

“Stop Looking at Me!”: Interpersonal Sexual Objectification as a Source of Insidious Trauma

Psychology of Women Quarterly
2015, Vol. 39(3) 363-374
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DOI: 10.1177/0361684314561018
pwq.sagepub.com



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Abstract

Objectification has been conceptualized as a form of insidious trauma, but the specific relationships among objectification experiences, self-objectification, and trauma symptoms have not yet been investigated. Participants were women with ($n = 136$) and without ($n = 201$) a history of sexual trauma. They completed a survey measuring trauma history, objectification experiences (body evaluation and unwanted sexual advances), constructs associated with self-objectification (body surveillance and body shame), and trauma symptoms. The relationships among the variables were consistent for both women with and without a history of sexual trauma. Our hypothesized path model fit equally well for both groups. Examination of the indirect effects showed that experiencing unwanted sexual advances was indirectly related to trauma symptoms through body shame for those with and without a history of sexual trauma. Additionally, for women with a history of sexual trauma, the experience of body evaluation was indirectly related to trauma symptoms through the mediating variables of body surveillance and body shame. The data indicate that the experience of sexual objectification is a type of gender-based discrimination with sequelae that can be conceptualized as insidious trauma. Clinicians may consider the impact of these everyday traumatic experiences when working with women who have clinical symptoms but no overt trauma history.

Keywords

objectification, posttraumatic stress disorder, victimization, social discrimination, body image

Research has found that, although more men than women are exposed to overt trauma (e.g., experience combat, witness death or injury, and experience accidents; Tolin & Foa, 2006), there are more cases of posttraumatic stress disorder (PTSD) and trauma-related symptomatology (e.g., depression and anxiety) among women than among men (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999; Cortina & Kubiak, 2006; Tolin & Foa, 2006). The discrepancy between genders in prevalence of trauma symptomatology is not entirely understood. Major traumas experienced predominantly by women, such as rape or battery, are known to be detrimental to well-being and mental health (Bargai, Ben-Shakhar, & Shalev, 2007; Root, 1992; Vrana & Lauterbach, 1994). However, even when controlling for the higher prevalence of rape or battery, the gender gap in the experience of trauma symptoms remains (Breslau et al., 1999; Norris, Foster, & Weishaar, 2002). Although some researchers have proposed that women are inherently less resilient in the face of trauma (Breslau et al., 1999; Norris et al., 2002), other research suggests that women's greater risk for trauma symptoms may be related to an increased likelihood of lifetime exposure to traumatic experiences such as aggressive interpersonal events

and sexual violence (Cortina & Kubiak, 2006; Pimlott-Kubiak & Cortina, 2003). Further research is needed in order to identify what unique traumatizing experiences women may have that men do not. Our study explores experiences of sexual objectification as a possible factor contributing to the presence of trauma symptoms in women.

Women, unlike men, live in a world where their bodies are constantly examined, scrutinized, and seen as objects designed for consumption by others (Fredrickson & Roberts, 1997; Gill, 2009; Szymanski, Moffitt, & Carr, 2011). Women are also more likely to have their bodies commented upon and even touched against their will. Although these experiences may not be traumatic or as traumatic as other bodily

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violations, research suggests that smaller, daily discriminatory events can lead to cumulative trauma over time (Root, 1992).

Insidious trauma refers to the psychological impact that low levels of discrimination can have when experienced throughout a lifetime (Nadal & Haynes, 2012; Root, 1992; Szymanski & Balsam, 2011). The experience of interpersonal sexual objectification has been conceptualized as a source of insidious trauma (Root, 1992); however, to our knowledge, the link between sexual objectification and trauma symptoms has yet to be explored. Trauma symptoms include both psychological (e.g., dissociation, anxiety, and depression) and physiological (e.g., headaches, high arousal, and sleep problems) symptoms that are frequently observed in individuals who have experienced trauma and who may or may not meet criteria for PTSD (Elliott & Briere, 1992; Gold, Milan, Mayall, & Johnson, 1994).

Recent research regarding the diagnosis of PTSD has suggested that the experience of trauma may be much more nuanced than once thought, adding strength to the conceptualizing of insidious trauma. According to the most current fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; American Psychiatric Association [APA], 2013), to meet criteria for PTSD, an individual must have experienced at least one event defined as traumatic within the manual; this is referred to as the "A1" criterion. Studies using diagnostic criteria for PTSD from the previous version of the *DSM* (4th edition, text revision; APA, 2000) have suggested that individuals who do not meet the A1 criterion may otherwise meet full criteria for the disorder and/or experience many debilitating symptoms of PTSD (Boals & Schuettler, 2009; Gold, Marx, Soler-Baillo, & Sloan, 2005; Long et al., 2008). In fact, more than one study has found significantly more symptoms of PTSD in individuals who do not meet the A1 *DSM-IV* criterion in comparison to individuals with A1 criterion traumatic events (Gold et al., 2005; Long et al., 2008). Additionally, a recent study found that lesbian, gay, and bisexual individuals who had experienced heterosexual discrimination (a non-A1 criterion event) experienced significantly more symptoms of PTSD as compared to those who had experienced sexual orientation-based hate crime victimization (an A1 criterion event; Bandermann & Szymanski, 2014). The findings of these studies strengthen the argument for a more comprehensive view of trauma that considers both large-scale events (e.g., rape and robbery) and smaller, yet still challenging events that occur more often (e.g., being stared at, catcalled, or touched).

