<tr>
<td>Desire</td>
<td>BISC</td>
<td>.91 - .97</td>
<td>2</td>
<td>- 2.9 - 2.7</td>
<td>0 - .48</td>
</tr>
<tr>
<td>Arousal</td>
<td>BISC</td>
<td>.90 - .98</td>
<td>2.0</td>
<td>-2.1 - 2.1</td>
<td>0 - .30</td>
</tr>
<tr>
<td>Orgasm</td>
<td>BISC</td>
<td>.91 - .97</td>
<td>2.16</td>
<td>-1.9 - 1.7</td>
<td>0 - .26</td>
</tr>
</tbody>
</table>
Partial regression plots indicated that linearity could be assumed for all of the variables on each outcome variable. In the models with desire as the outcome variable, the residuals of percent total fat, BESAA appearance and BESAA attribution were evenly dispersed, thus meeting the assumption of homoscedasticity. The residuals of GMREL, relationship length, EDI, BIAQ and BISC were heteroscedastic. In the models with arousal as the outcome variable, percent total fat, BESAA appearance and BESAA attribution met the assumption of homoscedasticity. The residuals of GMREL, relationship length, EDI, BIAQ and BISC were all heteroscedastic thus violating this assumption. Similarly, in the models with orgasm as the outcome variable, the residuals of GMREL, relationship length EDI, BIAQ and BISC were heteroscedastic. Based on these violations caution should be taken when making generalizations beyond the current sample (Field, 2009). All fifteen models had normally distributed errors. In all of the models the standardized residuals were below the recommended value of 3.30 (Field, 2009), indicating that all of the models had an acceptable fit to the data (Table 2). Cook’s distance values in all of the models were all less than the 1.00 indicating that there were no influential cases impacting the model, thus indicating good fit.

**Chapter Four: Discussion**

A handful of published studies to date have identified an association between body image and aspects of women’s sexuality. In these studies, negative body image has been associated with increased sexual anxiety, lower sexual esteem and less sexual satisfaction (Anderson & LeGrand, 1991; Faith & Schare, 1993; Trapnell, et al., 1997). A small number of studies have more specifically explored the connectedness of women’s body image to their sexual functioning. These studies suggest that negative body image is
associated with less arousability, more orgasm difficulty, decreased sexual desire and lower overall sexual functioning (Sanchez & Kiefer, 2007; Seal, et al., 2009; Steer & Tiggemann, 2008; Weaver & Byers, 2006). Although these studies provide preliminary evidence about the relationship between women’s body image and sexual functioning, methodological limitations, such as flawed operationalization of key constructs and a lack of consideration for potential confounding variables, render the external validity weak.

As such, it was the objective of this thesis to evaluate the association between body image (conceptualized multidimensionally) and components of sexual functioning over and above relationship satisfaction, percent total body fat and relationship length.

Eighty-eight women recruited via convenience and purposive sampling strategies participated in this study. Participants visited the Body Composition and Metabolism Laboratory at the University of Guelph where they underwent a DXA scan for body composition data and completed self-report demographic, body image and sexual functioning questionnaires. The FSFI (Rosen, et al., 2000) was used to assess the frequency, intensity and satisfaction a woman experienced with desire, arousal and orgasm. The body dissatisfaction subscale of the EDI (Garner, et al., 1983), the appearance and attribution subscales of the BESAA (Mendelson, et al., 2001), the Body Image Avoidance Questionnaire (Rosen, et al., 1991) and the BISC (Wiederman, 2000) were used to assess evaluative body image, affective body image and behavioural body image respectively. Results indicated that over and above the contribution of the control variables, body dissatisfaction and feelings that others evaluate one’s body negatively were associated with lower sexual desire and arousal. Negative feelings about one’s appearance were associated with lower sexual arousal. The desire to avoid certain sexual
or intimate behaviours because of body image concerns during a sexual encounter (body image self-consciousness) was associated with lower arousal and orgasm.

**Evaluative Body Image and Sexual Functioning**

*Perceptual or evaluative body image* refers to one’s evaluation or appraisal of their body (Banfield & McCabe, 2002). As in previous studies (Weaver & Byers, 2006), evaluative body image was assessed using the body dissatisfaction subscale of the EDI. Previous research has suggested that body dissatisfaction is detrimental to sexual feelings, sexual attitudes and sexual behaviours (Anderson & LeGrand, 1991; Faith & Schare, 1993; Weaver & Byers, 2006). The current findings are an extension of these, such that body dissatisfaction was predictive of decrements in women’s sexual desire and arousal.

Body dissatisfaction predicted decrements in desire as measured by frequency and intensity. It is not surprising that negative appraisals about a woman’s body would reduce her desire to be sexual with a partner. Body dissatisfaction may lead to reluctance about being intimate with a partner in a way which will put the body on display, as a result, this reluctance, fear, or anxiety may serve to reduce sexual desire over time. Objectification theory (Fredrickson & Roberts, 1997) suggests that women often evaluate themselves in terms of external, and often unobtainable, standards of beauty. A woman may worry that her partner will similarly negatively evaluate her and be turned off by her sexually. In the current study, participants had to be sexually active within the past four weeks to meet eligibility criteria. However, even among this sample of currently sexually active participants, negative body evaluations had an impact on desire. The attention processing element of the push-pull model of incentive motivation may provide
a framework for understanding this finding; negative evaluations about one’s body can serve as a form of cognitive distraction that may manifest in several ways. For instance, negative thoughts have the potential to occupy a significant proportion of the women’s attention, thus diminishing her capacity to recognize cues that would otherwise trigger her desire (i.e., signs from her partner that he is very attracted to her). Similarly, negative thoughts may distract a woman from identifying that she does feel desire. Finally, negative evaluations of one’s body may create a barrier to sustaining desire.

Body dissatisfaction also significantly predicted a decrement in sexual arousal, specifically, decreased frequency, intensity and satisfaction with arousal. Similar to desire, socialization and objectification theory may explain why women who are dissatisfied with their bodies may want to consciously inhibit arousal to avoid exposing their body. Considering desire and arousal are intricately connected (Brotto, 2010; Graham, 2010; Laan & Both, 2008) body dissatisfaction may disrupt arousal because of a disruption to desire. Similar to the influence on desire, body dissatisfaction may distract a woman from perceiving cues necessary for sexual arousal. As well, the negative self-evaluations may desensitize a woman to the experience of arousal to a point where signs of her own arousal are unrecognizable. Further, body dissatisfaction may make it difficult for a woman to sustain arousal.

Body dissatisfaction was not a significant predictor of problems with orgasm in the current sample. However, the trend indicated that if a woman was dissatisfied with her body, she scored lower on orgasm (indicating difficulty). Based on these results the difficulty with orgasm may be a culmination of a lack of desire and arousal. If desire and/or arousal are lacking, sensory stimuli necessary for orgasm may be missed. Orgasm
may also be influenced by body dissatisfaction apart from desire and arousal. For instance, body dissatisfaction is an assessment of dissatisfaction with one’s stomach, thighs, body shape, buttocks and hips, all of which are highly involved and exposed during sexual intimacy. Negative evaluations of these body parts may make a woman hesitant to allow her partner to stimulate her in these areas. As a result, she misses out on stimulation which may facilitate her experience of arousal, desire and orgasm.

