THE EFFECTS OF THE MARIANISTA GENDER ROLE AND ACCULTURATIVE EXPERIENCES ON LATINA AND HISPANIC WOMEN'S BODY DISSATISFACTION AND EATING PROBLEMS.

A dissertation submitted to Kent State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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CHAPTER 1

INTRODUCTION

Since the identification of anorexia nervosa in the 17th century (DiNicola, 1990), eating disorders have been conceptualized as culture-bound syndromes affecting a disproportionate number of European American women (Keel & Klump, 2003). Such conceptions are supported by estimates that between 0.5% and 4% of European American women suffer from anorexia nervosa, bulimia nervosa, or binge eating disorder (American Psychiatric Association [APA], 1994), a higher rate compared to women of other ethnic groups (Makino, Tsuboi, & Dennerstein, 2004). Because of the secretive nature of eating disorders, it is thought that these prevalence rates may be underestimates (APA, 1994). Furthermore, the number of women suffering from subclinical eating problems may be even greater (APA, 1994; Makino et al., 2004). Western culture's emphasis on thinness and a rigid female body ideal are thought to account for the disproportionate number of European American women with eating problems; hence current etiological models were developed with this population in mind.

Underlying etiological theories of eating disorders is the acknowledgement that, among women, gender plays an influential role in shaping body ideals, body image, and behaviors related to weight, shape, and appearance (Lancelot & Kaslow, 1994). Indeed the role of gender is demonstrated clearly when one considers that 90% of eating disorder cases occur among women (APA, 1994; Jacobi, Hayward, de Zwaan, Kraemer, & Agras,
Gender, a broader conceptualization than biological sex, encompasses the expectations and meanings associated with being a man or woman within a specific culture (Worell & Todd, 1996). Within many cultures, there exist well-defined stereotypes that, at their extremes, place men and women at opposing poles (Stevens, 1973). Women are characteristically stereotyped as emotionally intelligent, empathic, and caring, but weak, dependent, and overly concerned about their physical appearance. Additionally, women are seen as disinterested in sciences, math, and physical activity (Worell & Todd, 1996). In contrast, men are stereotypically characterized as strong, dominant, and competitive, but emotionally less expressive (Worell & Todd, 1996).

While gender is acknowledged as a pervasive, underlying social factor related to eating disorders, empirical research has focused primarily on cognitive (e.g. body dissatisfaction), attitudinal (e.g. thin-ideal internalization), and behavioral (e.g. dieting) factors of the individual to explain the various pathways to eating disorders (Fairburn, Cooper, Doll, & Davies, 2005; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006). The dual-pathway model put forth by Stice (1994; 2001) provides an empirically-supported framework of such factors and their contribution to bulimic symptomatology. Within this model (see Figure 1), perceived pressure to be thin contributes to internalization of a thin ideal and, subsequently, to body dissatisfaction, a major risk and maintenance factor for eating problems (Stice, 2002). Perceived pressure to be thin refers to the perceived sociocultural pressures to be thin that emanate from friends, family, and the media (Striegel-Moore, Schreiber, Pike, Wilfley, & Rodin, 1995). Pressure may come in the form of negative comments or criticisms about weight, modeling of dieting
by friends, and family, and idealization of thinness in television and print media (Cattarin & Thompson, 1994). This perceived pressure may lead some women to internalize the thin ideal. Thin-ideal internalization refers to a woman's endorsing not only the belief that thinness is more attractive, but that thinness is a symbol of success, empowerment, and self-control (Thompson & Stice, 2001). A longitudinal study among adolescent girls (Stice, Mazotti, Krebs, & Martin, 1998) demonstrated the predictive validity of BMI, perceived pressure, and thin ideal internalization to body dissatisfaction. Consistent with the dual pathway model, this study and others (Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006) found dietary restraint to be predicted by this dissatisfaction. Additionally, Sim and Zeman (2005) found evidence that body dissatisfaction led to negative affect, a second pathway to eating problems.

Ethnic minority women, it was assumed, were unlikely to develop eating disorders because of the lack of a cultural emphasis on thinness and an unrealistic body ideal. Furthermore, many cultures continue to associate a full-figured, plump body with prosperity, health, and fertility (Gil-Kashiwabara, 2002; Massara, 1989). However, there is now evidence that eating problems do exist among ethnic minority women, suggesting that cultural body ideals may not be as protective as was once thought (Makino et al., 2004; Root, 1990). Several studies have found that, although some ethnic minority women report lower levels of body dissatisfaction than European American women (Altabe, 1998), they are, nevertheless, body dissatisfied and are engaging in unhealthy dieting practices such as restraint, binge eating, and purging (Granillo, Jones-Rodriguez, Carvajal, 2005; Shaw, Ramirez, Trost, Randall, & Stice, 2004). Furthermore,
comparative investigations have found significant differences in body dissatisfaction among ethnic minority women, with Latino women experiencing greater body dissatisfaction than either African American or Asian American women (Altabe, 1998; Robinson et al, 1996). It is probable that gender contributes in some way to eating disorder etiology among ethnic minority women as well.

Currently, Latinos/Hispanics comprise the largest ethnic minority group in the United States (Ramirez, 2004). There is a significant debate over the terminology used to identify individuals from such diverse countries as Brazil, Mexico, Cuba, and Puerto Rico. Comas-Diaz (2003) notes that terms like Hispanic and Latino(a) are not all-inclusive. For example, the term Hispanic was coined by the U.S. Census Bureau to identify individuals of Spanish origin. The term also has colonial underpinnings and does not acknowledge the indigenous Indian roots and African heritage of many Latinos/Hispanics. Furthermore, the term Hispanic does not apply to individuals from Mexico, Central and South America. Similarly, the term Latino(a) ignores indigenous roots and may not be appropriate for individuals from the Caribbean. Comas-Diaz (2003) notes that even the categorization by language is not entirely accurate as Brazilians are not native Spanish-speakers. Although there are many significant differences in the customs and traditions of these various countries, they share some basic underlying historical and cultural foundations (e.g. colonization, Catholicism), which permit them to be considered, to a certain extent, as a collective cultural/ethnic group. While, acknowledging this diversity and heterogeneity, for the purposes of this study, we will hereafter refer to women of these groups as Latino women.
Despite their rapidly increasing numbers, there is a noticeable gap in the literature regarding Latino women's body ideals and eating attitudes. This oversight is unfortunate as there is growing evidence that these women endorse levels of body dissatisfaction and eating problems similar to those of European American women (e.g. Altabe, 1998; Granillo et al., 2005; Robinson et al., 1996). Studies of Latino women contradict the theory that body dissatisfaction and eating problems are the domain of European American women (Robinson et al., 1996). Instead, the current findings (Grabe & Hyde, 2006) provide impetus for research into the applicability of existing etiological models to Latino women and for the incorporation of potential cultural factors into such models (Grabe & Hyde, 2006; Toro et al., 2006).

Two cultural factors that may impact body dissatisfaction and eating problems among Latino women are gender role orientation and the acculturative experience. Latino/Hispanic culture defines a distinct gender role for women - *marianismo* - which is shaped by the spirituality, compassion, and chastity attributed to the Virgin Mary of Catholicism (Stevens, 1973). *Marianismo* encourages kindness, generosity, and emotional expressivity. However, it may be interpreted in a negative light, emphasizing self-denial and submissiveness. As with European American women, these gender roles may impact Latino women's body ideals, images, and eating attitudes directly and indirectly.

The second cultural factor is the acculturative experience. Acculturation is defined as the process by which minority individuals integrate behaviors and beliefs of the majority culture into their own cultural views and practices (Berry, 1980).
Successfully acculturated minority individuals have managed to balance their own cultural beliefs with those of mainstream society (Harris & Kuba, 1997). There is some evidence that greater acculturation is associated with greater body dissatisfaction and eating problems among African American and Hispanic females (e.g. Gray, Ford, & Kelly, 1987; Pumariega, 1986). However, other researchers have found no differences in body image and eating problems among individuals at varying degrees of acculturation (Becker, 2003; Joiner & Kashubeck, 1996). Alternately, there is a growing body of literature that a specific aspect of the acculturative experience, acculturative stress, is a greater risk factor than acculturative status per se. Acculturative stress refers to stress involved in undergoing cultural change. Individuals may experience language difficulties, cultural incompatibility, and alienation due to cultural differences (Rodriguez, Myers, Mira, & Garcia-Hernandez, 2002). The inconsistency in these findings may be a result of several methodological and theoretical issues that will be discussed in more detail.

The primary purpose of this paper is to examine the applicability of a culturally-relevant etiological model of Latino women's attitudes towards their bodies and eating. It is hypothesized that the dual pathway model may provide a useful theoretical framework to investigate these two outcomes. By including an examination of two cultural factors – marianismo and the acculturative experience – potential moderators of body dissatisfaction and eating problems among Latino women may be further elucidated. First, an introduction to the literature regarding body ideals, body image and dissatisfaction, and eating problems among Latino women will be presented. Second, the
concept of gender roles, specifically *marianismo*, will be discussed with regard to its
effects on body- and eating-related attitudes. Third, a review of the literature regarding
the effects of the acculturative experience and the methodology utilized to measure it will
be provided. Lastly, these constructs will be integrated and a culturally-specific
etiological model will be proposed.

*Body Ideals*

Despite the rapidly growing Latino/Hispanic population (Ramirez, 2004), the
literature on Latino women's body ideals remains sparse in comparison to the literature
on European and African American women. Body ideals refer to the values and
preferences of a culture or society related to physical appearance. There is evidence that
the ideals of Latino women may differ from that of European Americans. These women
often report a preference for a more curvaceous body (Rubin, Fitts, & Becker, 2003) and
appear to be less influenced by Western society's emphasis on thinness (Gil-Kashiwabara,
Puerto Rican immigrant women found that women who viewed weight gain positively
tended to be older, married, or of higher socioeconomic status. With the exception of
unmarried women who were encouraged to be slimmer, weight gain among women was
perceived as a sign of a husbands' prosperity and a woman's readiness to bear children.
Thus, these women's body ideals included a more realistic shape, rather than the
mainstream thin-ideal.