Women frequently experience discrimination and biased treatment as a result of their gender. These events occur in many forms, and one of the most frequent is interpersonal sexual objectification (Capodilupo et al., 2010; Fairchild & Rudman, 2008; Macmillan, Nierobisz, & Welsh, 2000; Nadal, 2010; Root, 1992; Swim, Hyers, Cohen, & Ferguson, 2001). Experiences of interpersonal sexual objectification have been operationalized as involving two main types of

events: body evaluation (e.g., leering and comments made about one's body) and unwanted sexual advances (e.g., unwanted touching, pinching, and sexual assault) in the Interpersonal Sexual Objectification Scale (ISOS; Kozee, Tylka, Augustus-Horvath, & Denchik, 2007). Often analyzed together, the subscales of the ISOS have been found to be related to numerous negative consequences (Carr & Szymanski, 2011; Engeln-Maddox, Miller, & Doyle, 2011; Kozee & Tylka, 2006; Kozee et al., 2007). Specifically, studies have found interpersonal sexual objectification to be related to self-objectification (Augustus-Horvath & Tylka, 2009; Carr & Szymanski, 2011; Engeln-Maddox et al., 2011; Kozee & Tylka, 2006), disordered eating (Augustus-Horvath & Tylka, 2009; Engeln-Maddox et al., 2011; Kozee & Tylka, 2006; Moradi, Dirks, & Matteson, 2005), and depression (Carr & Szymanski, 2011). Because the subscales measure such distinct constructs, some studies (e.g., Liss, Erchull, & Ramsey, 2011), including the present study, have analyzed the two subscales separately. In addition, given that many women frequently experience body evaluation (Swim et al., 2001), it seemed appropriate to assess the relationship separately from unwanted sexual advances, which likely occur with less frequency.

One of the ways in which body evaluation and unwanted sexual advances may lead to negative outcomes is through increased levels of self-objectification. Objectification theory posits that when women experience interpersonal objectification and are exposed to objectifying material, they may self-objectify, or take a third-person perspective of their bodies, essentially surveying themselves as though they are an outside observer (Fredrickson & Roberts, 1997; Moradi & Huang, 2008; Szymanski et al., 2011). In general, research has shown that experiences of interpersonal sexual objectification (including a combination of body evaluation and unwanted advances) are related to increased levels of body surveillance, often considered an operationalization of self-objectification (Augustus-Horvath & Tylka, 2009; Carr & Szymanski, 2011; Engeln-Maddox et al., 2011; Kozee & Tylka, 2006).

Body surveillance is associated with numerous negative mental health effects (Fredrickson & Roberts, 1997; Moradi & Huang, 2008; Szymanski et al., 2011). Associated negative effects include depression (Erchull, Liss, & Lichiello, 2013; Muehlenkamp & Saris-Baglana, 2002; Szymanski & Henning, 2007; Tiggemann & Kuring, 2004), disordered eating (Engeln-Maddox et al., 2011; Moradi et al., 2005; Tylka & Hill, 2004), and appearance anxiety (Noll & Fredrickson, 1998; Tiggemann & Kuring, 2004). Research has indicated that the relationship between body surveillance and negative outcomes is most often mediated by body shame (Augustus-Horvath & Tylka, 2009; Carr & Szymanski, 2011; Engeln-Maddox et al., 2011; Moradi et al., 2005; Noll & Fredrickson, 1998; Tylka & Hill, 2004). Specific outcomes that have been found to be mediated by body shame include depression (Szymanski & Henning, 2007; Tiggemann & Kuring, 2004)

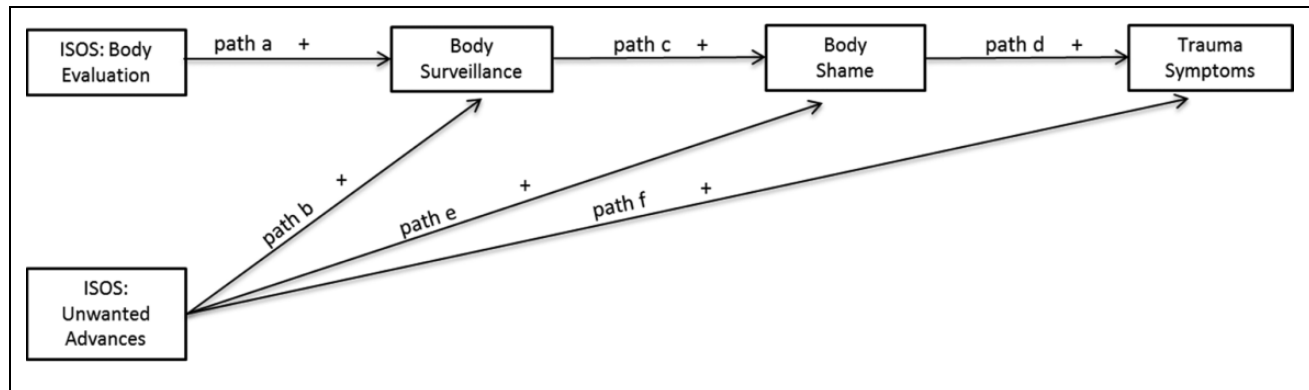


Figure 1. Hypothesized path model.

and negative eating attitudes (Moradi et al., 2005; Tiggemann & Kuring, 2004; Tylka & Hill, 2004).