Nonetheless, body dissatisfaction was not a significant predictor of orgasm difficulties, in contrast to desire and arousal. Empirically, orgasm has been linked with sexual experience (Fisher, 1973), relationship factors (McCabe, 1997) and personality characteristics (Bentler & Peeler, 1979; Mah & Binik, 2001). Therefore, it may be that these factors may have a more immediate effect on the experience of orgasm than does body dissatisfaction.

**Affective Body Image and Sexual Functioning**

*Affective body image* refers to one’s feelings about his or her body and appearance (Banfield & McCabe, 2002). Published research has indicated that negative affect about one’s appearance has been linked with increased sexual anxiety and lower sexual esteem in women (Seal, et al., 2009; Weaver & Byers, 2006). In the current study, the BESAA appearance and attribution subscales were selected to assess affective body image. The appearance subscale was an assessment of how a woman felt about her appearance (i.e., “I like what I see when I look in the mirror”). Higher scores were indicative of positive feelings whereas lower scores were an indication of negative feelings. The results indicated that negative feelings about one’s appearance were associated with lower arousal and feelings that others evaluate one’s body negatively were associated with
decreased desire and arousal. Consistent with previous findings on women’s general sexual behaviours, the current results indicate that negative feelings about one’s appearance are detrimental to women’s experience of sexual arousal. Outlined in the push-pull model of incentive motivation, sexual response is heavily reliant on positive affect elicited in response to a sexual cue (Laan & Both, 2008). Therefore, if a woman’s feelings about her body are negative it is likely this will push her away from allowing sexual cues to be arousing.

In contrast to the previous research which only assessed women’s feelings about their bodies (Seal, et al., 2009; Weaver & Byers, 2006), the current study also used an affective body image measure that assessed how a woman felt others (not specifically her sexual partner) evaluated her appearance. This measure was the attribution scale from the BESAA which was an assessment of how a woman felt others evaluated her appearance (i.e., “other people consider me good looking”) (Mendelson, et al., 2001). Considering sexual response is facilitated by affect elicited in response to a sexual cue (Laan & Both, 2008), if a woman feels others evaluate her body negatively this has the potential to push her away from sexual cues. However, considering the women in this study were currently sexual active, it is also likely that the feeling that others evaluate one’s body negatively generates hesitation with respect to exposing one’s body to one’s partner. The feeling that others evaluate one’s body negatively may occupy a considerable amount of a woman’s attention, thus disrupting her capacity to perceive and appraise sexual cues and sensory information. The finding that lower scores on desire and arousal are predicted by feelings that others negatively evaluate one’s body suggests they are at least partially influenced by how a woman feels she looks in the eyes of others.
Likely the result of cultural implications that feminine beauty engages male arousal (Kalof, 1993), female sexual scripts may delineate the perception that others (particularly her partner) enjoy her appearance as a trigger of desire and arousal. Perhaps how a woman feels others evaluate her body is a proxy for how she feels her partner evaluates her body. If she feels that others evaluate her body negatively, it is likely that she also feels her partner evaluates her body negatively. Thus, a woman’s desire to have sex and arousal to sexual cues may be disrupted by hesitation to expose one’s body to her partner due to the perception that her partner has negative judgments of her body.

Important to note, attribution exerted more influence on arousal than desire, this finding may signify that women’s arousal is more susceptible to others’ evaluations about them (i.e., cues that one is desirable) whereas desire is more likely influenced by other factors such as relationship length. Although not within the scope of this thesis, these findings highlight the need for future research to explore the difference in cues between desire and arousal. The attribution findings are also consistent with the findings related to body dissatisfaction. Specifically, similar to body dissatisfaction, feelings that others evaluate one’s body negatively (attribution) was a significant predictor of desire and arousal. Considering the significant bivariate correlation between these two variables and the interplay between cognitive and affective processing systems in the development of sexual response, this trend is not surprising. The push-pull model of incentive motivation model posits (Laan & Both, 2008) that that there is a bidirectional relationship between cognitions and feelings, thus explaining why negative evaluations and negative feelings would influence desire and arousal similarly.
Also, similar to body dissatisfaction, feelings about one’s own appearance and beliefs about how others feel about one’s body (attribution) were not a significant predictor of orgasm. This is likely because appearance and attribution, as measured in the current study, may not have been relevant to orgasm because they are distal to the physiological processes involved in orgasm. In particular, the measure used to assess appearance and attribution focused on how a woman felt about her appearance and how she felt she appeared to others on a daily basis. These thoughts presumably may not be prominent during sexual intimacy, thus not likely to distract a woman to the point where physiological cues for orgasm are missed. Existing literature on orgasm indicates that variables such as personality and sexual experience are salient predictors of orgasm (Bentler & Peeler, 1979; McCabe, 1997), thus it is likely these are more predictive of orgasm than affective body image.

**Behavioural Body Image and Sexual Functioning**

The BIAQ, which was one of the assessments of behavioural body image included in this thesis, did not significantly predict any of the sexual functioning domains. The BIAQ is an assessment of the degree to which an individual avoids behaviours that expose their body or weight (i.e., “I do not go out socially if the people I am with will discuss weight”). This result was consistent with previous research (Weaver & Byers, 2006). Weaver and Byers (2006) found that body image avoidance was not uniquely predictive of sexual anxiety, sexual esteem and sexual problems. Given that the inclusion criteria for this study required participants to be in relationships and have had sex in the previous month it could be that the women who avoid sexual behaviours because of negative body image were, as a result, excluded from the study. Negative
behavioural body image may act as barrier to actually engaging in sexual intercourse and/or a barrier to forming an intimate relationship. In the current sample, almost all (98%) of the women scored beneath the 50th percentile on the BIAQ, indicating that women in the study had very low levels of body image avoidance (similar to the women in Weaver and Byers’ sample). This supports the idea that women who are inclined to avoid certain behaviours because of negative body image likely were not interested in participating in a study of this type. Participation in this study required measurements of weight and body composition, both of which required high levels of body exposure. Therefore, the lack of relationship found between behavioural body image and sexual functioning in this thesis is likely not an indication that no such relationship exists in the general population; but more likely that body image avoidance was less common in the current sample as a function of the study focus and design. Future work should consider the influence body image avoidance has on the sexual functioning of women in a sample of women that are not required to be in relationships and/or women that have not necessarily had sex in the previous month and/or in a study that requires minimal levels of body exposure.

Developed specifically for sex research, the BISC questionnaire (Wiederman, 2000) assesses an individual’s desire to avoid certain sexual or intimate behaviours because of body image concerns (i.e. negative thoughts and feelings about one’s body) during physical intimacy with a partner. Previous findings indicate that the BISC is associated with body shame, appearance anxiety and overall sexual functioning (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Current results indicated that BISC significantly predicted decrements in arousal and orgasm but not desire. From the
framework of the Masters and Johnson/Kaplan model of sexual response, this finding may be an indication that body image self-consciousness is not relevant to women’s sexual desire because desire is likely present prior to (or at least during) engaging in sexual activity.