Research also has found that Latino women appear to place more emphasis on
other physical features besides shape and size (e.g. skin color and hair texture). One of
the earliest studies (Altabe, 1998) to examine these non-weight-related variables found that Latino women placed importance on hair length, hair and skin color. Furthermore, as has been found among European American women, Latino women rated attractiveness as an important component of their self-esteem. A recent study of Ecuadorian adolescents, (de Casanova, 2006) found that girls held a body ideal, coined the "generic Latina", that emphasized a specific body shape and size, and Caucasian physical features. The "generic Latina" body was described as "slightly heavier than that popular in North American and European media," and emphasized "a large bust, and hips, small waist, and long shapely legs" (de Casanova, 2006). The girls explained that this figure, un buen cuerpo (a good body), was preferred by Ecuadorian men, for whom hips, buttocks, and breasts were "focal points." In addition, the girls believed that racially-determined physical features and skin color were important in judging a woman's attractiveness. They reported a strong negative response to images of darker-skinned women or those with prominent African or Asian features (e.g. broad noses, large lips, slanted eyes). Similarly, focus groups of Latino adolescents in the U.S. found an emphasis on the importance of buttocks and breasts to physical attractiveness (Gil-Kashiwabara, 2002; Rubin et al., 2003).

Finally, Latino girls have described the importance of being well-dressed, "having a sense of style," and demonstrating proper grooming and hygiene (Rubin et al., 2003). That is, a woman may still be considered attractive if she is "well-put-together," although she may lack the much-preferred lighter skin or Caucasian features (Gil-Kashiwabara, 2002). As one participant commented, you "make what you got work for you" (Rubin et
all, 2003). All girls acknowledged that greater attention to appearance was important for social approval from family and, especially, friends (de Casanova, 2006; Gil-Kashiwabara, 2002; Rubin et al., 2003).

**Body Image and Body Dissatisfaction**

Several explanations for the prevalence of body dissatisfaction among European American women have been proposed. One major risk factor has been women's internalization of the societally-defined thin beauty ideal. The internalization of the thin-ideal has been attributed to perceived pressure to be thin from the media, friends, and family, and negative commentary which includes criticisms and teasing about weight/shape. There is evidence that teasing about weight/shape has deleterious effects on body dissatisfaction and self-esteem and is a risk factor for depression (Gleason, Alexander, & Somers, 2000). Additionally, criticism about weight/shape or encouragement to diet has been associated with unhealthy dieting behaviors, including dietary restraint and binge eating (Neumark-Sztainer et al., 2002). It has been shown that most women are aware of the pressures placed upon them by the mainstream media, family, and peers to attain a thin body ideal (Cash, Winstead, & Janda, 1986). However, it is thought that when women internalize the thin-ideal they are at increased risk for body dissatisfaction. It appears, then, that perceived sociocultural pressures may exert undue influence upon women who have internalized the thin-ideal. Indeed, thin-ideal internalization may act as a mediator between sociocultural pressures and body dissatisfaction (Stice, 1994).

Because of the centrality of thin-ideal internalization to body dissatisfaction
among European American women, it was assumed that women whose cultures did not emphasize a thin-ideal would be more satisfied with their bodies and, subsequently, would be protected against eating disorders. Comparative studies (Robinson et al., 1996; Shaw, Ramirez, Trost, Randall, & Stice, 2004) find Latinas/Hispanics have significantly lower levels of thin-ideal internalization than European and Asian Americans. In a multi-ethnic comparison of body dissatisfaction, Shaw et al. (2004) found only one significant effect size across all four ethnic groups. European and Asian Americans reported significantly more thin-ideal internalization than Latinas/Hispanics or African Americans. In a related vein, Latino girls in another multi-ethnic sample (Robinson et al. 1996) reported that being "too large" or "too big" was not a contributor to their body dissatisfaction. Consistent with these findings, a recent cross-sectional study of Latino women (Henrickson, unpublished dissertation) found that thin-ideal internalization was associated with more negative body experiences, but that the relationship was not as strong as expected.

Paradoxically, Latino participants in the Shaw et al. study (2004) expressed the same levels of body dissatisfaction as their European American peers. Furthermore, Latino girls in the Robinson et al. (1996) study were the most dissatisfied of all participants. Even among the leanest girls, Latinas/Hispanics expressed the most body dissatisfaction. Among 4th and 5th grade Latino and African American girls (Vander Wal & Thomas, 2004), the former group reported the greatest body dissatisfaction, with a large percentage (12.7%) meeting criteria for an eating disorder. Although weight status has been found to be predictive of greater binge eating severity, it appears to have little
effect on ratings of body dissatisfaction among Latino girls (Robinson et al., 1996; Vander Wal & Thomas, 2004). Researchers have noted that such findings are troubling, as the large perceived discrepancy between the girls' actual and ideal bodies is a potential risk factor for development of clinical eating disorders (Robinson et al., 1996).

The most recent and comprehensive meta-analysis (Grabe & Hyde, 2006) supports data derived from quantitative studies. Researchers analyzed 98 studies and compared the four major ethnic groups – European American, African American, Latino, and Asian American – on body dissatisfaction. Consistent with previous findings (Altabe, 1998), the greatest significant difference was between European American and African American women with the former being more body dissatisfied. However, unlike previous studies, Grabe and Hyde (2006) noted that the effect size for this comparison was rather small ($d = .29$). Comparisons of Latino women to European American ($d = .09$), African American ($d = -.18$), and Asian American ($d = -.07$) women resulted in small to non-existent effect sizes, suggesting, "body dissatisfaction may not be the golden girl problem promoted in the literature" (Grabe & Hyde, 2006). Taken as a whole, these data suggest that Latino women may have more flexible and varied body ideals, are less influenced by the thin-ideal, but are still body dissatisfied. The conclusion that emerges from these data is that Latino women are experiencing body dissatisfaction at levels comparable to European American women. What remain unclear are the predictors of body dissatisfaction among Latinas/Hispanics, as thin-ideal internalization appears to have a relatively smaller impact. More research is needed into potential culture-specific predictors.
In addition to more research, there may be methodological issues to consider. Specifically, there appears to be a significant difference in the reports of body dissatisfaction derived from qualitative (e.g. Gil-Kashiwabara, 2002) and quantitative studies (e.g. George et al., 2007). Women who participate in qualitative studies such as focus groups, in-depth interviews, and naturalistic studies report greater body esteem and attribute their satisfaction to flexible body ideals that include physical attractiveness, confidence, attitude, and style (Parker, Nichter, Nichter, Vuckovic, Sims et al., 1995; Rubin et al., 2003). These women express a greater appreciation for a wide range of body shapes and sizes. However, these focus groups often include African American women (e.g. Gil-Kashiwabara, 2002), a potential confound, and find few differences in the body esteems of both groups of women. In contrast, women who participate in self-report quantitative studies (e.g., Shaw et al., 2004) often do not differ from European American women in their levels of body dissatisfaction. Moreover, within these studies, Latino women appear much more body dissatisfied than African American women (e.g. Altabe, 1998).

Thus, in order to gain a better understanding of correlates of body dissatisfaction, a quantitative approach may be more useful for several reasons. First, qualitative studies often result in smaller sample sizes because of their greater time commitment and involvement by both researchers and participants. While providing rich and detailed information, self-selection may further limit generalizability of qualitative studies. Individuals who are willing and able to participate in time-intensive qualitative studies may be better educated, more affluent, or have a specific interest in body image issues.
Furthermore, an element of social desirability or cultural pride may prevent focus group participants from openly expressing certain body ideals that may be seen as denigrating to their own background (de Casanova, 2006). For example, lighter skin color is a valued physical trait across many ethnic groups, despite its acknowledged roots in colonialism and slavery (Hill, 2002; Neal & Wilson, 1989; Sahay & Piran, 1997). Participants may acknowledge skin color preferences within their ethnic group, but deny the importance of skin color in the evaluation of their own body image, thereby portraying themselves as body satisfied. Finally, qualitative studies tend to focus on body ideals rather than the individual's body image and dissatisfaction.

An issue of concern in both quantitative and qualitative studies is the lack of differentiation between various Latino ethnic groups. A recent study (George, Erb, Harris, & Cassaza, 2007) found significant differences in body dissatisfaction among several Latino groups. For example, South American and Dominican women expressed greater concern for physical appearance than Mexican or Central American women. Additionally, Puerto Rican women expressed the greatest satisfaction and Brazilian women the lowest satisfaction with their bodies. Therefore, in addition to exploring potential cultural predictors of body dissatisfaction, future studies need to address the issues of generalizability and cultural specificity.

*Eating Problems*

Because women of color were thought to have a positive body image, the early eating disorder literature assumed that women of color were immune to eating problems. Additionally, their generally lower socioeconomic status (Pumariega, 1986), a traditional
preference for plumpness (DiNicola, 1990; Massara, 1989), and a lack of emphasis on physical appearance (Altabe, 1998) were thought to be protective factors against eating problems. However, eating problems do exist, and appear to be as common among Latino women as they are among European American women (Shaw et al., 2004). A large-scale study of more than 40,000 junior-high and high school girls in Minnesota (Croll et al., 2002) collected information about disordered eating and found Latino girls to have the highest rates of disordered eating compared to European, Asian, and African Americans. Similarly, a large sample of high school girls (Smith & Krejci, 1991) found the highest rates of disordered eating among Latino females even after controlling for weight status.

Specifically, binge eating is reported more frequently than other disordered eating behaviors among these women (Bisaga et al., 2005; Cachelin, Phinney, Schug, & Striegel-Moore, 2006; Gowen et al. 1999). In a multi-ethnic community study (Fitzgibbon et al., 1998), findings indicated a significantly greater proportion of binge eating disorder among Latino women than other groups. Also, Latino women appear to suffer from bulimic symptomatology more than anorectic symptoms (Crago, Shisslak, & Estes, 1996; Shaw, Ramirez, Trost, Randall & Stice, 2004). More recent and larger population-based studies (Regan & Cachelin, 2006) found not only binge eating but purging (self-induced vomiting) to be as common among Latino women as among European American women. Among junior high and high school populations, these rates are even higher among Latinas/Hispanics, especially self-induced vomiting (Croll et al., 2002). These behaviors have been endorsed by younger girls as well (Bisaga et al.,
2005). Additionally, studies have found laxative and diuretic use to be on par with use by European American girls (Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000). Story, French, Resnick, and Blum (1995) found such use to be twice as high among Latino adolescents as adolescents of other ethnic groups. Age differences have been noted as well, with binge eating and diet pill use occurring at younger ages among Latino girls (Bisaga et al., 2005).