Body shame refers to the experience of negative feelings and thoughts about one's own body when an individual feels like his or her body does not look the way that it "should" (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996). Within the self-objectification framework, body shame occurs as a result of body surveillance (Fredrickson & Roberts, 1997; Moradi & Huang, 2008). Thus, body shame may mediate the relationship between experiences of sexual objectification, body surveillance, and trauma symptoms. To our knowledge, the link between unwanted sexual advances, body shame, and trauma symptoms has yet to be investigated. However, studies looking at constructs similar to interpersonal sexual objectification, such as sexual harassment, have found such events to be related to increased body image dissatisfaction (Harned, 2000; Weiner & Thompson, 1997; Whealin & Jackson, 2002). Furthermore, multiple studies have indicated that feelings of shame can play a key role in the experience of PTSD symptoms in individuals with a history of trauma (Andrews, 1995; Harman & Lee, 2010; La Bash & Papa, 2014), particularly those with a history of sexual trauma (Feiring, Taska, & Chen, 2002; Vidal & Petrak, 2007; Weis, 2010).

Additionally, women who experience sexual objectification may have decreased feelings of safety, and this vulnerability is likely only enhanced by the societal narrative of the constantly endangered woman who is in charge of protecting herself from a dangerous world (Beneke, 1982; Brownmiller, 1975; Griffin, 1979; O'Donovan, Devilly, & Rapee, 2007). Heightened vigilance, as is societally encouraged, could be compared to a state of hyperarousal, a subcategory of symptoms within the PTSD diagnosis. Over time, these high levels of observance of one's self and of the environment could contribute to feelings of anxiety and decreased safety both in public and at home, contributing to the experience of trauma symptoms.

Furthermore, the removed perspective that women take when surveying their own bodies could be conceptualized as a form of dissociation, although likely less severe than that

which occurs in individuals with PTSD. Dissociation is a symptom commonly experienced by those who have a history of trauma and involves feelings of being outside one's own body (Briere, 2006). One recent study found that a path model linked higher levels of body surveillance to greater reports of dissociative experiences (Erchull et al., 2013). The fact that body surveillance has been linked with dissociation indicates that self-objectification, and body surveillance in particular, may have effects that are more commonly associated with trauma (Erchull et al., 2013).

In the present study, we proposed a path model to explore the mechanisms through which experiences of interpersonal sexual objectification may lead to symptoms of trauma (see Figure 1). This model allowed us to study both direct and indirect relationships between experiencing body evaluation and unwanted sexual advances and the occurrence of trauma symptoms. Given that body surveillance and body shame have been well established as mediators between interpersonal experiences of objectification and negative outcomes (Augustus-Horvath & Tylka, 2009; Carr & Szymanski, 2011; Kozee & Tylka, 2006), we believed that interpersonal experiences of objectification, both body evaluation and unwanted sexual advances, would predict body surveillance (Paths a and b) which would then predict body shame (Path c) which would then predict trauma symptoms (Path d). In addition, given the severity of the violation in experiencing unwanted sexual advances and the links between trauma and body shame discussed previously, we hypothesized a direct relationship between unwanted sexual advances and body shame (Path e). Finally, given that unwanted sexual advances can involve an actual assault against the body, we hypothesized a direct path to trauma symptoms (Path f). We hypothesized that all of these path loadings would be positive and statistically significant.

In addition to our core hypotheses about the model, we had specific hypotheses about indirect paths. We hypothesized that both body evaluation and unwanted sexual advances would indirectly predict trauma symptoms through body surveillance and then body shame (i.e., Path a → Path c → Path d and Path b → Path c → Path d). Furthermore, given that we

hypothesized that unwanted sexual advances would directly relate to body shame, we hypothesized an indirect effect where unwanted advances would predict trauma symptoms through body shame (i.e., Path e \rightarrow Path d).

We also sought to explore how the relationships among the variables might differ for individuals with and without a history of sexual trauma. The negative effects of body evaluation and unwanted sexual advances may be enhanced among women with a history of rape or attempted rape. For women with such a history, experiences of being gazed at or being touched against one's will may remind them of the original assault and, thus, be related to greater levels of psychological harm (for a review on the impact of sexual assault, see Resick, 1993).

Thus, we hypothesized that the bivariate relationships between the variables would be stronger among women with a history of rape or attempted rape. Additionally, we hypothesized that the relationships among variables in the path model would be stronger in the group reporting a history of sexual trauma, although we did not have any specific hypotheses as to whether our hypothesized indirect effects would differ based on trauma history. We also hypothesized that women with a history of sexual trauma would report experiencing more trauma symptoms because experiencing a sexual assault has been found to be related to a variety of negative mental health consequences (Koss, 1990; Resick, 1993; Resnick, Acerno, & Kilpatrick, 1997).