Body image self-consciousness has been associated with decreased arousability (Sanchez & Kiefer, 2007). In the Sanchez and Kiefer article, as measured by the Arousability Index (Anderson, Broffitt, Karlsson, & Turnquist, 1989), arousability was operationalized as a women’s self-reported arousal to written sexual scenarios. In contrast, the sexual arousal domain of the FSFI assesses the frequency, intensity and satisfaction with the experience of arousal. Interestingly, self-consciousness about the body during a sexual encounter (as measured by the BISC in both studies), appears to influence both tendencies to become aroused and sexual functioning specific to arousal. Cognitive distraction and affect generation (both elements of the push pull model of incentive motivation) may explain why sexual behaviours that are influenced by body image concerns would be associated with decrements in arousal. Cognitive distraction may unconsciously inhibit a woman’s arousal, whereas the negative feelings about one’s body experienced during intimacy may unconsciously or consciously influence a woman to inhibit her arousal (Laan & Both, 2008).

Women who had high body image self-consciousness were likely to report problems with orgasm operationalized by less frequent orgasms, less satisfaction with their ability to orgasm and more difficulty reaching orgasm. Given that high scores on the BISC indicate that sexual behaviours are influenced by body image concerns, it is clear that as scores on the BISC increase, body images concerns that are present during sexual
activity also increase. Increased body image self-consciousness likely results in decreased attention capacity to perceive sexual cues and sensations during sexual activity. This diminished capacity increases the likelihood of disruptions to orgasm. Increased body image self-consciousness may also result in avoiding stimulation by one’s partner to particular areas of one’s body that are linked to orgasm. Interestingly, Sanchez and Kiefer (2007) found that orgasm was not influenced by body image self-consciousness. Differences in these findings are likely the result of differences in sample characteristics. Sanchez and Kiefer’s (2007) sample included women both in relationships and single. Based on the current findings, relationship duration positively predicts orgasm. Considering 29% of Sanchez and Kiefer’s (2007) sample were not in relationships, variation in orgasm may have been driven by a lack of familiarity with one’s partner. Finally, orgasm was measured differently in the studies. Sanchez and Kiefer (2007) used two questions which assessed: frequency of orgasm and frequency of difficulty reaching orgasm. In this thesis, orgasm was assessed by three questions pertaining to: frequency of orgasm, frequency of difficulty with orgasm and satisfaction with orgasm. Body image self-consciousness accounted for more variance in arousal than orgasm; this is likely due to the cognitive nature of arousal versus the physiologically-based response of orgasm.

Control Variables

Selection of the control variables in the current study was informed by previous research and theory. For instance, existing research has identified a positive correlation between relationship satisfaction and sexual functioning (Steer & Tiggemann, 2008). To statistically control for this association, relationship satisfaction was included in the analysis. Bivariate correlations indicated that relationship satisfaction was not
significantly correlated with desire, arousal or orgasm. Similarly, the multivariate results indicated that relationship satisfaction did not significantly contribute a unique proportion of variance to any of the three outcome variables (desire, arousal and orgasm). This result contrasts findings reported by Steer and Tiggemann (2008). However, Steer and Tiggemann (2008) used total FSFI score to assess overall sexual functioning which contains questions related to sexual satisfaction. Thus, it is likely that the strong correlation between sexual satisfaction and relationship satisfaction drove this finding (Byers, 2005). Results suggest that body image is more relevant than relationship satisfaction to a woman’s experience of desire, arousal and orgasm.

Relationship length was included as a control variable based on research indicating that sexual desire decreases as relationship length increases (Johnson, Wadsworth, Wellings, & Field, 1994; Klusmann 2002; Levine, 2002). The findings from this thesis are consistent with existing literature. In the three models in which desire was the outcome variable, relationship length was the strongest predictor. In all three of the models with orgasm as the outcome variable, relationship length was a significant positive predictor. In the two models that included body dissatisfaction and attribution as the predictors of interest, relationship length was the strongest predictor of orgasm. In the model with body image self-consciousness as the predictor of interest, relationship length was the second strongest predictor of orgasm. To the researcher’s knowledge this is the first study to date to report a finding suggesting familiarity with one’s partner may be an important contributor to the experience of women’s orgasm. Replication in future studies would help to validate this relationship.
To examine the relationship between body image and sexual functioning independent of body composition, percent body fat (a biologically relevant assessment of body composition; Albanese, et al., 2003) was included as a control variable. Based on findings from previous studies, the relationship between body composition and sexual functioning is somewhat unclear. In comparison to normal-weight counterparts, obese women have reported less frequent sexual desire suggesting body weight is associated with sexual functioning (Castellini, et al., 2010). Bajos et al. (2010) did not find a statistical difference between obese and normal weight women on sexual dysfunction related to desire and arousal; however they did report an association between less frequent desire and BMI. Other similar findings include an association between BMI, and lack of enjoyment of sexual activity (Kolotkin, et al., 2006); and decreased arousal and orgasm (Esposito, et al., 2007). Weaver and Byers (2006) reported that BMI was not predictive of women’s sexual problems. The results of the current study are consistent with those of Weaver and Byers (2006); percent body fat was not a significant predictor of desire, arousal or orgasm. The findings of the current study indicate that, in this sample, a woman’s perception of her body is much more influential on her sexual functioning than her actual body composition. Given the studies that do report an association between BMI and sexual functioning and/or sexual behaviours do not account for body image, the results of this thesis indicate that their findings may have been a result of body image concerns and not necessarily body composition. More research is needed to support this hypothesis.
**Strengths and Limitations**

The relationship between body image and sexual functioning varies as a function of age, ethnicity, sexual orientation and relationship status (Davison & McCabe, 2005; Laumann, et al., 2005). Therefore, with respect to these demographic characteristics a homogenous sample was recruited. The homogeneity of the sample allowed for conclusions regarding the relationship between body image and sexual functioning in the absence of several extraneous influences, and may serve as a foundation for future inquiry. However, the homogeneity of the sample limits the ability to generalize findings to various ages, ethnicities and sexual orientations. To rectify these limitations, future research should attempt to recruit large samples of women of different ages, ethnicities and sexual orientations. Large samples of women should be recruited to allow for the examination of these variables as independent predictors and/or to statistically control for them. Although the external validity is a limitation, the methodological control that produced the homogenous sample in this thesis is also a strength. For instance, given that the sample consisted of only 91 women; statistically controlling for age, ethnicity, sexual orientation and relationship status in a sample of this size may have produced unstable estimates (Field, 2009). Therefore, methodologically controlling for these variables allowed for stable estimates.

The sample consisted of healthy weight, overweight and obese women in university, thus findings are limited to this demographic (i.e. excluding underweight women and women not in university). Despite considerable efforts to recruit an equal number of healthy weight, overweight and obese women from the community, 96% of the sample were university students, just over half of the sample were in the normal weight category (53.4%), 32% were overweight and only 15% were obese. Future
research should focus recruitment efforts on women who are overweight and obese, and women from the community to improve upon such limits to generalizability. On average, as indicated by skewed and kurtotic distributions, the women in the study had relatively high body image and sexual functioning scores, thus limiting generalizability. However, body image was a significant predictor of sexual functioning within a sample that would be considered relatively healthy. Therefore, this may be an indication of the significant influence body image has on sexual functioning, which may be particularly salient in other samples (i.e., obese women, or women with sexual problems).