After reviewing the literature on body ideals, body dissatisfaction, and eating problems among Latino women, several conclusions may be drawn. First, there are some discrepancies between the body ideals of traditional Hispanic culture and mainstream European American culture. Many Hispanic women report valuing a larger and more shapely figure in contrast to the conventional thin-ideal. Despite a greater acceptance for a larger figure, Hispanic women are reporting high levels of body dissatisfaction which suggest that other factors besides internalization of a thin-ideal may be contributing to body dissatisfaction. Indeed, several studies have noted the importance among Latino women of skin and hair color, personal style, and feminine qualities in judging a woman's attractiveness (e.g. Rubin et al., 2003). Second, eating problems among Latino women appear to be as common as they are among European American women. More specifically, binge eating and bulimia appear to be disproportionately represented among this population of women.

Based on these conclusions, it appears that there may be factors other than thin-ideal internalization contributing to body dissatisfaction and eating problems among Latino women. Two potentially significant factors are gender role orientation and
acculturative experiences. Gender role orientation has been commonly associated with eating disorders among European American women and has received significant attention. However, the effects of gender role orientation on the mental health of ethically diverse women has yet to be examined within the psychological literature. 

There has been more research into the effects of acculturation on women's mental health in general and eating disorders in particular; however findings have been inconsistent.

*Gender Role Orientation, Machismo, and Marianismo*

Within Western society, adherence, or orientation, to conventional gender roles has been examined extensively with regard to psychopathology (Hoffmann, Powlishta, & White, 2004; Horwitz & White, 1987; Huselid & Cooper, 1994; Nolen-Hoeksema & Gergus, 1994). There is evidence that women experience higher levels of psychopathology than men (Wiessman & Klerman, 1977). Furthermore, depression and anxiety, commonly known as internalizing disorders, are far more common among women, whereas externalizing behaviors such as aggression and hostility are more common among men (Weissman & Klerman, 1977). These divergent manifestations of psychopathology are thought to be rooted in masculine/feminine gender role orientations. Conventionally, masculinity is grounded in dominance, assertiveness, and independence. Such traits, often considered instrumental traits, are highly valued by society and are associated with higher self-esteem, greater competency, and fewer symptoms of distress (Hoffman et al., 2004). In contrast, femininity is associated with warmth, nurturance, and emotional sensitivity, traits considered to be expressive in nature. Such traits, at their extremes, may contribute to less assertive coping strategies, feelings of low self-efficacy,
and helplessness (Horwitz & White, 1987; Nolen-Hoeksema & Girgus, 1994).

Nolen-Hoeksema and Girgus (1994) proposed a diathesis-stress model in which young girls are socialized to develop such traits during adolescence, while simultaneously being faced with numerous biopsychosocial challenges, or stressors, that may place them at a greater risk for internalizing disorders. That is, young girls who are less assertive and engage in cooperative interaction styles with males (who are taught to value dominance) may be already predisposed to develop internalizing disorders. Combined with the biological (pubertal development), psychological (body image), and social (narrowing of activities to more feminine interests) changes of adolescence, girls may be much more likely to develop internalizing symptoms of distress.

Despite our knowledge of how gender role orientations affect psychopathology, little is known about the effects of culture-specific gender roles on the psychopathology of ethnic minority women. Latino/Hispanic culture defines gender roles for men and women in distinctly different ways. Both roles are rooted in a collectivist culture that emphasizes the family as the most important unit (familismo) and demands respect (respeto) for elder relatives. Individual roles and obligations are shaped in the context of what is best for the family as a whole. Thus, both male and female gender roles are seen as necessary and complementary to one another.

Within the psychological literature, the male Latino/Hispanic gender role, machismo, has received the most attention, and is commonly portrayed in a negative light. Machismo often is characterized by emotional insensitivity, philandering, alcoholism, and physical aggression (Santiago-Rivera, Arredondo, & Gallando-Cooper,
2002; Stevens, 1973). However numerous researchers have argued that such a portrayal is skewed and places undue emphasis on exaggerated negative qualities. The positive aspects of *machismo* include providing for and protection of family, personal integrity, physical strength, and stoicism. Such men, who lived up to their moral obligations, were considered *caballeros*, or gentlemen (Gil & Vazquez, 1996).

The complementary role for women, *marianismo*, emphasizes a life devoted to family and interpersonal relationships (*personalismo*). Like the Virgin Mary of Catholicism, upon whom the role is based, women are viewed as spiritual beings, able to endure endless suffering and be compassionate towards others (Stevens, 1973). Ideally, because of their commitment to caring for others, women are to be treated with reverence and respect. As much as *machismo* emphasizes stoicism, *marianismo* encourages compassion, empathy, and feelings (*simpatía*). Also similar to *machismo*, there are negative qualities associated with *marianismo*. Women who solely identify as caretakers may deny or neglect their own needs, which they may believe to be selfish. They may hold back their opinions, needs, or desires, believing that to voice these concerns would be seen as signs of assertiveness or disrespect towards male relatives (Gil & Vazquez, 1996). Women who take on this submissive role also may experience feelings of helplessness or dependence on male relatives. Interestingly, although these attitudes towards women may be held by male relatives, more often, it is the women who enforce or encourage these attitudes in their female relatives (Gil & Vazquez, 1996; Massara, 1989).

*Confluence of Gender Role Orientation, Body Image, and Eating Attitudes*
The relationships among gender role orientation, body image, and eating attitudes have been examined in depth among European American women. A brief review of these relationships may provide a useful context for discussing their relevance to Latino women. Among European American women, several reasons have been proposed as to why the female gender role predisposes some women to develop body dissatisfaction and eating problems. First, and perhaps most obviously, is the relatively recent association of femininity with a thin body. Dolan (1994) notes the co-occurrence of the 1920s women's suffrage movement and the 1960s sexual liberation movement with trends toward idealization of a thin-ideal. A woman's plump and full-figured body was indicative of her good health and fertility as well as her husband's prosperity. The growing popularity of a thin-ideal was interpreted as a rejection of these traits in favor of independence and empowerment (Dolan, 1994). Currently, it is estimated that 2 in 5 women are dieting at any one point in time (Gilbert, 1989), illustrating the "normative discontent" (Rodin, Silberstein, & Striegel-Moore, 1984) of most American women. Paradoxically, Wolf (1990) notes, a thin body ideal is not the image of an adult, but of an adolescent or child. Therefore, although the thin-ideal represents independence from husband and family, the pressure to achieve such an ideal is another form of female obedience, according to Wolf.

Secondly, domains of accomplishment and definitions of success differ for men and women. Based on prescribed gender roles, men are expected to develop careers and succeed professionally. In contrast, women's success conventionally has been defined through personal appearance, marriage, and family (Worell & Todd, 1996). Although more women are working outside the home today, the importance of personal appearance
and motherhood have not faded into the background (Timko, Striegel-Moore, Silberstein, & Rodin, 1987). Women are expected to excel in multiple roles, as professionals, primary caregivers, and household managers (Selvini-Palazzoli, 1985; Steil, 1994). It has been argued by some that the pressure to excel in all domains may lead some women to feel overwhelmed and not in control of their lives. For these women, according to some theorists, weight-loss and dieting may be seen as methods to control their personal appearance, one important aspect of their identity (Dolan, 1994).

Finally, personality traits traditionally considered to be feminine are thought to predispose more women to develop general psychopathology (Nolen-Hoeksema, 1987; Tinsley, Sullivan-Guest, & McGuire, 1984). Conflict avoidance, dependency upon others, and conformity to sociocultural gender expectations are thought to have negative consequences on women's psychological well-being (Worell & Todd, 1996). However, being agreeable, passive, dependent, emotionally sensitive, and polite are all considered feminine qualities. Jack (1991) argues that women are expected to be outwardly compliant and are socialized at an early age to value interpersonal harmony over all else (Pipher, 1994). In interviews with 3rd to 6th grade gifted girls, Bell (1989) found girls were most concerned about their physical attractiveness, pleasing others, appearing modest about their successes, and excelling academically. Compared to more androgynous women, women who exhibit extremely gender-typed behaviors have been found to experience more anxious and depressive symptoms (Nolen-Hoeksema, 1987; Thornton, Leo, & Alberg, 1991). Jack (1991) argues that feminine traits that encourage outward compliance and harmony, belie the inner hostility, resentment, and feelings of
ineffectiveness that may develop as a result of such self-silencing.

Although evidence for the role of thin-ideal internalization among Hispanic women is weak (Rubin et al., 2003; Shaw et al., 2004) and research on domains of success is lacking, there appears to be some overlap between some aspects of the European American female gender role and aspects of marianismo. One interesting finding that has emerged from descriptive studies of Latino women is the emphasis on personality traits that contribute to body image. Study participants in Ecuador (de Casanova, 2006) reported that qualities of personalismo, respeto, and simpatia (e.g. politeness, respectfulness, modesty, and kindness) were important in rating a woman's attractiveness. The emphasis on personality traits has been found among Latino women in the U.S. as well (Gil-Kashiwabara, 2002; Rubin et al., 2003). These findings may be indicative of not only the importance of personality traits, but the more general influence of marianismo on body image and eating attitudes. For example, marianismo stresses the importance of sexual purity and naïveté in order for women to be deemed honorable and respectable. Respectability of the family is dependent, in part, upon the respectability of its women. Additionally, positive valuation of self-denial or self-sacrifice (e.g. fasting for religious reasons) also may affect women's body image and eating behaviors (Gil & Vazquez, 1996). As a result, Latino women may hold negative attitudes towards their sexuality and their bodies due to cultural perceptions of or a lack of accurate knowledge about sexuality. No definite conclusions about these relationships currently exist, as theories remain few in number, and no studies have been designed to assess them. Furthermore, it is possible that these relationships are affected by acculturation, a
construct that has received more attention in recent years.