Method

Participants

We recruited 337 female participants between the ages of 18 and 69 to complete our survey. Of these participants, 40% ($n = 136$) reported a history of sexual trauma and 60% ($n = 201$) did not. On average, participants were 31.41 years old ($SD = 11.26$). Our sample was relatively ethnically diverse in that only 49.9% self-identified as White. The other participants identified as Asian/Pacific Islander (24%), American Indian (14.8%), Black/African American (7.1%), Latina (2.1%), multiracial (1.5%), and "other" (0.6%). The majority of our participants self-identified as heterosexual (80.7%), with other participants identifying as bisexual (12.5%), lesbian (5.6%), and "other" (0.3%). An additional 0.9% chose not to disclose. Our participants varied in the level of education they reported as follows: grade school (0.9%), some high school (1.5%), high school graduate (8.6%), some college or an associate's degree (17.9%), college degree (34.8%), some graduate school (15.2%), master's degree (19.6%), and doctoral degree (1.5%). In addition, most participants self-identified as working class (31.8%) or middle class (48.7%); the other participants identified as poor (5.0%), upper-middle class (13.6%), and wealthy (0.6%). An additional 0.3% of the participants did not disclose their socioeconomic status (SES). There were no significant differences

between the women with a history of sexual trauma and those without a history of trauma on age, $F(1, 333) = 1.14, p = .29$, or education, $F = (1, 334) = 2.80, p = .10$. The two samples did, however, differ significantly on SES, $F = (1, 334) = 6.26, p = .01$; on average, participants with a history of sexual trauma reported a lower SES.

Procedure

Female participants over the age of 18 who were living in the United States were recruited using Amazon Mechanical Turk (MTurk). MTurk is a website that has a large and relatively diverse participant pool (Buhrmester, Kwang, & Gosling, 2011; Casler, Bickel, & Hackett, 2013). Studies exploring the quality of data collected from MTurk have yielded results comparable to data collected using traditional methods of online recruitment (Buhrmester et al., 2011; Casler et al., 2013) or in-person assessments (Casler et al., 2013; Goodman, Cryder, & Cheema, 2012). In order to use this website, researchers must set up an account and then deposit money to cover the compensation for the desired number of participants and associated fees prior to the start of the study. Then, when a participant completes a survey and enters a study-specific code verified by the researchers, a portion of the researchers' money is transferred to the participant's Amazon Payments account, where it can be used to purchase an Amazon.com gift card or transferred to the participant's bank account. Participant payment on MTurk is generally nominal. For example, three studies investigating the quality of data collection on MTurk paid between US\$0.02 and US\$0.50 per completed survey (Buhrmester et al., 2011; Casler et al., 2013; Goodman et al., 2012); however, depending on the length and complexity of a survey, participants may be paid more.

The larger survey used to collect the data for our study was described as a study to learn more about variables that may impact women's mental health. The posted survey link on MTurk took participants to an online informed consent. Upon giving consent, they completed the secure survey hosted through Surveygizmo.com before being taken to an online debriefing statement. The measures used to collect data for the present investigation were given in the order that they are described below. After participants entered a code from the debriefing form in MTurk, they received US\$0.25 as compensation for completing the survey.

Materials

Objectified Body Consciousness Scale (OBCS). Two 8-item subscales of the OBCS (McKinley & Hyde, 1996) were used to assess participants reported feelings of body surveillance (e.g., "I rarely think about how I look") and body shame (e.g., "When I can't control my weight, I feel like something must be wrong with me"). Participants indicated their agreement with statements on a 6-point scale ranging from 0

(*disagree strongly*) to 5 (*agree strongly*); there was no *not applicable* option given. Mean scores were calculated such that higher scores indicated greater endorsement of the measured construct. Validity for the body surveillance subscale was confirmed in the original investigation by correlations with the Appearance Orientation Scale and the Public Body Consciousness scale (McKinley & Hyde, 1996). The body shame subscale's validity was assessed using the Cultural Standards Scale and the Personal Endorsement Scale, which measure the degree to which individuals identify and internalize societal appearance standards (McKinley & Hyde, 1996). Responses to the surveillance subscale were internally consistent in both the original ($\alpha = .79$) and the present ($\alpha = .76$) studies. The body shame subscale was also found to have internally consistent responses in both the original ($\alpha = .84$) and the current ($\alpha = .75$) studies.

ISOS. The ISOS (Kozee et al., 2007) is a 15-item measure that was used to assess participants' experiences of sexual objectification. Participants indicated their agreement with the statements on a 5-point scale ranging from 1 (*never*) to 5 (*almost always*) and were instructed to report about experiences from the last year. The scale consists of two subscales: body evaluation (11 items; e.g., "How often have you felt that someone was staring at your body") and unwanted sexual advances (4 items; e.g., "How often has someone grabbed or pinched one of your private body areas against your will"). For the purposes of our study, the two subscales of the ISOS were utilized separately, and mean scores were calculated for each subscale such that higher scores indicated greater frequency of objectification. Positive correlations with scales measuring sexist degradation, sexist events, self-objectification, and internalization of the thin-ideal supported the validity of this measure in the original investigation (Kozee et al., 2007). The Cronbach's α s for the two subscales in the original study were .91 for body evaluation and .78 for unwanted sexual advances. Cronbach's α s were .94 and .91, respectively, in the current study.

Sexual trauma history. We used 2 items from The Lifetime Trauma and Victimization History measure (Widom, Dutton, Czaja, & DuMont, 2005) to screen for history of sexual assault ("coerced into unwanted sex") and attempted sexual assault ("attempted forced sex"). Participants who answered yes to at least one of these questions were considered to have a history of sexual trauma. Participants who answered no to both questions were considered to have no history of sexual trauma.