To collect data on body composition, participants were required to visit the Body Composition and Metabolism Lab at the University of Guelph. During the visit participants were required to undergo a DXA scan which produced information regarding the percentage of total and regional body fat (among other calculations). Similarly, participants were required to be in relationships and have had sex in the previous month, both of which may potentially be inhibited by poor behavioural body image. Therefore, individuals who had extremely negative body image, and, in particular, those who were more likely to avoid certain behaviours because of their body image, likely did not participate. Considering that future work should continue to use body composition in the analyses of body image and sexual functioning, it may be difficult to do research which assesses body image avoidance and sexual functioning. However, it is recommended that participants are assured of the confidentiality and minimal exposure of their body during testing. Further, not requiring participants to be in relationships or to have had sex in the previous month may also increase the number of people with poor behavioural body image.
The external validity of the findings is limited by the convenience sample. Similarly, inherent in sexuality research is self-selection bias, such that, there may be something systematically different about the sexual functioning of individuals that choose to participate versus those that do not (Morokoff, 1986; Saunders, Fisher, Hewitt, & Clayton, 1985). Consequently, this bias also limits the generalizability. Participation was confidential and participants completed questionnaires independently, it is believed that this helped to buffer the influence of self-selection. The cross-sectional and correlational nature of the data does not permit conclusions about cause and effect. For instance, it is unclear if negative body image causes decreased sexual functioning or if poor sexual functioning causes negative body image. Further, on average, body image uniquely accounted for 6% of the variability in women’s desire, arousal and orgasm. On average, in combination with the control variables, body image accounted for 13% of the variability in desire, arousal and orgasm. The amount of variance unaccounted for suggests that there are other important factors not taken into account in the current study which exert a significant influence on aspects of sexual functioning. Therefore, future research needs to continue to explore contributors to women’s sexual functioning in conjunction with body image.

The sexual functioning domains are not mutually exclusive and there is a great deal of overlap among them, particularly between desire and arousal (Brotto, 2010; Graham, 2010; Laan & Both, 2008). Although conclusions were made regarding the influence body image had on each of the domains, it should be noted that it is unlikely that these influences are independent of each other. For instance, decreased arousal, caused by intrusive thoughts related to body image, may make achieving orgasm more
difficult. Therefore, it may not be that orgasm is directly influenced by negative body image but rather that orgasm suffers as a function of disrupted arousal. Future studies should attempt to investigate if the relationship between body image and arousal is mediated by desire. Similarly, further exploration of the possibility that the relationship between body image and orgasm is mediated by desire and arousal should be undertaken.

To date, this is the first study of women’s body image and sexual functioning to account for a biologically relevant measurement of body composition. Including percent body fat allowed for conclusions to be made about body image and sexual functioning independent of body composition. Using such an accurate tool to assess body composition is also important for the field of human sexuality; this study has set a precedent for the usage of specific measures of body composition (i.e. percent body fat) rather than BMI or self-report weight. Given the complexity of body image as a concept (i.e. that it is comprised of evaluations and feelings about one’s body and individual behaviours that are influenced by thoughts and feelings about one’s body) a strength of the current study was the recognition of this complexity and assessment of body image as a multidimensional concept. Similarly, sexual functioning has typically been studied piecemeal, in which the outcome variable of interest within individual studies is often only one of the sexual functioning domains (i.e. desire or arousal or orgasm). This poses a challenge when drawing conclusions considering there is variation among the samples and the scales that are used to assess body image and sexual functioning. Studying the impact the multiple dimensions of body image have on sexual desire, arousal and orgasm in the same study (i.e. using the same population and methods) provides a comprehensive understanding of this relationship. Finally, a study of this nature that has documented an
association between cognitive and affective processing related to body image with the domains of sexual functioning highlights the interconnectedness between mind and body in women’s sexuality. This finding demonstrates that human sexuality is a cognitive process not just a physiological one and should be understood, researched and treated (i.e. sexual problems) as such.

**Implications**

Identified in existing literature is a negative association between women’s sexuality and body image, previously both narrowly defined. The current thesis advances this knowledge by demonstrating that multiple dimensions of body image are associated with all of the domains of women’s sexual functioning. In particular, body dissatisfaction and negative feelings about how others evaluate one’s body predicted less frequent and intense desire and arousal. Negative feelings about one’s body predicted decreased arousal. Body image self-consciousness during a sexual encounter was predictive of less intense and less frequent arousal and orgasm. Therefore, clinical assessments of women’s sexual problems should include an assessment of body satisfaction, feelings about one’s appearance, attribution and body image self-consciousness. Assessments of each of these types of body images will facilitate the development of treatment plans. For instance, considering body image self-consciousness likely serves as a cognitive distraction, if a woman is highly concerned with her appearance during sexual intimacy treatment plans should incorporate exercises designed to reduce cognitive distraction, such as mindfulness techniques (Brotto, Basson, & Luria, 2008; Brotto & Heiman, 2007). In addition to demonstrating the value of conceptualizing body image as multidimensional when assessing sexual functioning, this thesis also demonstrated that sexual desire,
arousal and orgasm are all influenced to different degrees by the various dimensions. Therefore, it is also important that sexual problem assessments focus on identifying the disrupted domain of sexual functioning.

The findings from this thesis are specific to 18-25 year old women, however the results are consistent with trends identified in populations with broader age ranges (Sanchez & Kiefer, 2007; Weaver & Byers, 2006). Considering many women experience difficulties with body image this research in conjunction with the abundant body image literature draws attention to the need for public health education on body image. In particular, women should be taught skills and strategies to develop and maintain healthy body image. Further, the present findings underscore a need for comprehensive education that emphasizes positive evaluations of one’s body, positive feelings about one’s body both on an everyday basis and in sexual situations. The data from this thesis were predominately from university students, thus making a case for body image education and skill development programs on university campuses. In addition to such programs, it may advantageous for positive body image education and skill development to target preteen and teenage girls. This is an age that images of ideal beauty and thinness standards become salient, thus making girls of this age susceptible to the development of concerns about their body (McCabe, et al., 2006). Therefore, prevention and treatment programs aimed at preteen and teens should be designed to foster the development of strong body images. In addition to highlighting the need for education and treatment programs designed for developing and maintaining positive body images, the present findings also highlight the need for effectiveness and program evaluation research to evaluate the experience of desire, arousal and orgasm as outcome measures.
Future Research

Although the present findings indicate dimensions of body image are associated with women’s sexual functioning, they also suggest however, that body image concerns do not account for a large portion of the variance in sexual functioning, thus, it would be worthwhile to consider the myriad of other factors which influence sexual desire, arousal and orgasm (i.e., sexual attitudes, previous sexual experience, etc.). Considering the sexual functioning of this sample was relatively high, perhaps body image and sexual functioning may be more strongly associated in samples of women with sexual problems. Following the same structure as Castellini et al. (2010) in addition to controlling for body image, the sexual functioning of healthy weight, overweight and obese women should be compared to explore for differences in the relationship between body image and sexual functioning based on body composition.