*Acculturation*

As with other ethnic minority groups, the acculturative experience can affect the psychosocial functioning of Latinos/Hispanics. Acculturation refers to the process through which an individual's culture comes into first-hand contact with the culture of mainstream society (Berry, 2003). At its core, acculturation is the continuous contact of two or more cultures and the resulting effects on the individual (Padilla & Borrero, 2006). Early assessment of acculturation was uni-dimensional and often characterized individuals as either less or more acculturated. These measures implied that an individual who was highly acculturated only identified with the mainstream culture and not that of their own ethnic group. Thus, being highly acculturated was synonymous with *assimilation*, or complete identification with the majority culture. The fact that many ethnic minority individuals are *bicultural*, or incorporate aspects of multiple cultures in their lives, was largely ignored.

Berry's (1980) model acknowledges the multidimensional nature of acculturation and that individuals can integrate several cultures successfully. Those who cannot adapt successfully may feel rejected by mainstream society (known as *separation*) or *marginalized* by both societies. Feeling rejected from one or both cultures may contribute to poorer self-identity, impair day-to-day functioning, and limit social support resources. Complete assimilation into the majority culture is thought to have negative consequences on ethnic identity (i.e. one's sense of self as a member of a distinct ethnic group) as well (Phinney, 2003). Ideally, it is thought, integration of the positive aspects
of both cultures allows individuals to maintain ethnic self-identity and pride while adopting mainstream behaviors and practices necessary in negotiating day-to-day activities (Berry, 1980; Phinney, 2003).

One specific element of the acculturative experience, *acculturative stress*, has received attention as a factor affecting psychosocial functioning among some ethnic minority individuals. Berry (2006) notes that some acculturative changes are easier than others. Changes that do not involve challenges to belief systems, values, or basic living arguably elicit considerably less stress. Acculturative stress refers to stress associated with changes that affect these basic foundations, and cannot be addressed by assimilation alone. For example, lack of language fluency can elicit considerable stress as it affects one's ability to communicate with others and, therefore, has consequences in almost every aspect of life (e.g. socioeconomic status, education, health care). However, increasing language fluency through additional schooling and practice requires commitment of both time and resources. Acculturative stress also may result from the conflict between family members at different stages of acculturation. The collectivistic nature of Latino/Hispanic culture emphasizes family cohesiveness, respect for elders, and deference to male relatives. Exposure to American culture may foster greater individualism among some family members, challenges to traditional authority figures, and a greater desire for autonomy among women (Padilla & Borrero, 2006).

Acculturation was thought to be positively and linearly related to a greater risk for body dissatisfaction and eating problems. That is, as women acculturated, their greater exposure to Western body ideals was thought to cause increases in body dissatisfaction,
dieting, and unhealthy eating behaviors. In contrast, women who identified strongly with their ethnic background were believed to be protected against such risk factors and psychopathology (Nasser, 1988). This assumption was supported, in part, by evidence, especially from research on African American women, that non-European cultures valued larger body sizes, were less body dissatisfied, and had fewer eating problems (Soh, Touyz, & Surgenor, 2006). Furthermore, some cross-cultural studies have demonstrated significant positive correlations between heavier industrialization (i.e. Westernization) and the incidences of eating disorders (e.g. Lee & Lee, 2000).

However, the evidence for this simple relationship is mixed at best (Soh et al., 2006). Research has found body dissatisfaction and eating problems among ethnic minority women at various stages of acculturation (Ball & Kenardy, 2003; Becker, 2003; Tsai, Curbow, & Heinberg, 2003; Joiner & Kashubeck, 1996; Lake, Staiger, & Glowinski, 2000). In a review of the literature, Soh et al. (2006) raises questions about the assumption that ethnicity and ethnic identity protect against body dissatisfaction and eating problems. Tsai et al. (2003) found Taiwanese students demonstrated more body and eating disturbances than their Taiwanese-American peers. Similarly, studies of South Asian British girls document higher rates of eating problems among more traditional girls than more acculturated girls (Anand & Cochrane, 2005).

Soh et al. (2006) noted that these unexpected findings may be due to two different reasons. First, there is a possibility that risk factors for body dissatisfaction and eating problems exist within other cultures besides Western culture. Secondly, those who have greater ethnic identification may experience more significant acculturative stress unlike
their less traditional counterparts. More generally, the review (Soh et al., 2006) notes these studies' methodological shortcomings including the inconsistent assessment of acculturation. For example, years of residency often is used as a proxy for acculturation (Ball & Kenardy, 2003), while other studies utilize more standardized measures (Joiner & Kashubeck, 1996). Finally, comparative cross-cultural studies often compare samples drawn from various studies, rather than comparing groups within a study. The likelihood of differences in sample recruitment, study administration, and measures increases due to this type of methodology.

The relationship between acculturation and gender role identification is equally complex. One of the earliest studies (Kranau, Green, & Valencia-Weber, 1982) found increases in acculturation and education to be associated with a less traditional feminine role and more liberal attitudes about women. Among Puerto Rican women, Soto and Shaver (1982) found evidence that greater acculturation and education were associated with less traditional beliefs and, subsequently, greater assertiveness. Furthermore, the findings indicated that education exerted its effects on assertiveness indirectly through level of sex-role traditionalism. More traditional feminine qualities such as submissiveness were associated with more negative psychological symptoms (e.g. depression and anxiety).

Subsequent studies have made more extensive attempts to parse out the actual gender role changes that accompany acculturation. Sabogal, Marin, and Otero-Sabogal (1987) discussed familismo, the strong identification and attachment to the family unit, as a multidimensional construct encompassing three major components: familial
obligations, family as referents, and perceived support from family. While the first two components were affected by acculturation, the latter component was unchanged. Rueschenberg (1989) found that acculturation was associated with greater contact with external social networks, but had no effect on internal family relationship patterns. That is, although acculturation may result in increased interactions with mainstream society, it may have little influence on the interpersonal relationships within the family.

As Soh et al. (2006) mentioned, there are several methodological shortcomings that may account for mixed findings. The uni-dimensional conceptualization of the acculturative experience common in earlier research persists currently, although to a lesser degree. Perhaps due to constraints of research design, studies continue to utilize proxy indicators of acculturation rather than more comprehensive assessments. Place of birth, years of residence, or language spoken, although informative, yield less data than measuring an individual's sociocultural environment (i.e., ethnicity of friends, adherence to specific cultural values, perception of belonging to an ethnic group). Finally, the role of acculturative stress, a construct that was less widely researched in the early literature, is now beginning to draw more attention. Henrickson (unpublished dissertation) found acculturative stress moderated the relationship between sociocultural pressures and thin-ideal internalization. These findings reiterate the importance of acculturative stress as an important construct that should be included in future studies. Because of the nascent quality of these findings, several major questions remain: Are body dissatisfaction and eating problems more likely among individuals who are most acculturated or among those who are experiencing the most acculturative stress? If both are considered risk
factors, what is the significant contribution of each?

Present Study

The primary purpose of the current research was to examine the utility of two etiological models of body dissatisfaction and eating problems among Latino women. The first model tested constructs in the original dual pathway model, while the second model tested a more culturally-relevant model. Both models incorporated acculturative experiences (i.e. acculturation and acculturative stress) and the marianista gender role as moderators of the relationship between sociocultural pressures and thin-ideal internalization. The first hypothesis was that the dual-pathway model would be supported in this sample of women (Stice, 1994). That is, sociocultural pressures (i.e. perceived pressure to be thin and negative communications about weight and shape) would predict thin-ideal internalization. Subsequently, thin-ideal internalization would be a predictor of body dissatisfaction and would mediate the relationship between sociocultural influences and body dissatisfaction. It was hypothesized that body dissatisfaction would predict disordered eating behaviors and that this pathway would be partially mediated by negative affect (see Figure 2).

Conventionally, the unrealistic body ideal thought to contribute to body dissatisfaction has been the thin-ideal (Thompson & Stice, 2001). However, based on qualitative reports (Rubin et al., 2003) and some empirical evidence (Shaw et al., 2004), it appears that thin-ideal internalization may be a less powerful contributor to body dissatisfaction among Latino women. Rather, internalization of a curvaceous, voluptuous, yet slim-waisted body ideal may be a greater risk factor for these women.
Thus, a separate model that included curvaceous-ideal internalization was tested. This model was identical to the previously mentioned dual-pathway model with the exception of the inclusion of curvaceous-ideal internalization in place of thin-ideal internalization (see Figure 3). It was hypothesized that curvaceous-ideal internalization would mediate the relationship between sociocultural pressures and body dissatisfaction. Third, based on previous findings (Rubin et al., 2003; Shaw et al., 2004), it was hypothesized that there would be a stronger relationship between curvaceous ideal internalization and body dissatisfaction than between thin-ideal internalization and body dissatisfaction.

Regarding potential moderators, the fourth hypothesis was that the relationship between sociocultural pressures and internalization of body ideals, either thin or curvaceous, would be moderated by acculturative status. Among women who were less acculturated, it was hypothesized that there would be a stronger relationship between sociocultural pressures and curvaceous-ideal internalization. For women who were more acculturated, it was hypothesized that there would be a stronger relationship between sociocultural pressures and thin-ideal internalization. That is, women who were less acculturated would be more likely to internalize a curvaceous ideal, whereas women who were more acculturated would internalize a thin ideal.

Fifth, it was hypothesized that acculturative stress would act as a moderator of the relationship between sociocultural pressures and internalization. Among women experiencing greater acculturative stress, it was hypothesized that there would be a stronger relationship between sociocultural pressures and thin-ideal internalization. Greater acculturative stress was hypothesized to be correlated with more body
dissatisfaction and greater eating problems. It was expected that this relationship would persist regardless of level of acculturation.