Trauma Symptom Checklist (TSC). The TSC-40 (Elliott & Briere, 1992) is a 40-item measure that was used to assess physical and psychological symptoms associated with past traumas. Sample items include the following: "nightmares," "sexual problems," "spacing out, for example, going away in your mind," and "feelings that you are not always in your body." Participants indicated the frequency with which they

experienced symptoms in the past 2 months on a 4-point scale ranging from 0 (*never*) to 3 (*often*). A sum was calculated such that higher scores indicated experiencing more trauma symptoms. This measure has previously been shown to accurately assess trauma symptoms in nonclinical samples of women with histories of sexual assault and to discriminate between those with and without a history of abuse (Elliott & Briere, 1992; Gold et al., 1994; Neal & Nagle, 2013). Cronbach's α in the original study was .90, and was .96 in the current study.

Results

Prior to conducting analyses to test our hypotheses, we examined patterns of missing data among our participants. At the item level, all data had less than 2.5% missing responses. We used Little's Missing Completely at Random test to examine the nature of our missing data. The test was non-significant, indicating that data were missing completely at random, $\chi^2(4, 916) = 4,682.13, p = .99$. In creating individuals' scale scores, we allowed 1 missing item per scale. This procedure resulted in no more than four participants having missing data for a given scale. We then assessed the data for possible violations of the assumptions of normality and homogeneity of variance. No assumptions were violated so our analyses proceeded as planned.

In order to determine whether women who reported a history of sexual trauma differed from women who did not on the variables included in our hypothesized model (see Table 1), we ran a multivariate analysis of covariance (MANCOVA) in which SES, the only demographic variable that significantly differed between groups, was the covariate. The MANCOVA was significant, $F(5, 323) = 8.72, p < .001, \eta_p^2 = .12$, indicating that, overall, women with and without a history of sexual trauma differed. The covariate of SES was not significant, $F(5, 323) = 1.97, p = .08, \eta_p^2 = .03$. Examination of the univariate analyses of variance, after controlling for SES, indicated that the groups were significantly different on all variables except for the body surveillance subscale of the OBCS (see Table 1 for means, standard deviations, and univariate *F*-test results). Women with a history of sexual trauma reported higher levels of body evaluation, more unwanted sexual advances, more body shame, and more trauma symptoms.

Table 2 shows the correlations among the measured variables for both the sexual trauma and the no sexual trauma samples. All the variables were significantly positively inter-correlated in both samples, with the exception of the body surveillance subscale of the OBCS. Body surveillance was significantly positively correlated with the body shame subscale of the OBCS for both samples and was significantly negatively correlated with the unwanted sexual advances subscale of the ISOS for the trauma sample. The correlations between body surveillance and the other measured variables were not significant for either group. The effect sizes of the

Table 1. Descriptive Statistics and Univariate ANCOVA Results.

Variable	No Sexual Trauma (<i>n</i> = 198)		Sexual Trauma (<i>n</i> = 133)		Main Effect of Trauma History
	<i>M</i> (<i>SD</i>)	Range	<i>M</i> (<i>SD</i>)	Range	
ISOS Body Evaluation	2.51 (0.88)	1–5	2.88 (0.89)	1–4.73	$F(1, 327) = 15.67, p < .001, \eta_p^2 = .05$
ISOS Unwanted Advances	2.02 (1.01)	1–4.50	2.47 (1.07)	1–5	$F(1, 327) = 16.25, p < .001, \eta_p^2 = .05$
OBCS Body Surveillance	2.56 (0.78)	.63–5	2.64 (0.91)	.13–5	$F(1, 327) = .43, p = .51, \eta_p^2 = .001$
OBCS Body Shame	2.26 (0.85)	.25–4.88	2.48 (0.86)	.13–4.63	$F(1, 327) = 6.57, p = .01, \eta_p^2 = .02$
Trauma Symptoms	32.52 (24.47)	0–108	50.00 (24.28)	0–102	$F(1, 327) = 39.13, p < .001, \eta_p^2 = .12$

Note. ANCOVA = analysis of variance; ISOS = Interpersonal Sexual Objectification Scale; OBCS = Objectified Body Consciousness Scale. Higher scores represent greater endorsement of the construct. Possible range for ISOS subscales was 1–5. Possible range for OBCS subscales was 0–5. Possible range for trauma symptoms was 0–120.

Table 2. Bivariate Correlations for Sexual Trauma (*n* = 133) and No Sexual Trauma Women (*n* = 198).

	1	2	3	4	5
1. ISOS Body Evaluation	—	.79***	-.09	.23**	.48***
2. ISOS Unwanted Advances	.78***	—	-.25**	.28**	.61***
3. Body Surveillance	.03	-.10	—	.36***	-.12
4. Body Shame	.26***	.30***	.25**	—	.42***
5. Trauma Symptoms	.28***	.37***	-.10	.27***	—

Note. ISOS = Interpersonal Sexual Objectification Scale. Correlations for women who reported a history of sexual trauma are reported above the diagonal; correlations for women who did not report a history of sexual trauma are below the diagonal.

** $p < .01$. *** $p < .001$.

correlations were similar across the samples. However, there was a general pattern of correlations being stronger among the trauma sample. For example, the relationship between body evaluation and unwanted sexual advances scores with trauma symptoms were in the small-to-moderate range for the no trauma sample but were in the moderate-to-strong range for the trauma sample (Cohen, 1988).

We used path analysis with maximum likelihood estimation and bootstrapped standard errors in M-plus version 6.12 (Muthén & Muthén, 1998–2010) to test our hypothesized model (see Figure 1). Missing data were handled with the full information maximum likelihood estimation procedure. There were three distinct patterns of missing data, and only four cases had missing data at the scale level.