With the growing body of literature on women’s body image and sexual functioning, this thesis identified that body image concerns can be a cognitive impediment to women’s sexual functioning. Further research is needed to identify the cognitive pathways and mechanisms whereby the various dimensions of body image interfere with sexual functioning. The use of statistical techniques such as structural equation modelling should be used to understand the relationship between the multiple dimensions of body image and the sexual functioning domains. Sanchez and Kiefer (2007) used this technique; however their study was missing key body image dimensions, did not statistically account for relationship status, and did not use sexual functioning as the outcome variable. Structural equation models that incorporate the multiple dimensions to predict sexual functioning will help to identify cognitive pathways. Knowledge of these pathways will have the potential to aid clinicians and researchers in
the development of treatment plans for disrupted sexual functioning. Structural equation modelling can also be used to further explore the dynamic relationship between body composition, body image and sexual functioning. Perhaps, body image acts as a mediator or moderator between body composition and sexual functioning.

Women’s sexual desire is triggered by a variety of sexual motives. For instance, women have reported being motivated to have sex out of obligation, to increase closeness and intimacy with their partner, to avoid conflict, etc. (Impett, Peplau, & Gable, 2005; Meston & Buss, 2007). Although extensive research has been conducted to identify such motives, very little research has been conducted to identify predictors of these motivations. Interestingly, body image may be a predictor of sexual motivations. For instance, women have reported engaging in sex out of obligation or out of a desire to hold on to a sexual partner (Impett, Peplau, & Gable, 2005; Meston & Buss, 2007). Using structural equation modelling, future research could explore whether poor body image (conceptualized multi-dimensionally) predicts these or other motivations for sex.

Considering the findings from this thesis identify body image as a predictor of sexual functioning, research on the predictors of body image concerns should be undertaken. In particular, future research should attempt to indentify populations that are particularly vulnerable to developing body image concerns.

In the present study data on female sexual functioning was self-report. As such, data on physiological sexual functioning was not assessed, however technology is available and is commonly used in sexuality research to assess for women’s physiological sexual arousal (Graham, 2010). Therefore, to capture a comprehensive understanding of how the multiple dimensions of body image influence sexual functioning the impact body
image has on physiological arousal should be explored in future studies. As previously noted, due to the correlational nature of the study, causal statements about body image and sexual functioning were not possible. Future research should explore the relationship between body image and sexual functioning using experimental or longitudinal designs.

How a woman felt others perceived her body and appearance (attribution) was significantly predictive of sexual desire and arousal. Presumably, how a woman feels her partner evaluates her body would be of equal or greater importance to her sexual desire and arousal (Sanchez & Kiefer, 2007). As such, future research should explore this relationship further. The attribution subscale of the BESAA assesses how an individual feels others evaluate their body (i.e., “people my own age like my looks”). Perhaps items on the scale could be adapted in future studies to assess how an individual feels their partner evaluates their body (i.e., “my partner likes my looks”) or a new scale could be developed to explore the relationship between how one feels their partner evaluates their body and their sexual functioning. If, using such a measure, it is revealed that body image support is relevant to women’s sexual functioning, treatment of sexual problems can include discussion on partner support for the woman’s body and the woman’s perception of her partner’s support. Moreover, structural equation modelling could be used to identify whether perceived partner support improves dimensions of body image or whether it attenuates/buffers poor body image. A better understanding of this relationship can inform evidence-based solutions for such problems.

Body image has largely been considered a concern salient to women. As a result, several body image questionnaires were designed for and validated on women (Rosen, et al., 1991; Wiederman, 2000). Recently, male body image concerns have garnered more
theoretical and empirical attention (Aubrey, 2006; Sanchez & Kiefer, 2007). However, in the few studies that have examined male body image and its association with sexual functioning, body image has been evaluated by a tool that was developed for and/or validated on, women (Sanchez & Kiefer, 2007). As such, the validity of the findings and implications are questionable. Therefore, future research should develop body image questionnaires intended for men. Further, model equivalence/invariance testing across genders should be undertaken for existing measures of body image. The development of body image questionnaires valid for assessing male body image concerns should be used in future studies to evaluate the impact body image has on men’s sexual functioning. This research would allow for valid gender based comparisons regarding the impact body image has on sexual functioning.

**Conclusion**

The objective of this thesis was to examine the impact the multiple dimensions of body image had on the domains of women’s sexual functioning above and beyond the influence of relationship characteristics and body composition. The results were consistent with existing body image and sexual functioning literature, such that, body image dimensions were predictive of women’s sexual functioning. In particular, body dissatisfaction and feeling that others evaluate one’s body negatively were predictive of decrements in women’s desire and arousal. Negative feeling about one’s appearance were predictive of decrements in arousal and negative thoughts and feelings about one’s body that influence sexual behaviours were predictive of decrements in arousal and orgasm. These findings highlight the value in educating women on the importance of developing and maintaining positive body image. Future research should focus on exploring this
relationship further within other samples (e.g. older women, more culturally diverse populations, men).
References


A. Traish (Eds.), *Women's sexual function and dysfunction: Study, Diagnosis and Treatment*. London: Taylor and Francis.


Psychophysiology of Sex (pp. 278-290). Bloomington, Indiana: Indiana University Press.


Tiefer, L. (2010). Beyond the medical model of women's sexual problems: a campaign to resist the promotion of 'female sexual dysfunction'. *Sexual and Marital Therapy*, 17(2), 127-135.


Appendix A

Does Size Matter?

We are conducting a study to find out whether body size influences sexual function.

Are you interested in participating in this 2 hour study?

If so, you need to:

- Be 18 to 25 years old
- Be Caucasian
- Be in a heterosexual romantic relationship
- Have had sex at least once in the past month
- Not be taking any anti-depressant medication
- If female, you cannot be pregnant or taking birth control pills

You will be compensated for your time.
Appendix B

What impacts YOUR sexuality?
-Participate in a Health and Sexuality Study-

To Participate you must be:
- 18 to 25 years of age
- White/Caucasian
- In a heterosexual romantic relationship
- Have had sex once in the past month

Why Participate?
- It only takes one hour
- Learn about yourself
- Receive a $10 gift card
- See how research is conducted
- Confidential
- Approved by the University of Guelph Research Ethics Board

INTERESTED?
Email: bodycomp@uoguelph.ca
Appendix C

Not Feeling Sexy?

Participate in a Health and Sexuality Study
Learn about yourself, and how physical activity, body image, body composition, nutrition and relationship satisfaction may influence your sex life!

Why Participate?
- It only takes one hour
- Learn about yourself
- Receive a $10 gift card
- See how research is conducted
- Confidential
- Approved by the University of Guelph Research Ethics Board

To Participate you must be:
- 18 to 25 years of age
- White/Caucasian
- In a heterosexual romantic relationship
- Have had sex once in the past month

INTERESTED?
Email: bodycomp@uoguelph.ca

UNIVERSITY OF GUELPH
Appendix D

What impacts YOUR sexuality?
Participate in a Health and Sexuality Study

Body Image  Nutrition

Relationship Satisfaction  Physical Activity  Body Composition

Why Participate?
• It only takes one hour
• Learn about yourself
• Receive a $10 gift card
• See how research is conducted
• Confidential
• Research Ethics Board Approved

INTERESTED?
Email: bodycomp@uoguelph.ca

To Participate you must be:
• 18 to 25 years of age
• White/Caucasian
• In a heterosexual romantic relationship
• Have had sex once in the past month

UNIVERSITY OF GUELPH
Sex, Health and YOU!
Participate in a Health and Sexuality Study!