Regarding marianismo, the sixth hypothesis was that this construct would moderate the relationship between sociocultural pressures and internalization, either thin or curvaceous. That is, among women who identify with more marianista beliefs, it was hypothesized that there would be a stronger relationship between sociocultural pressures and curvaceous-ideal internalization. Among women who identify less with marianista beliefs, it was hypothesized that there would be a stronger relationship between sociocultural pressures and thin ideal internalization. Seventh, it was hypothesized that marianismo would be associated with greater eating problems, as certain aspects of marianismo (e.g. self-sacrifice and denial of one's own needs) may have direct associations with eating habits (e.g. fasting or dietary restraint). Finally, it was hypothesized that the relationship between marianismo and eating problems would be partially mediated by negative affect due to the established effects of dietary restraint on mood (Stice et al., 1998; see Figure 4).
CHAPTER 2

METHOD

Participants

A total of 209 women participated in the study. There is some evidence that the impact of body image on psychological functioning of women over the age of 30 may differ from that of younger women. For example, body checking and disordered eating behaviors appear to decrease as women enter middle age (Tiggemann & Lynch, 2001), while ideal figure size appears to be larger among this age group as well (Stevens & Tiggemann, 1998); thus the decision was made to restrict the range of women to those between the ages of 18 and 30. Women who were excluded from the study included those that reported their age to be greater than 30 (n=17) and one woman who did not self-identify as Latina and did not respond when contacted to clarify her ethnic identification (n=1). The final sample consisted of 191 women between the ages of 18-30 (mean age = 23.65, SD = 3.5). The sample was slightly overweight (mean BMI = 26.83, SD = 6.9).

The majority was either 2nd generation (50.3%) or 1st generation (28.3%) and reported being of Mexican origin (42.9%). A large number of women (34.9%) self-identified with more than one ethnic group. The remaining women self-identified as Puerto Rican (11.6%), South American (7.9%), Dominican (6.3%), Central American (3.2%), Spanish (2.1%), and Cuban (1.1%). More than ¾ of the sample (76.3%) were
born in the U.S. (not including Puerto Rico). Among 1st generation women, 93.5% reported immigrating to the United States prior to the age of 10. The majority of the sample was single (78%), had no children (81.2%), were middle class (62%), and had at least a partial college education (76.4%). More than ½ (63.4%) of the sample reported their state of residence with the majority residing in California (17.3%), New York (10%), or Texas (9%). A smaller number of women reported residing in Florida, North Carolina, Illinois, Ohio, Arizona, Nevada, New Jersey, Georgia, New Mexico, Tennessee, Colorado, and Virginia. With regard to treatment for or diagnosis of an eating disorder, 26 women (13.6%) reported receiving treatment and 15 (7.9%) were able to identify a specific eating disorder diagnosis.

Procedure

Participants were recruited through postings on an online classified advertisement website as well as through student organizations at universities and community colleges across the country. Instructions on how to access the website were sent via e-mail to participants who expressed an interest in the study, which was described as an investigation into beauty ideals and eating behaviors among Hispanic women. Following informed consent, women were permitted to complete the survey. Upon completing or withdrawing from the study, participants were sent a debriefing e-mail including further information about the study. Notably, only one participant withdrew early from the study. All women were entered into a lottery to win one of 25 $10 gift certificates to Amazon.com as well as a lottery to win one iPod Shuffle. Participants completed a
battery of measures described below. Time for completion of the questionnaire was between 60 and 90 minutes.

**Measures**

*Demographics form.* Participants reported their height and weight (to calculate body-mass index, [BMI]), age, ethnic origin, parents' ethnic origins, occupation, socioeconomic status (SES), education level, country of birth, generational status, immigration history, and state of residence. Participants were asked about their history of eating disorder diagnosis and/or treatment. BMI was calculated utilizing the following formula: \[ \text{BMI} = \frac{\text{weight}}{(\text{height})^2} \times 703. \]

*Perceived Sociocultural Pressures Scale* (PSPS; Stice & Bearman, 2001). The PSPS is an 8-item assessment of the perceived pressure from family and friends to achieve a thin-ideal (e.g. "I've noticed a strong message from my friends to have a thin body"). Participants rate the amount of perceived pressure using a 5-point Likert scale ranging from *never* (1) to *always* (5). The seven items are averaged to obtain participants' total scores. The scale has been demonstrated to have good internal consistency (\(\alpha = .88\)), high test-retest reliability (\(r = .93\)) and good validity (Stice & Bearman, 2001). Studies have utilized the PSPS in diverse samples that have included Latino women and have found no significant differences by ethnicity.

*Negative Communications Scale* (NCS; Kichler & Crowther, 2001). The NCS is a subscale of the Negative and Positive Communications Scale and consists of 9-items designed to assess negative comments (e.g., "How frequently are you teased about your weight?") about weight and appearance and encouragement to diet by both family and
peers. Participants rate the perceived frequency of comments made using a 5-point Likert scale ranging from "Never" (1) to "Always" (5). A negative communication score is calculated by summing the perceived frequency of comments made by family and peers. Internal consistency ($\alpha = .85$) as well as the validity of the NCS has been demonstrated previously among a large sample of Latino women (Henrickson, unpublished dissertation).

*The Sociocultural Attitudes Towards Appearance Questionnaire* (SATAQ; Heinberg, Thompson, & Stormer, 1995). The SATAQ is a 14-item self-report measure of the awareness and internalization of sociocultural beauty ideals. The two subscales assess women's *awareness* of the societal thin ideal, (e.g., In our society, fat people are regarded as attractive."), and women's *internalization* of the thin-ideal (e.g., "I would like my body to look like the women who appear in TV shows and movies."). Participants rate their level of agreement with such statements using a 5-point Likert scale ranging from “strongly disagree” (1) to “strongly agree” (2). Scores for the overall measure range from 14-60, with higher scores indicating greater awareness and internalization of the thin ideal. Both subscales have demonstrated a high level of internal consistency (Awareness: $\alpha = .71$; Internalization: $\alpha = .88$). The psychometric properties of the SATAQ have been examined among a sample of Hispanic women (Cashel, Cunningham, Landeros, Cokley, & Muhammad, 2003). Within this sample, Cronbach's alpha was relatively poor (.57) for the awareness subscale but high for the internalization subscale (.89). Regression analyses have found that while both awareness and internalization are predictors of body image disturbance, internalization is the stronger predictor of the two.
Participants in the present study completed the entire 14-item SATAQ.

Internalization of a curvaceous ideal (CI). To assess a preference for a curvaceous or more voluptuous ideal, five items were created by modifying three internalization and two awareness items from the SATAQ. Statements referring to being thin or preferring a thin body were reworded to ask about having curves or a more voluptuous body. For example, the SATAQ internalization item, "Music videos that show thin women make me wish that I were thin," was reworded as, "Music videos that show curvy or voluptuous women make me wish that I had more curves." The SATAQ awareness subscale item, "People think that the thinner you are, the better you look," was reworded to address internalization of a curvaceous ideal as well ("I think the curvier or more voluptuous you are, the better you look in clothes"). Instructions and scoring for these items was the same as for the SATAQ. Reliability of the measure was poor for this sample (Cronbach’s $\alpha = .59$). Cautious interpretation of results involving this variable is warranted.

Goldfarb Fear of Fat Scale (FFS; Goldfarb, Dykens, & Gerrard, 1985). The FFS is a 10-item measure of fear of gaining weight and becoming fat (e.g., "Becoming fat would be the worst thing that could happen to me."). Participants indicated how true each statement is for them using a 4-point Likert scale ranging from "very untrue (1) to "very true" (4), with higher scores indicating a greater fear of fat. The measure has demonstrated good discriminant validity between women with bulimia, dieters, and nondieters. Cronbach's alpha for internal consistency is high ($\alpha = .85$). A greater fear of
fat was positively correlated with depression, neuroticism, anxiety, and maladjustment indicating good convergent validity as well. Due to investigator error, item 8 (“I feel like all my energy goes into controlling my weight”) was omitted from the survey.

*Body Esteem Scale* (BES; Franzoi & Shields, 1984). The BES is a 35-item multidimensional self-report measure of body satisfaction that assesses three factor-analytically-derived dimensions – sexual attractiveness (Cronbach’s $\alpha = .78$), physical condition ($\alpha = .82$), and weight concern ($\alpha = .87$). Participants rate each physical feature (e.g. eyes, thighs, buttocks) on a 5-point Likert scale ranging from “have strong negative feelings” (1) to “have strong positive feelings” (5). Higher scores indicate greater body esteem and less dissatisfaction. The BES is a culturally neutral measure and has been utilized in studies of Latino adolescent girls previously (Hahn-Smith & Smith, 2001). The measure demonstrates both convergent and discriminant validity with measures of self-esteem and body dissatisfaction, respectively (Franzoi & Herzog, 1986). Participants completed the entire 35-item measure.

*Body Shape Questionnaire* (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987). The BSQ is a 34-item self-report questionnaire that assesses concerns about body shape and weight (e.g. "Have you thought that your thighs...are too large for the rest of you?"). Participants rate their level of concern within the past four weeks using a 6-point Likert scale ranging from "never" (1) to "always" (6). Higher scores are indicative of greater concern about body shape and weight. The measure has demonstrated good discriminant validity when administered to women with and without a diagnosis of an eating disorder (Cooper et al., 1987), as well as high convergent validity with the Body Dissatisfaction
Subscale of the Eating Disorders Inventory (Pearson $r = .66$). Test-retest reliability for the BSQ in previous studies was high (Pearson $r = .88$; Rosen, Jones, Ramirez, & Waxman, 1996). Among Latino/Hispanic populations, the internal consistency has been excellent ($\alpha = .98$; Hrabosky & Grilo, 2007).

**Figure Rating Scale** (FRS; Stunkard, Sorenson, & Schulsinger, 1980). The Figure Rating Scale assesses satisfaction with one's adiposity, or fat levels. The FRS consists of a scale ranging from one (smallest body figure) to nine (largest body figure). Participants are asked to rate (1) their current figure, (2) their ideal figure, and (3) the figure most attractive to the opposite sex. In order to measure body dissatisfaction, the ideal figure rating is subtracted from the current figure rating resulting in a discrepancy score (Stunkard et al., 1980). The Figure Rating Scale has been used previously to assess body dissatisfaction among Latino women (Cachelin, Monreal, & Juarez, 2006; George, Erb, Harris, & Cassaza, 2007) and demonstrated high test-retest reliability (Pearson $r = .90$; Stunkard et al., 1980; Thompson & Altabe, 1991).