We began our analyses by testing the model with the sample that did not report a history of sexual trauma. The model had good fit, $\chi^2(3) = 3.53, p = .32$; root mean square error of approximation (RMSEA) = .03; comparative fit index (CFI) = .99; standardized root mean square residual (SRMR) = .03 (see Figure 2 for standardized path loadings). All modeled pathways were significant and positive except for the pathway between unwanted sexual advances and body surveillance, which had a significant negative relationship. The model explained 16.4% of the variance in trauma symptom scores.

The model was then tested with the women who reported experiencing sexual trauma. The model again fit well, $\chi^2(3)$

= 2.64, $p = .45$; RMSEA < .001; CFI = 1.00; SRMR = .02 (see Figure 2 for standardized path loadings). Once again, all pathways were significant and positive except for the pathway between unwanted sexual advances and body surveillance which was significant and negative. The model explained 43.3% of the variance in trauma symptom scores.

We also sought to determine if the model fit the data from both groups of women equally well. We did this by comparing the fit of the model when the values of the paths were free to vary between groups to a model in which the values of the paths were constrained to be invariant. We found that there was no significant difference in fit between these models, $\chi^2_{\Delta}(6) = 9.99, p = .13$, indicating that the model fit the data from both groups equally well.

Next, we tested our hypotheses about indirect effects. We first tested whether body evaluation and unwanted sexual advances had indirect effects on trauma symptoms in the sample that did not report a history of sexual trauma. Body evaluation did not have a significant indirect effect on trauma symptoms through body surveillance and body shame. The estimated indirect effect was .01 with 95% confidence intervals (CIs) of [-.007, .03]. Unwanted sexual advances did have a significant indirect effect on trauma symptoms through body shame, standardized estimate = .05 with a 95% CI of [.02, .09]. We had hypothesized an indirect effect from unwanted advances to trauma symptoms through both surveillance and body shame. Because the path from unwanted advances to surveillance was negative, rather than positive as we expected, the clear interpretation of any indirect effects from unwanted advances through body surveillance would be impossible. Thus, we did not test this specific indirect effect.

Finally, we tested whether body evaluation and unwanted sexual advances had indirect effects on trauma symptoms in the sample that reported a history of sexual trauma. In this sample, body evaluation did have a significant indirect effect on trauma symptoms through body surveillance and body shame, standardized estimate = .04 with a 95% CI of [.002, .07]. Unwanted sexual advances also had a significant indirect effect on trauma symptoms through body shame, standardized estimate = .11 with a 95% CI of [.04, .17]. Again,

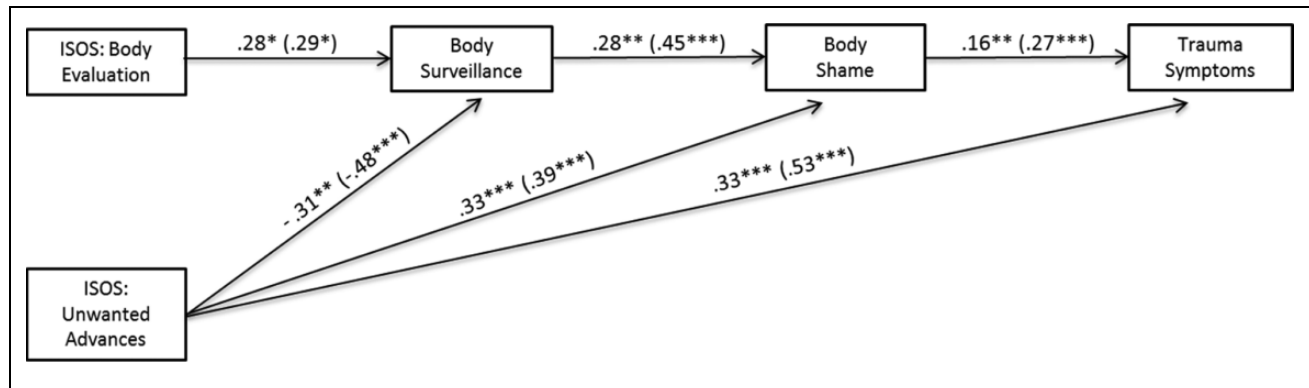


Figure 2. Final path model of the relationships among the variables of interest. Fit was good for both the no trauma sample, $\chi^2(3) = 3.53$, $p = .32$; RMSEA = .03; CFI = .99; SRMR = .03, and the sexual trauma sample, $\chi^2(3) = 2.64$, $p = .45$; RMSEA < .001; CFI = 1.00; SRMR = .02. Standardized path coefficients are reported with those for the no trauma sample presented first and those for the sexual trauma sample presented in parentheses. RMSEA = root mean square error of approximation; CFI = comparative fit index; SRMR = standardized root mean square residual. * $p < .05$. ** $p < .01$. *** $p < .001$.

because the path from unwanted sexual advances to surveillance was negative, the clear interpretation of any indirect effects from unwanted advances through body surveillance would be impossible, so we did not test this path.