Learn about yourself, and how physical activity, body image, body composition, nutrition and relationship satisfaction may influence your sex life!

Interested? Email bodycomp@uoguelph.ca
Appendix F

Sex, Health and YOU!
Participate in a Health and Sexuality Study!

Learn about yourself, and how physical activity, body image, body composition, nutrition and relationship satisfaction may influence your sex life!

What’s In It For You?

- It only takes one hour
- Receive a $10 gift card
- See how research is conducted
- Confidential
- Approved by the University of Guelph Research Ethics Board

Interested? Email bodycomp@uoguelph.ca
The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human subjects in the above-named research project and considers the procedures, as described by
the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement.

The REB requires that you adhere to the protocol as last reviewed and approved by the REB. The REB must approve any modifications before they can be implemented. If you wish to modify your research project, please complete the Change Request Form. If there is a change in your source of funding, or a previously unfunded project receives funding, you must report this as a change to the protocol.

Adverse or unexpected events must be reported to the REB as soon as possible with an indication of how these events affect, in the view of the Responsible Faculty, the safety of the participants, and the continuation of the protocol.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research protocols.

The Tri-council Policy Statement requires that ongoing research be monitored by, at a minimum, a final report and, if the approval period is longer than one year, annual reports. Continued approval is contingent on timely submission of reports.

Membership of the Research Ethics Board: M. Dwyer, Legal Representative; M. Fairburn, Ethics and External; D. Emslie, Physician; B. Ferguson, CME; Lachapelle, S. COA; J. Minogue, EHS; Saunders, P. Alternative Health Care and External; Spriet, L. CBS; L Trick, Psychology; J. Tindale, FRAN, T. Turner; SOAN.

Approved: ____________________________  Date: ____________________________

per                        Chair, Research Ethics Board
Appendix H

Screening Questionnaire

Which of these commonly used terms would you use to best describe yourself?

0. Heterosexual/straight
1. Bisexual
2. Lesbian/gay/homosexual
3. Other
4. Uncertain

What is your current relationship status?

0. Not dating anyone
1. Casually dating one or more partners
2. Seriously dating one person
3. Living with partner, but not married
4. Married
5. Widowed
6. Separated/divorced

Have you had sexual intercourse (penis-in-vagina penetration) at least once over the past month?

0. Yes
1. No

Are you currently taking any prescription medications?

0. Yes
1. No

If so, can you tell me what they are?
Appendix I

CONSENT TO PARTICIPATE IN RESEARCH

Does Size Matter?

You are being asked to participate in a research study conducted by Dr. Robin Milhausen and Dr. Andrea Buchholz of the Dept Family Relations and Applied Nutrition.

If you have any concerns about this project please feel free to contact:

- Dr. Robin Milhausen, tel 519-824-4120 ext 54397, email rmilhaus@uoguelph.ca
- Dr. Andrea Buchholz, tel 519-824-4120 ext 52347, email abuchhol@uoguelph.ca
- [Graduate Student Investigator] tel 519-824-4120 ext 56715 email [Graduate Student Investigator email]

PURPOSE AND OVERVIEW

The main purpose of this project is to investigate the link between body composition (how much body fat you have) and sexual functioning. We will also look at whether body image (how you feel about your body) explains the link between body composition and sexual functioning; as well as evaluate whether the effect of body composition on sexual functioning is influenced by relationship satisfaction.

PROCEDURES

If you volunteer to participate, we would ask you to do the following.

The study day will take place in the Body Composition and Metabolism Lab, room 206 of the J.T. Powell Building at the University of Guelph, and will last approximately 2 hours.

Please wear loose comfortable clothing with no metal fasteners (snaps, buttons or zippers). Sweats, fleece, leggings, T-shirts, etc, are ideal.
You will start by having your height, weight and waist circumference measured. This will be done by the Graduate Student Investigator.

You will have your body composition analyzed using an instrument called a DXA. It is a quick and painless procedure. You will lie on a scanning bed for approximately 5 to 7 minutes, during which x-rays will be emitted from below your body and measured above by a moving “arm”. A DXA examination to determine body composition involves exposure of the research subject to a small dose of radiation. Each time this procedure is done the radiation dose to the subject is 0.025 millisieverts (mSv, a unit used to measure radiation dose to people). This is less than the daily dose of radiation that a person receives from a variety of different sources (e.g. spending 2 hours in direct sunlight) and less radiation than the amount received during an average flight. In the general population, the risk of developing fatal cancer is 400 in 2000, approximately 20%. Following one DXA examination this risk will increase by a very small fraction of 1%. (Cancer risk figures from US Food and Drug Administration Center for Devices and Radiological Health, update 17th April 2002). If you are pregnant, or think you might be pregnant, you should not do this test. This test will be done by a Medical Radiation Technologist.

We will then ask to you to complete a series of questionnaires about your overall health and lifestyle, body image, sexual function, and relationship satisfaction. Many of these questions are of a sensitive and intimate nature. You will be seated in front a privacy screen so that only you, and no one else, will be able to see your answers. During this time we will provide refreshments.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

There are no direct benefits to you for participating in this project. You will receive a data printout which will tell you your body composition.

PAYMENT FOR PARTICIPATION

You will receive $15 for participating in this project.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying materials obtained during the study. Data are coded immediately and are stored in password-protected computer files. Thus your individual data are not identifiable with your name. Any results published or presented will be done using group data and/or
coded (unidentifiable) individual results. Data will be stored in a secure cabinet for two years. After this time, it will be shredded and discarded in confidential waste.

PARTICIPATION AND WITHDRAWAL

Your decision to participate in this study is voluntary and you are free to withdraw from the study at any time.

In the unlikely event of an adverse or questionable reaction to any of the experimental interventions, please contact Dr. Robin Milhausen or Dr. Andrea Buchholz (see p. 1 for contact information).

FURTHER RESOURCES

If participating in this study has raised issues for you about your body image or sexual functioning, you may choose to access the following resources:

University of Guelph Counselling Services
Level 3, University Centre
University of Guelph
Guelph - Ontario - N1G 2W1

counsell@uoguelph.ca
(519) 824-4120 ext. 53244

The Wellness Centre
2nd Floor, J.T. Powell Building
(Above Student Health Services)
University of Guelph
Guelph - ON - N1G 2W1
wellness@uoguelph.ca
(519) 824-4120 ext. 53327

Couple and Family Therapy Centre
Department of Family Relations and Applied Nutrition
University of Guelph
Guelph - Ontario - N1G 2W1
(519) 824-4129 ext. 56335

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, please contact:

Sandy Auld, Research Ethics Officer
CONSENT

I have read this Consent to Participate in Research. The study has been explained to me to my satisfaction. I understand that I am free to stop participating in testing at any time, even after signing this consent form.