**Contour Drawing Rating Scale** (CDRS; Thompson & Gray, 1995). The Contour Drawing Rating Scale assesses satisfaction with body contour, or the curves of one's body. Similar to the Figure Rating Scale, the CDRS has a nine-figure range from one (smallest body figure) to nine (largest body figure). Participants are asked to rate (1) their current figure, (2) the figure they would most like to have, (3) and the figure they think that the opposite sex would find most attractive. Body dissatisfaction is determined by the discrepancy between participants’ ratings of their current figure and their ideal figure. The CDRS is a reliable measure (test-retest reliability = .79; Thompson & Gray,
that has demonstrated good construct validity (Wertheim, Paxton, & Tilgner, 2004), and has been utilized with Hispanic populations (Henrickson, unpublished dissertation).

*Eating Attitudes Test-26* (EAT-26; Garner & Garfinkel, 1979; Garner, et al., 1982). The EAT-26 is a widely used brief self-report measure that assesses symptoms and characteristics of eating disorders. Participants rate their eating habits using a 6-point Likert scale ranging from "never" (1) to “always” (6), with higher scores indicating greater eating problems. The measure has three subscales: dieting, bulimia and food preoccupation, and oral control. The dieting subscale assesses concern related to dieting behaviors (e.g. "Aware of the calorie content of foods I eat."). The bulimia and food preoccupation subscale assesses compensatory behaviors such as vomiting and time spent thinking about food (e.g., "Give too much time and thought to food."). Oral control refers to behavioral restraint (e.g., "Avoid eating when I am hungry."). The measure has been used among Latino women (e.g. Bisaga et al., 2005) and has demonstrated high reliability ($\alpha = .83$) and high validity. The total score on the EAT-26 was utilized in this study.

*Eating Disorder Diagnostic Scale* (EDDS; Stice, Telch, & Rizvi, 2000). The EDDS is a 22-item measure assessing anorexia nervosa, bulimia nervosa, and binge eating disorder. Items were derived from the diagnostic criteria for each disorder included in the DSM-IV (APA, 1994). The measure utilizes a combination of Likert-style responses, yes/no, and frequency response formats. The measure has been tested with ethnically, regionally, and age-diverse women with and without eating disorders
(Stice et al., 2000). The measure demonstrated excellent convergent validity with other measures of eating disorders and high overall high 1-week test-retest reliability ($\kappa = .87$).

*Acculturation Rating Scale for Mexican Americans - II* (ARSMA-II; Cuellar, Arnold, Maldonado, 1995). The ARSMA-II is a 30-item instrument intended to measure Mexican and Anglo cultural characteristics with an optional 18-item marginalization subscale. Items on the ARSMA-II assess language use and preference, ethnic identity and classification, cultural heritage, ethnic behaviors, and ethnic interactions. Scale 1 of the ARSMA-II assesses levels of Mexican orientation, Anglo orientation, assimilation and integration. Scale 1 is comprised of two orthogonal and independently-derived subscales, the Mexican Orientation Subscale (MOS) and Anglo Orientation Subscale (AOS), which facilitate measurement of characteristics of both cultures relevant to bicultural individuals. Scores for each subscale are obtained by calculating the mean. Subtracting the MOS mean from the AOS mean produces an overall acculturation score. A higher score is indicative of greater Anglo orientation. Cronbach's alphas for both the AOS and MOS are high (.86 and .88, respectively).

Scale 2, also known as the Marginality scale, assesses the remaining two outcomes as described by Berry (1980), separation and marginalization. The revised ARSMA-II was re-designed to be utilized with a more general Hispanic population. Items on the ARSMA-II assess language use and preference, ethnic identity and classification, cultural heritage, ethnic behaviors, and ethnic interaction. Test-retest reliability for Scale 1 (Pearson $r = .96$) is excellent, while Scale 2 reliability is also high (Pearson $r = .87$). The measure has been designed to have high validity among the
general Hispanic population. Participants completed Scale 1 and Scale 2, although only Scale 1 was utilized in subsequent analyses.

Multidimensional Acculturative Stress Inventory-R (MASI-R; Rodriguez, Myers, Mira, Flores, & Garcia-Hernandez, 2002). The MASI-R is a 36-item measure of acculturative stress among individuals of Mexican origin, although it has been revised for use among other Hispanic populations as well. The instrument assesses Spanish competency pressures (Cronbach’s α = .93), English competency pressures (α = .91), pressure to acculturate (α = .84), and pressure against acculturating (α = .77). Similar to the intent of the ARSMA-II, the MASI-R was designed to assess stress emanating from both Anglo culture and Mexican culture. Although a measure of stress, the MASI-R is designed to measure stress specific to the acculturative process rather than stress surrounding SES, education, or discrimination, and is therefore different from other stress measures.

Participants respond “yes/no” to questions regarding whether they have experienced a particular event (e.g., “It bothers me when people assume that I speak Spanish”). If the participant answers in the affirmative, she is then asked how stressful the event was using a 5-point Likert scale ranging from “not at all stressful” (1) to “extremely stressful” (5). An overall acculturative stress score was calculated by summing all items. All subscales of the MASI-R have demonstrated good convergent and discriminant validity (Rodriguez et al., 2002).

Silencing the Self Scale (STSS; Jack, 1991; Jack & Dill, 1992). The STSS is a 31-item measure comprised of four subscales, including Externalized Self-Perception (α
Care as Self-Sacrifice ($\alpha = .60$), Silencing the Self ($\alpha = .81$), and the Divided Self ($\alpha = .83$). Externalized Self-Perception refers to a woman's tendency to judge herself based on the perception of others around her (e.g. "I tend to judge myself by how I think other people see me"). Care as Self-Sacrifice refers to the tendency to put others' needs before one's own needs in an effort to ensure the security of the relationship (e.g. "Caring means putting the other person's needs in front of my own"). The Silencing the Self subscale measures the extent to which a woman censors or silences her thoughts in an effort to avoid conflict (e.g. "I do not speak my feelings in an intimate relationship when I know they will cause disagreement"). The Divided Self subscale assesses whether a woman appears to be compliant outwardly, but harbors anger and hostility inwardly (e.g. "Often I look happy enough on the outside, but inwardly I feel angry and rebellious").

The overall scale has demonstrated high internal consistency ($\alpha = .89$) and test-retest reliability (Pearson $r = .89$; Jack & Dill, 1992). The measure also demonstrated high internal consistency among a sample of Latino women ($\alpha = .90$; Melendez, 2004), and good convergent validity with measures of depression (Jack & Dill, 1992). Participants completed the entire measure.

*Latina Values Scale-Revised* (LVS-R; Melendez, 2004). The LVS-R is a 27-item measure designed to assess certain aspects of *marianismo* (e.g. "I believe sacrificing yourself for others makes you a better person"). Items on the self-report measure were drawn primarily from writings by Gil and Vazquez (1996) regarding *marianista* ideals. The LVS-R was subsequently revised in order to increase its validity among Hispanics of all nationalities (Melendez, 2004). The measure also contains a Conflict subscale to
assess the degree of conflict associated with these marianista ideals (e.g. “Has the response to this question caused problems or conflicts in your life?”). Participants respond to both subscales using a 5-point Likert scale ranging from "strongly disagree" (1) to "strongly agree" (5), with a higher score indicating greater agreement with marianista ideals and greater perceived conflict due to those ideals. The measure asks women if they have heard the term marianismo prior to their participation in this study and to describe the concept in their own words. Internal consistencies for the primary scale (α = .94) and the Conflict subscale (α = .95) are excellent. The revised scale also has greater validity for the general Hispanic population (Melendez, 2004).

*Center for Epidemiological Studies – Depression Scale* (CESD; Radloff, 1977). The CESD is a 20-item, 4-point Likert scale measure designed to assess the frequency of depressive symptoms within the last seven days. Participants are asked how many days out of the week they experience symptoms including, dysphoria, low motivation, irritability, loss of appetite, and anhedonia. Higher scores indicate greater depressive symptomatology. The measure has demonstrated high internal consistency and has been cross-validated with other, longer measures of depressive symptomatology (Radloff, 1977).

*Somatic and Psychological Health Report-12* (SPHERE; Hickie, Davenport, Scott & Naismith, 2001). The SPHERE-12 is a brief self-report measure, which was modified from an original 34-item measure designed to assess somatic and psychological components of depression and anxiety. Participants respond using a 3-point Likert scale ranging from “never or some of the time” (1) to “most of the time” (3). Reliability and
validity of the original measure have been demonstrated previously (McFarlane, McKenzie, Van Hoofe, & Browne, 2008). Some have argued that the SPHERE-12 measure provides a high rate of false positives and may be a more appropriate measure of lifetime rather than current disorders; thus have cautioned against using it as a sole indicator of depressive symptomatology (McFarlane et al., 2008). For these reasons, the SPHERE-12 was used in conjunction the CES-D to provide additional assessment of somatic symptoms of depression and anxiety.

Statistical Analyses

Structural equation modeling (SEM) was utilized to examine sociocultural pressures, internalization of body ideals, and body dissatisfaction as predictors of disordered eating behaviors. SEM is seen as an extension of the general linear model, which also includes multiple regression, and conceptualizes multiple variables within a specified model. In a sense, SEM facilitates consideration of variables at a higher level of abstraction than does multiple regression (Kline, 1005). This type of analysis not only identifies correlational patterns, but also attempts to explain as much variance as possible through the specified model. Additionally, SEM takes into consideration the modeling of interactions, measurement error, and latent variables (Kline, 2005). For these reasons, SEM was deemed the best statistical approach to examine the fit of the dual pathway model (and the curvaceous ideal model) with the current sample.