Discussion

The primary intent of our study was to provide empirical support for the conceptualization of sexual objectification as a form of gender-based discrimination resulting in the experience of trauma symptoms or insidious trauma. Although previous literature has suggested that objectification is a form of discrimination that may result in the experience of insidious trauma (Nadal & Haynes, 2012; Root, 1992), little data exist to support this assertion. By developing a path model, we sought to explore the impact that these discriminatory events may have on women's psychological welfare. Finally, we wanted to better understand how this model fit for women with and without a history of sexual trauma, allowing inferences to be made about the degree to which past trauma might affect the traumatic sequelae of subsequent experiences of sexual objectification.

Women with a history of sexual trauma reported greater experiences of sexual objectification, as well as higher levels of body shame and trauma symptoms, compared to women in the no trauma sample. The significant difference between scores on trauma symptoms was hypothesized originally because we believed that those who had experienced more overt trauma would, as a result, experience more trauma symptoms. Although the findings for the other variables were not hypothesized, it is not particularly surprising that these differences existed, given that experiencing a sexual assault can impact many facets of an individual's life (Resick, 1993; Resnick et al., 1997).

Overall, we found that our hypothesized model had good fit and fit equally well for both samples. Nevertheless, we had

one unexpected finding. We hypothesized that all pathways would be positive; however, we found that the path between unwanted sexual advances and body surveillance was negative for both groups of women. Although not hypothesized in the present study, one study on gay men, which used a total ISOS score, found a negative path coefficient between ISOS scores and body surveillance, although this path was not significant (Engeln-Maddox et al., 2011). However, prior research has generally used the ISOS as a combined scale and found a positive relationship between the total score and body surveillance (Augustus-Horvath & Tylka, 2009; Carr & Szymanski, 2011; Kozee & Tylka, 2006); this pattern of positive correlations was also found in one study looking at the subscales separately (Liss et al., 2011).

One possible explanation for our finding comes from research suggesting that women who have experienced unwanted sexual contact or sexual harassment are more wary and anxious in their surroundings (Culbertson, Vik, & Kooiman, 2001; Fairchild & Rudman, 2008; Macmillan et al., 2000). Thus, these women may spend more time surveying the environment and less time observing their own bodies. Whereas our finding that unwanted advances related to decreased surveillance could be considered a positive effect, when considering the direct effect of unwanted advances on body shame and on trauma symptoms, the net impact of unwanted advances on women's psychological health is clearly detrimental. Our results suggest that unwanted sexual advances may decrease the attention a woman puts on her own body, but increase the level of shame she feels about her body.

Our hypotheses about the indirect effects among experiences of sexual objectification, body surveillance, body shame, and trauma symptoms were largely supported. For women with a history of trauma, the tested indirect effects were significant. Specifically, for women with a history of sexual trauma, there was a significant indirect effect of body

evaluation on trauma symptoms through body surveillance and body shame. This finding adds further support to the conceptualization of body evaluation as a source of insidious trauma, suggesting that minor events that occur multiple times over extended periods can have a cumulative negative impact on individuals. In regard to body evaluation, the findings of our study support those of Erchull, Liss, and Lichiello (2013) and strengthen the conceptualization of body surveillance as a dissociative-like experience that may contribute to trauma symptoms, at least for women who have experienced sexual trauma. Even though experiences of trauma symptoms in association with sexual objectification may not be as severe as those occurring following a major traumatic event, the findings presented here suggest that, particularly for women with a history of trauma, sexual objectification may be associated with experiencing more trauma symptoms. This conceptualization is further supported by research indicating that feelings of shame can play a key role in the experience of PTSD symptoms in individuals with a history of trauma (Andrews, 1995; Harman & Lee, 2010; La Bash & Papa, 2014), particularly among those with a history of sexual trauma (Feiring et al., 2002; Vidal & Petrak, 2007; Weis, 2010).

In addition, the experience of unwanted sexual advances was significantly related to trauma symptoms indirectly through body shame. This finding further adds support to the conceptualization of objectification as a source of insidious trauma and suggests that, when women feel body shame in relation to unwanted sexual advances, this may contribute to the experiencing of trauma symptoms. The relationship between unwanted sexual advances and body shame is consistent with studies that have found that women who have experienced sexual harassment, unwanted sexual attention, or “covert” sex abuse (all constructs similar to unwanted sexual advances) have increased rates of body image distortion/dissatisfaction (Harned, 2000; Weiner & Thompson, 1997; Whealin & Jackson, 2002), exhibit more eating disorder symptoms (Harned, 2000; Weiner & Thompson, 1997), and have lower self-esteem (Whealin & Jackson, 2002).

For women without a history of sexual trauma, the indirect effect of unwanted sexual advances on trauma symptoms through body shame was also significant, as we hypothesized. This pattern suggests that women may experience adverse psychological consequences as a result of unwanted sexual advances, even in the absence of a sexual assault history. More specifically, it suggests that the experience of shame, with which many survivors of sexual assault/abuse struggle (Feiring et al., 2002; Vidal & Petrak, 2007; Weis, 2010), may occur even when an individual has no history of overt sexual trauma and that this can contribute to the presence of trauma symptoms. In contrast to our hypotheses, body evaluation did not have a significant indirect effect for this group. This nonsignificant finding suggests that the relationships among body evaluation, body surveillance, body shame, and trauma symptoms may be stronger for those who have directly experienced trauma.