I agree to allow the investigators to use my anonymous data in research publications.

I agree to participate in the Does Size Matter? study.

PARTICIPANT

____________________________
(Printed name)  
____________________________
(Signature)

____________________________
(Date)

WITNESS

____________________________
(Printed name)  (Signature)

_______________________________
(Date)
Appendix J

This anonymous survey takes about 45-60 minutes to complete and asks about you to report on your perceptions of your physical and sexual health. We will also be asking questions about your current relationship.

If you take this opportunity to contribute information to this study, it is essential that you do so seriously and honestly. Your responses should represent only your own personal opinions and experiences. Every precaution has been taken to ensure that your responses remain private. This study has been approved by the university ethics committee for the protection of human subjects’ rights.

DEMOGRAPHICS

1. How old are you?

4. Are you:

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<th>Working</th>
<th>In High School</th>
<th>In College</th>
<th>In University</th>
<th>Other</th>
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5. What year are you in at University?

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<th>First year (freshman)</th>
<th>Second year (sophomore)</th>
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<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I am a graduate student

4 Are you:
0 Female
1 Male

6. How do you define yourself? (Check one or more responses)
0 Black, African Canadian, African American
1 Middle Eastern, Arabic
2 South Asian (i.e., Indian, Pakistan)
3 East Asian (i.e., China, Japan)
4 Southeast Asian (i.e., Thailand, Philippines, Malaysia)
5 Hispanic
6 White, Caucasian
7 Native
8 Other

7. What is your current relationship status?
0 Not dating anyone
1 Casually dating one or more partners
2 Seriously dating one person
3 Living with partner, but no married
4 Married
8. If you are currently in a relationship or married how long have you been together?
   0 Years
   1 Months

8. Do you have any children?
   0 Yes
   1 No

If yes, do your children live at home with you?
   0 Yes
   1 No

If yes, please indicate their ages: ________________________________

9. (a) With how many different male partners have you engaged in penis in vagina sexual intercourse in your lifetime?

___________# of male partners (enter 0 if you never had sex with a male partner)

(b) With how many different female partners have you engaged in penis in vagina sexual intercourse in your lifetime?

___________# of female partners (enter 0 if you never had sex with a female partner)
(c) With how many different male partners have you engaged in penis in vagina sexual intercourse during the last year?

____________# of male partners (enter 0 if you never had sex with a male partner)

(d) With how many different female partners have you engaged in penis in vagina sexual intercourse during the last year?

____________# of female partners (enter 0 if you never had sex with a female partner)

If you are male skip to question 13:

10. How old were you when you got your first period?

11. Please indicate which of these categories best describes your menstrual cycle:

☐ ☐ I do not have periods because I am pregnant.

☐ ☐ I do not have periods because I have had a hysterectomy.

☐ ☐ I am taking birth control pills, depo-provera, or other hormonal contraception.

☐ ☐ I am taking hormone replacement therapy (HRT).

☐ ☐ I have regular menstrual periods every 25 to 36 days.

☐ ☐ I have had irregular cycles for a long time.

☐ ☐ My cycles have become irregular in the past few years and are accompanied by symptoms of hot flashes and/or night sweats.

☐ ☐ I have not had a menstrual period for at least 12 months.

12. If you currently have menstrual periods (bleeding), please choose the statement that best applies to you.

☐ ☐ I currently have my period.
☐ ☐ I just finished a period in the last week.
☐ ☐ I am about midway between periods.
☐ ☐ I expect my next period to start within a week.

13. Do you have any health conditions?

<table>
<thead>
<tr>
<th>0</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, please list any current health problems:

14. Have you ever broken a bone?

<table>
<thead>
<tr>
<th>0</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
</tbody>
</table>

15. Do you have a known family history of osteoporosis?

<table>
<thead>
<tr>
<th>0</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>

16. Do you suffer from hyperthyroidism or hypothyroidism?

<table>
<thead>
<tr>
<th>0</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
</tbody>
</table>

17. Are you aware of any illnesses in your family which involve estrogen?

<table>
<thead>
<tr>
<th>0</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>

18. Do you suffer yourself from these illnesses?
19. Are you dieting?

  0 Yes
  1 No

20. If yes, are on a physician prescribed medical diet?

  0 Yes
  1 No

21. Number of meals you eat in an average day:

    ________

22. Do you consume caffeine? (Check as many that apply)

  0 None
  1 Coffee
  2 Tea
  3 Cola

   If yes, how many total cups/cans per day?

23. On average, how many alcohol-containing drinks do you consume per week? (one drink is equivalent to: 12 oz beer, 12 oz alcoholic cooler, 4 oz wine, 1 oz hard liquor)

24. How many alcohol-containing drinks do you consume in an average sitting on a weekday?

25. How many alcohol-containing drinks do you consume in an average sitting on a weekday?

26. Do you smoke cigarettes?
27. If yes, how many cigarettes do you smoke on an average day?

0. Less than ½ pack
1. More than ½ pack to 1 pack
2. More than 1 pack

28. If yes, how long have you smoked cigarettes?

Months______
Years_______

29. How would you describe your body weight?

0. Very underweight
1. Slightly underweight
2. About the right weight
3. Slightly overweight
4. Very overweight

30. How satisfied are you with your body weight?

0. Very satisfied
1. Satisfied
2. Somewhat satisfied
3. Very dissatisfied

31. Which of the following are you trying to do about your body weight?
27. Are you currently taking any prescription medications? If so, please list
Appendix K

The Global Measure of Relationship Satisfaction (Lawrence & Byers, 2005)

The following options represent different degrees of happiness in your relationship. The middle point, “happy” represents the degree of happiness in most relationships. Please click the dot which best describes the degree of happiness, all things considered, of your relationship.

1. 

<table>
<thead>
<tr>
<th>Extremely unhappy</th>
<th>Fairly unhappy</th>
<th>A little unhappy</th>
<th>Happy</th>
<th>Very happy</th>
<th>Extremely happy</th>
<th>Perfect</th>
</tr>
</thead>
</table>

9. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very Good 7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Very Bad 1</th>
</tr>
</thead>
</table>

10. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very pleasant 7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Very unpleasant 1</th>
</tr>
</thead>
</table>

4. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very positive 7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Very negative 1</th>
</tr>
</thead>
</table>

11. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very satisfying 7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Very unsatisfying 1</th>
</tr>
</thead>
</table>

12. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very 6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Worthless</th>
</tr>
</thead>
<tbody>
<tr>
<td>valuable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>---------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix L

The Female Sexual Functioning Index (FSFI; Rosen et al., 2000)

1. Over the past 4 weeks, how often did you feel sexual desire or interest?
   5 = Almost always or always
   4 = Most times (more than half the time)
   3 = Sometimes (about half the time)
   2 = A few times (less than half the time)
   1 = Almost never or never

2. Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?
   5 = Very high
   4 = High
   3 = Moderate
   2 = Low
   1 = Very low or none at all

3. Over the past 4 weeks, how often did you feel sexually aroused (“turned on”) during sexual activity or intercourse?
   0 = No sexual activity
   5 = Almost always or always
   4 = Most times (more than half the time)
   3 = Sometimes (about half the time)
   2 = A few times (less than half the time)
   1 = Almost never or never