Several mediations were examined including the mediating role of internalization of body ideals between sociocultural pressures and body dissatisfaction, the mediating role of body dissatisfaction between internalization of body ideals and eating problems,
and negative affect as a partial mediator of the body dissatisfaction and eating problems pathway. Multisample SEM was used to examine the moderating influences of acculturative status, acculturative stress, and marianismo on the pathway from sociocultural pressures to internalization of body ideals (Neff, 1985).
CHAPTER 3

RESULTS

Preliminary Analyses

Table 1 presents means, standard deviations, and Cronbach’s alpha coefficients for reliability for all measures used in the present study. Bivariate correlational analyses examined relationships among independent and dependent variables (See Table 2).

Significant correlations were found between all variables within the original dual-pathway model (Figure1). Negative communication and perceived pressures were significantly correlated with internalization of a thin ideal ($r = .35, r = .44; ps < .05$). Greater internalization of a thin ideal was correlated with lower body esteem and greater body shape dissatisfaction ($r = -.37, r = .77; ps < .01$). Lower body esteem and higher body shape dissatisfaction were associated with higher EDDS symptom scores ($r = -.48, r = .76; ps < .01$). Body esteem and body shape dissatisfaction were also correlated with measures of negative affect, the CESD ($r = -.45, r = .54; ps < .01$) and SPHERE ($r = -.49, r = .59, ps < .01$). Finally, CESD and SPHERE scores were correlated with EDDS symptoms ($r = .57, r = .56$, all $ps < .01$).

Acculturative stress, acculturative status, and marianista values were proposed as moderators of the pathway from sociocultural pressures to internalization of body ideals. Increased acculturative stress was significantly associated with greater identification with
marianista values ($r = .39, p < .01$). There were no significant correlations between acculturative status and the remaining moderators.

Bivariate correlations between sociocultural pressures and internalization of body ideals and the proposed moderators revealed that increased negative communication and perceived pressure were associated with greater acculturative stress ($r = .42, r = .36; ps < .01$). Acculturative status was not associated with any variables with the exception of curvaceous-ideal internalization ($r = -.18, p < .05$). Finally, marianismo was associated with negative communication and perceived pressure ($r = .39, r = .36; ps < .01$), as well as thin-ideal internalization ($r = .59, p < .05$).

*Structural Equation Modeling (SEM)*

Because only 6 cases, or 0.03% of the dataset, were missing one or more data points, analyses were conducted excluding these cases. Four additional cases did not meet criteria for univariate normality based on positive kurtosis on several scores (Kline, 2005); thus they were excluded from analyses, resulting in a total of 181 cases.

Maximum Likelihood Estimation was utilized to conduct all analyses in EQS, Version 6.1 (Bentler, 2006). Fit indices used to evaluate the model included the Chi-square statistic, Comparative Fit Index (CFI), and the Root Mean Square Error of Approximation (RMSEA) and its confidence interval (Kline, 2005). Hu and Bentler (1999) recommend a non-significant chi-square, a CFI value greater than .95, and an RMSEA less than .05 to be a good fit, although an RMSEA value between .05 and .08 is considered a reasonable fit.
Two separate structural models were constructed to examine two types of body ideals – the thin ideal and a curvaceous ideal. Latent factors in both models included sociocultural pressures (NCS, PSPS), body dissatisfaction (BES, BSQ, FRS, CDRS), negative affect (SPHERE, CESD), and disordered eating (EAT-26, EDDS). A latent variable for thin ideal internalization (FFS, SATAQ) was included in the first model. The second model included an indicator for curvaceous-ideal internalization rather than the thin ideal latent variable. For each latent variable, one pathway was fixed at 1.0.

For the first model, results indicated that the model was a relatively poor fit to the data, \( \chi^2 (49, N = 181) = 179.92, p < .001, \text{CFI} = .91, \text{RMSEA (CI}_{90\text{th percentile}} = .12 (.10-.14) \). Unfortunately, the Lagrange Multiplier test yielded theoretically inconsistent and conflicting results regarding model modifications. Given the relatively lower reliability for the SATAQ variable in this sample (Cronbach’s alpha = .73) and the fact that the SATAQ Awareness subscale has demonstrated poor reliability among Hispanics in previous studies (\( \alpha = .57; \text{Cashel et al., 2003} \)), the first decision was to further refine this construct by using the Internalization subscale alone (Cronbach’s alpha = .88) as a measure of thin-ideal internalization. It has been shown that internalization of a thin ideal, rather than awareness of the thin ideal, may be a more salient risk factor in the development of body dissatisfaction. Second, the decision was made to eliminate the fear of fat construct as a measure of thin-ideal internalization, as it is possible that a fear of fat is not equivalent to internalization of a thin-ideal (Brown & Dittmar, 2005). Thus the thin-ideal latent variable was simplified to an indicator variable within the structural equation model.
Finally, the latent variable of eating problems also was simplified. The construct of eating problems within the dual pathway model is best described as behavioral rather than attitudinal (Stice, 2001); thus the decision was made to simplify the disordered eating latent variable by removing the attitudinal scale, the EAT-26. Thus, the disordered eating latent variable was simplified to an indicator variable comprised of the EDDS Symptoms subscale alone (see Figure 5). The Symptoms subscale targets specific eating behaviors (e.g., fasting, binge eating, taking diet pills), rather than broader eating attitudes and beliefs; thus it was thought this would provide a purer assessment of eating behaviors. For the sake of consistency, this subscale was used in the curvaceuous ideal model as well.

The first structural model involved the internalization of a thin-ideal (Figure 5) as a mediator of the relationship between sociocultural pressures and body dissatisfaction. The model converged after 9 iterations. Goodness of fit indices indicated the model provided a slightly improved but still relatively poor fit to the data, \( \chi^2 (32, N = 181 = 170.32, p < .001, CFI = .87, RMSEA (CI_{90th\, percentile}) = .16 (.13-.18). \) All direct paths were significant.

A revised model was developed based on the Wald Test and Lagrange Multiplier Test. The Wald test recommended dropping the pathway from negative affect to disordered eating symptoms. The Lagrange Multiplier Test recommended adding a pathway directly from sociocultural pressures to body dissatisfaction as well as correlating the error terms of the FRS and the CDRS. These changes were made and the revised model converged after 7 iterations. Goodness-of-fit indices indicated an
improved fit to the data. $\chi^2 (31, N = 181) = 53.16, p < .01$, CFI = .98, RMSEA (CI$_{90\text{th\ percentile}}$) = .06 (.03-.09). Again, all direct paths were significant (see Figure 7). The revised model revealed indirect effects of thin ideal internalization on disordered eating behaviors with body dissatisfaction serving as a mediating variable (standardized coefficient = 13.63, $p < .05$). Thin ideal internalization acted as a mediator between sociocultural pressures and body dissatisfaction (standardized coefficient = 6.42, $p < .05$). Finally, body dissatisfaction mediated the pathway from thin ideal internalization to negative affect (standardized coefficient = 8.62, $p < .05$).

The second structural model examined internalization of a curvaceous ideal as a mediator (see Figure 6). The model converged after 8 iterations. Goodness-of-fit indices indicated a poor fit to the data. $\chi^2 (32, N = 181) = 203.16, p < .001$, CFI = .83, RMSEA(CI$_{90\text{th\ percentile}}$) = .18 (.15 -.20).

The Wald Test suggested dropping pathways from sociocultural pressures to curvaceous-ideal internalization and curvaceous-ideal internalization to body dissatisfaction. Recommendations from the Lagrange Multiplier Test included adding a direct pathway from sociocultural pressures to body dissatisfaction. These recommendations were incorporated into a revised model, which was then tested (see Figure 8). Although the revised model offered improved fit indices, the model represented a relatively poor fit to the data, $\chi^2 (25, N = 181) = 100.20, p < .001$, CFI = .93, RMSEA(CI$_{90\text{th\ percentile}}$) = .13 (.10 -.16). All direct paths were significant. With regard to indirect effects, sociocultural pressures predicted disordered eating behaviors with body dissatisfaction serving as a mediator of this pathway (standardized coefficient
= 16.08, \( p < 05 \)). The pathway from sociocultural pressures to negative affect was also mediated by body dissatisfaction (standardized coefficient = 8.74, \( p < .05 \)). The curvaceous-ideal internalization indicator was not included in the revised model.

*Multisample Analysis: Acculturative Status, Acculturative Stress, and Marianista Beliefs as Moderators*

Three separate multisample analyses were conducted in order to assess the moderating effects of acculturative status, *marianismo*, and acculturative status on the relationship between sociocultural pressures and thin-ideal internalization. These analyses were not conducted on the relationship between sociocultural pressures and curvaceous-ideal internalization due to the relatively poor model fit previously demonstrated.

In order to conduct the first multisample analysis with acculturative stress as a moderator, the sample was divided into two groups based on the upper and lower tertiles of scores on the ARSMA-II Acculturation Score subscale (\( n = 60 \), \( n = 61 \), respectively). For acculturative stress and for *marianismo*, the sample was divided based on scores that fell within the upper and lower tertiles on the MASI-R and upper and lower tertiles on a *marianismo* composite score comprised of the LVS-R and STSS (\( n = 60 \), \( n = 61 \), respectively for both analyses). First, each model was tested with the hypothesized moderated pathway constrained to be equal. Second, the model was tested with this pathway unconstrained. If fit indices are significantly different, specifically, if change in the CFI is greater than .01 (Cheung & Rensvold, 2002), there is evidence that moderation has occurred.
The first multisample analysis examined acculturative status as a moderator. There were no differences in fit indices between the constrained and unconstrained models (constrained model $\chi^2 (80, n_{upper} = 61, n_{lower} = 60) = 135.06, p < .001, \text{CFI} = .93, \text{RMSEA (CI}_{90\text{th percentile}}) = .07 (.08 - .14)$; unconstrained model $\chi^2 (80, n_{upper} = 60, n_{lower} = 61) = 135.06, p < .011, \text{CFI} = .93, \text{RMSEA (CI}_{90\text{th percentile}}) = .07 (.08 - .14)$. These findings suggest that acculturative status did not moderate the relationship between sociocultural pressures and thin-ideal internalization.