Although objectification has been conceptualized as a source of insidious trauma (Root, 1992), prior known empirical studies have not looked at these relationships, nor have they investigated whether prior history of sexual trauma affects these relationships. The higher levels of trauma symptoms in women (as compared to men) indicate that there must be events to which women are disproportionately exposed that negatively impact their psychological well-being (Cortina & Kubiak, 2006; Tolin & Foa, 2006). Our study suggests that the experience of sexual objectification may be part of a cycle of discrimination, the effects of which may contribute to higher rates of trauma symptoms in women. Additionally, the significant indirect effects from body evaluation → body surveillance → body shame → trauma symptoms for those with a history of sexual trauma indicate that there is a unique relationship for women who have been previously assaulted. It is possible that experiencing bodily evaluation may have a greater impact on women with a history of trauma, given that being evaluated may serve as a reminder of their vulnerability to further assault. Research has shown that, even in women without a history of sexual trauma, fear of rape or sexual assault may lead them to avoid contexts where they feel most vulnerable to bodily evaluation or unwanted advances (Fairchild & Rudman, 2008; Hickman & Muehlenhard, 1997; Swim, Cohen, & Hyers, 1998).

Limitations and Future Research

As with all research, it is necessary to consider our findings in light of limitations. Our participants were recruited online and, therefore, were comfortable with the use of the Internet. In addition, we only screened for two kinds of sexual trauma (rape and attempted rape), and as a result, we may have missed individuals who had been sexually victimized in other ways. For example, the phrasing of the questions used for screening in our study may have resulted in childhood sexual abuse victims answering nonaffirmatively. Furthermore, women who have experienced sexual assault and rape often do not answer affirmatively to such questions (Koss, 1993). Therefore, it is possible that some of the women in the no trauma sample actually have a history of sexual trauma. As a result, we suggest that future research consider screening women with a wider variety of questions (see Koss, 1993, for a review of sexual assault screening methodology). Finally, one study found that individuals on MTurk were significantly less extroverted, had lower levels of emotional stability and self-esteem, and were less open to new experiences than a community sample (Goodman et al., 2012). Although the differences were relatively small, it is possible that an alternate sample of participants from the community might have more “normative” personality characteristics.

Additionally, although it makes theoretical sense that experiences of objectification could lead to trauma symptoms, it should be noted that path models do not allow for confirmation of causality. Therefore, it is possible that

women with higher levels of trauma symptoms are more likely to notice and report experiences of sexual objectification. Furthermore, it should be noted that, as with all self-report data, the validity of our data is limited by the willingness and ability of participants to disclose information about themselves.

One direction for future research is to consider how race or sexual orientation may affect our model. It remains an open question as to whether or not holding such identities may relate to one's experiences of interpersonal sexual objectification. Researchers may also want to explore how an individual's response to sexual objectification may alter our model. For example, responding in a passive way may have different effects than responding in a more active way. Similar research has been conducted studying responses to sexual harassment and sexism (Cochran, Frazier, & Olson, 1997; Swim et al., 1998; Swim & Hyers, 1999). The amelioration of negative effects may be particularly likely to occur if a woman feels like her interpretation of the event is then validated by others who witnessed the event or even by the perpetrator when confronted.

Practice Implications

The current study adds support to the conceptualization of objectification as a form of gender-based discrimination that may contribute to insidiously traumatic outcomes in the forms of body surveillance, body shame, and trauma symptoms. Our data suggest that everyday experiences of sexual objectification may act as a source of insidious trauma and may contribute to the experience of trauma symptoms in women. In addition, for women with a history of sexual trauma, our analyses of indirect effects indicated that experiences of body evaluation pose a particular risk in terms of contributing to increased body surveillance and body shame, indirectly resulting in higher levels of trauma symptoms. Mental health professionals working with women who have been sexually assaulted should consider the role that continued gender-based discrimination may play in sustaining or creating mental health problems. The findings of our study suggest that interpersonal sexual objectification may be a factor contributing to the fact that women are diagnosed with PTSD at higher rates than are men (Breslau et al., 1999; Cortina & Kubiak, 2006; Tolin & Foa, 2006). Furthermore, given that our overall path model fit equally well for women with and without a history of sexual trauma, mental health professionals may wish to monitor for the presence of trauma symptoms even in female clients without a history of overt sexual trauma.

Conclusions

Women in the United States frequently experience sexual objectification in the forms of both body evaluation and unwanted sexual advances (Capodilupo et al., 2010; Nadal,

2010; Swim et al., 2001). Studies such as ours indicate that interpersonal objectification has the potential to have serious negative consequences, and unfortunately, failure to recognize these events may leave women wondering if the discrimination they believe they have experienced is real (Nadal & Haynes, 2012; Sue & Capodilupo, 2008). As a result women become caught in a Catch-22; if they speak out about how they are treated, they are likely to be labeled as "overly sensitive," and if they say nothing, they have to live with these experiences without the chance of social support or vindication (Nadal, 2010; Sue & Capodilupo, 2008; Sue et al., 2007). The ambiguous and subtle nature of sexual objectification, particularly the experience of body evaluation, can make this experience of discrimination difficult to acknowledge, discuss, and cope with. Gender-based discrimination in the form of interpersonal sexual objectification can have a significant impact on the psychological health of women and, although some may wish to minimize the impact that these events can have, studies such as ours indicate that these are not matters to be taken lightly. In order to create true and lasting change, we must, as a society, give more weight to reports of interpersonal sexual objectification and consider, on an individual level, how our behaviors may be perpetuating such gender-based discrimination and its ill effects.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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