4. Over the past 4 weeks, how would you rate your level of sexual arousal (“turn on”) during sexual activity or intercourse?
   0 = No sexual activity
   5 = Very high
   4 = High
   3 = Moderate
   2 = Low
   1 = Very low or none at all

5. Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?
   0 = No sexual activity
   5 = Very high confidence
   4 = High confidence
3 = Moderate confidence
2 = Low confidence
1 = Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   0 = No sexual activity
   1 = Almost always or always
   2 = Most times (more than half the time)
   3 = Sometimes (about half the time)
   4 = A few times (less than half the time)
   5 = Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated (“wet”) during sexual activity or intercourse?
   0 = No sexual activity
   5 = Almost always or always
   4 = Most times (more than half the time)
   3 = Sometimes (about half the time)
   2 = A few times (less than half the time)
   1 = Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated (“wet”) during sexual activity or intercourse?
   0 = No sexual activity
   1 = Extremely difficult or impossible
   2 = Very difficult
   3 = Difficult
   4 = Slightly difficult
   5 = Not difficult

9. Over the past 4 weeks, how **often** did you **maintain** your lubrication (“wetness”) until completion of sexual activity or intercourse?
   0 = No sexual activity
   5 = Almost always or always
   4 = Most times (more than half the time)
   3 = Sometimes (about half the time)
   2 = A few times (less than half the time)
   1 = Almost never or never
10. Over the past 4 weeks, how difficult was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?
0 = No sexual activity
1 = Extremely difficult or impossible
2 = Very difficult
3 = Difficult
4 = Slightly difficult
5 = Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?
0 = No sexual activity
5 = Almost always or always
4 = Most times (more than half the time)
3 = Sometimes (about half the time)
2 = A few times (less than half the time)
1 = Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?
0 = No sexual activity
1 = Extremely difficult or impossible
2 = Very difficult
3 = Difficult
4 = Slightly difficult
5 = Not difficult

13. Over the past 4 weeks, how satisfied were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
0 = No sexual activity
5 = Very satisfied
4 = Moderately satisfied
3 = About equally satisfied and dissatisfied
2 = Moderately dissatisfied
1 = Very dissatisfied

14. Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?
0 = No sexual activity
15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

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

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

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

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

0 = Did not attempt intercourse
1 = Almost always or always
2 = Most times (more than half the time)
3 = Sometimes (about half the time)
4 = A few times (less than half the time)
5 = Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

0 = Did not attempt intercourse
1 = Almost always or always
2 = Most times (more than half the time)
3 = Sometimes (about half the time)
4 = A few times (less than half the time)
5 = Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

0 = Did not attempt intercourse
1 = Very high
2 = High
3 = Moderate
4 = Low
5 = Very low or none at all
Appendix M

Body Dissatisfaction Scale from Eating Disorders Inventory (Garner et al., 1983)

This is a scale which measures a variety of attitudes and feelings about your body. THERE ARE NO RIGHT OR WRONG ANSWERS SO TRY VERY HARD TO BE COMPLETELY HONEST IN YOUR ANSWERS. RESULTS ARE COMPLETELY CONFIDENTIAL. Read each question and place an (X) under the column which applies best for you. Please answer each question very carefully. Thank you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I think that my stomach is too big.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>2. I think that my thighs are too large.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>3. I think that my stomach is just the right size.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>4. I feel satisfied with the shape of my body.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>5. I like the shape of my buttocks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>6. I think my hips are too big.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>7. I think that my thighs are just the right size.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>8. I think by buttocks are too large.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
<td>(  )</td>
</tr>
<tr>
<td>9. I think that my hips are just the right size.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(  )</td>
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<td>(  )</td>
<td>(  )</td>
</tr>
</tbody>
</table>
Appendix N

Body-Esteem Scale for Adolescents and Adults (Mendelson, et al., 2001).

Indicate how often you agree with the following statements ranging from "never" (0) to "always" (4). Circle the appropriate number beside each statement.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Never</th>
<th>Seldom</th>
<th>Some times</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I like what I look like in pictures.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Other people consider me good looking.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>I'm proud of my body.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I am preoccupied with trying to change my body weight.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>I think my appearance would help me get a job.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>I like what I see when I look in the mirror.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>There are lots of things I'd change about my looks if I could.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I am satisfied with my weight.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>I wish I looked better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>I really like what I weigh.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>I wish I looked like someone else.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>People my own age like my looks.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>My looks upset me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>I'm as nice looking as most people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15</td>
<td>I'm pretty happy about the way I look.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I feel I weigh the right amount for my height.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>I feel ashamed of how I look.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Weighing myself depresses me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>My weight makes me unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>My looks help me to get dates.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>I worry about the way I look.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>I think I have a good body.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>I'm looking as nice as I'd like to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
## Appendix O

Body Image Avoidance Questionnaire (BIAQ; Rosen et al., 1991)

Circle the number which best describes how often you engage in these behaviors at the present time.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I wear baggy clothes</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. I wear clothes I do not like</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. I wear darker color clothing</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. I wear a special set of clothing, e.g., my “fat clothes”</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. I restrict the amount of food I eat</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6. I only eat fruits, vegetables and other low calorie foods</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. I fast for a day or longer</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. I do not go out socially if I will be “checked out”</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. I do not go out socially if the people I am with will discuss weight</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. I do not go out socially if the people I am with are thinner than me</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. I do not go out socially if it involves eating</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. I weigh myself</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. I am inactive</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14. I look at myself in the mirror</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. I avoid physical intimacy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16. I wear clothes that will divert attention from my weight</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>17. I avoid going clothes shopping</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>18. I don’t wear “revealing” clothes (e.g., bathing suits, tank tops, or shorts)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>19. I get dressed up or made up</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix P

Body Image Self-Consciousness Scale (Wiederman, 2000)

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

0 = never
1 = rarely
2 = sometimes
3 = often
4 = usually
5 = always

1. I would feel very nervous if a partner were to explore my body before or after having sex.
2. The idea of having sex without any covers over my body causes me anxiety.
3. While having sex I am (would be) concerned that my hips and thighs would flatten out and appear larger than they actually are.
4. During sexual activity, I am (would be) concerned about how my body looks to my partner.
5. The worst part of having sex is being nude in front of another person.
6. If a partner were to put a hand on my buttocks I would think, “My partner can feel my fat”
7. During sexual activity it is (would be) difficult not to think about how unattractive my body is.
8. During sex, I (would) prefer to be on the bottom so that my stomach appears flat
9. I (would) feel very uncomfortable walking around the bedroom, in front of my partner, completely nude.
10. The first time I have sex with a new partner, I (would) worry that my partner will get turned off by seeing my body without clothes.
11. If a partner were to put an arm around my waist, I would think, “My partner can tell how fat I am.”
12. I (could) only feel comfortable enough to have sex if it were dark so that my partner could not clearly see my body.
13. I (would) prefer having sex with my partner on top so that my partner is less likely to see my body.
14. I (would) have a difficult time taking a shower or bath with a partner.
15. I (would) feel anxious receiving a full-body massage from a partner.