These analyses were repeated with acculturative stress as a moderator of the sociocultural pressures to thin ideal internalization pathway. There were no differences in fit indices between the constrained and unconstrained models (constrained model: $\chi^2 (60, n_{upper} = 61, n_{lower} = 60) = 95, p < .001, \text{CFI} = .96, \text{RMSEA (CI}_{90\text{th percentile}}) = .06 (.06 - .14)$; unconstrained model: $\chi^2 (60, n_{upper} = 61, n_{lower} = 60) = 95, p < .001, \text{CFI} = .96, \text{RMSEA (CI}_{90\text{th percentile}}) = .06 (.06 - .14)$. These fit indices suggest that acculturative stress does not moderate the sociocultural pressures – thin-ideal internalization pathway.

The final multisample analysis examined marianismo as a moderator of the sociocultural pressures to thin ideal internalization pathway. Again, there were no differences in fit indices between the constrained and unconstrained model (constrained model: $\chi^2 (60, n_{upper} = 61, n_{lower} = 60) = 72.5, p > .05, \text{CFI} = .97, \text{RMSEA (CI}_{90\text{th percentile}}) = .07 (.00, .11)$; unconstrained model: $\chi^2 (60, n_{upper} = 61, n_{lower} = 60) = 72.50, p < .001, \text{CFI} = .97, \text{RMSEA (CI}_{90\text{th percentile}}) = .06 (.00 - .11)$. These results suggest that marianismo does not moderate the pathway.

*Hierarchical Multiple Linear Regression*
**Composite scores.** The constructs of sociocultural pressures, body image, marianismo, and negative affect were conceptualized as multidimensional and thus were assessed with multiple measures. A composite score was created for each construct by standardizing scores for each measure, dividing the standardized score by $\frac{1}{2}$ or $\frac{1}{4}$ (depending on the number of measures comprising the construct), and summing. The sociocultural pressures construct was comprised of the NCS and the PSPS. The body image construct was comprised of four measures – the BES, BSQ, FRS, and CDRS. The negative affect construct was comprised of the CES-D and SPHERE. Finally, the construct of marianismo was assessed with the STSS and the LVS-R.

**Tests of mediation.** In order to confirm the results of the structural equation modeling, hierarchical linear multiple regression was utilized to examine several mediational and moderational hypotheses. In order to establish mediation, a series of regression analyses were conducted to establish that the independent variable is related to the mediator and dependent variable, and that the mediator is related to the dependent variable. When the introduction of the mediator variable reduces the relationship between the independent and dependent variable to non-significance (Baron & Kinney, 1986), mediation has occurred. Age, educational attainment, and treatment of an eating disorder were entered as covariates (see Table 3). Educational attainment was covaried in order to control for any effect of attending a college or university, where body image and eating problems are more prevalent due to the social nature of college campuses (Vohs, Heatherton, & Herrin, 2001). Socioeconomic status was not entered as a covariate due to a lack of evidence that body dissatisfaction or eating problems differ in prevalence.
rates across this variable (Breitkopf, Littleton, & Berenson, 2007; Reagan & Hersch, 2005; Wang, Byrne, Kenardy, & Hills, 2005).

First, the dual pathway model (see Figure 1) was examined through regression analyses. The first series of analyses examined thin ideal internalization as a mediator of the relationship between sociocultural pressures and body dissatisfaction. A second series of analyses examined body dissatisfaction as a mediator in the pathway from thin-ideal internalization to disordered eating behaviors. Third, the role of negative affect as a mediator between marianismo and eating disordered behaviors was examined (Table 4).

Sociocultural pressures predicted thin-ideal internalization ($B = .37, SE B = .06, \beta = .45, t = 6.51, p < .001$) and body dissatisfaction ($B = .31, SE B = .04, \beta = .52, t = 8.05, p < .001$). Thin-ideal internalization also predicted body dissatisfaction ($B = .37, SE B = .05, \beta = .51, t = 8.16, p < .001$). After entering thin-ideal internalization, the relationship between sociocultural pressures and body dissatisfaction was significantly reduced ($\beta$ reduced from .52 to .34; Sobel test-statistic = 4.20, $p < .001$), indicating thin-ideal internalization partially mediated the relationship between sociocultural pressures and body dissatisfaction.

A second series of regression analyses examined body dissatisfaction as a mediator in the pathway between thin ideal internalization and disordered eating behaviors as measured by the EDDS Symptoms subscale. Internalization of a thin-ideal was found to predict body dissatisfaction ($B = .37, SE B = .05, \beta = .51, t = 8.16, p < .001$) and disordered eating behaviors ($B = 1.41, SE B = .13, \beta = .61, t = 11.15, p < .001$). Body dissatisfaction also predicted disordered eating behaviors ($B = 2.01, SE B = .19, \beta = $
.63, \( t = 11.01, p < .001 \). After including body dissatisfaction, the pathway between thin-ideal internalization and disordered eating behaviors was reduced (\( \beta \) reduced from .61 to .40; Sobel test-statistic = 5.29, \( p < .001 \)), indicating body dissatisfaction partially mediated the relationship between thin-ideal internalization and disordered eating behaviors.

The final series of regression analyses examined negative affect as a mediator between marianismo and disordered eating behaviors. Marianismo was found to predict negative affect (\( B = .63, SE \, B = .06, \beta = .60, t = 10.51, p < .001 \)) and disordered eating behaviors (\( B = .96, SE \, B = .12, \beta = .50, t = 7.89, p < .001 \)), while negative affect also predicted eating disordered behaviors (\( B = 1.11 \, SE \, B = .11, \beta = .61, t = 9.93, p < .001 \)). After inclusion of the mediator, the relationship between the predictor and outcome variable was reduced (\( \beta \) reduced from .50 to .22; Sobel test-statistic = 5.29, \( p < .01 \)), indicating negative affect partially mediated the relationship between marianismo and disordered eating behaviors.

Tests of moderation. Since the SEM analyses for moderation required division of the sample into tertiles, it is possible that the non-significant findings were a result of a reduced sample size and decrease in power. Thus, a series of regression analyses were conducted with the entire sample to evaluate acculturative status, marianista beliefs, and acculturative stress separately as potential moderators of the pathway from sociocultural pressures to thin-ideal internalization (Table 5). To establish moderation, centered covariates, the centered predictor and moderator, and predictor-moderator interaction term are entered into the regression equation. When the interaction term accounts for a
significant proportion of the variance in the dependent variable (Baron & Kinney, 1986), moderation has occurred.

As recommended, low-to-moderate correlations were found between the moderator, independent and dependent variables (Baron & Kenny, 1986). Acculturative status was not significantly correlated with thin ideal internalization ($r = .13, p > .05$) or sociocultural pressures ($r = .10, p > .05$). *Marianismo* was moderately correlated with sociocultural pressures ($r = .44, p < .001$) and thin-ideal internalization ($r = .34, p < .001$). Acculturative stress was moderately correlated with sociocultural pressures ($r = .42, p < .05$), and thin ideal internalization ($r = .09, p > .05$). A moderate correlation was found between sociocultural pressures and thin ideal internalization ($r = .43, p < .001$).

The first regression analysis examined acculturative status as a moderator of the sociocultural pressures to thin-ideal internalization pathway. The interaction term did not significantly predict thin-ideal internalization ($B = .03, SE B = .06, \beta = .03, t = .46, p > .05$); thus moderation was not supported. A second regression analysis examined *marianismo* as a moderator of the same pathway; this interaction term also was not significant ($B = -.01, SE B = .01, \beta = -.11, t = -1.71, p > .05$). The third regression analysis examining acculturative stress as a moderator of this same pathway was also non-significant ($B = .00 SE B = .00, \beta = .07, t = .91, p > .05$).
CHAPTER 4

DISCUSSION

The primary goal of the present study was to examine the applicability of the dual pathway model (Stice, 2001) as a framework for predicting disordered eating behaviors among Latino women. A second major goal of the study was to examine the role of culture-specific variables as moderators of the pathway from sociocultural pressures to societal body ideals. Results provided greater support for thin-ideal internalization than curvaceous ideal internalization as a mediator of the pathway from sociocultural pressures to body dissatisfaction. Contrary to expectations, none of the culture-specific variables moderated this relationship.

Suitability of the Dual Pathway Model

Consistent with Stice’s model (2001), sociocultural pressures were associated with body dissatisfaction, which mediated the pathway between sociocultural pressures and disordered eating behaviors. Internalization of a thin ideal partially mediated the pathway from sociocultural pressures to body dissatisfaction. Although both measures of negative affect were significantly associated with disordered eating behaviors, the results of the structural equation model indicated that negative affect did not mediate the relationship between body dissatisfaction and disordered eating behaviors. These findings suggest that, as with Caucasian, non-Hispanic women, negative commentary and pressure about weight and shape can influence body image and predict unhealthy eating.
behaviors among Latinas/Hispanic women, partially through their influence on thin-ideal internalization.

The fact that thin-ideal internalization acted as a partial mediator between sociocultural pressures to be thin and increased body dissatisfaction suggests that thinness is relevant among women of this ethnic group. These findings are particularly noteworthy as the self-reported weight and height of these women indicated that they are slightly overweight. The discrepancy between their ideal body type and their current weight status as demonstrated by figure rating scale scores also contributes to this body dissatisfaction. These findings are consistent with previous research in this population (Henrickson, unpublished dissertation) and provide further support for investigation of the thin-ideal among Latino women. Surprisingly, there was relatively less support for the idea that these women hold a more curvaceous body ideal as this construct was not associated with sociocultural pressure, body dissatisfaction, or disordered eating.

With regard to the second pathway to disordered eating behaviors, negative affect is thought to precipitate such behavior because it functions as a maladaptive emotion regulation strategy (Heatherton & Baumeister, 1991; Nolen-Hoeksema, Stice, Wade, & Bohon, 2007). The absence of a significant pathway between negative affect and disordered eating behavior in this study may have been due to the nature of assessment of negative affect. Negative affect has been conceptualized as a general factor including a range of negative mood states such as anxiety, sadness, and depressive symptoms. It has been conceptualized as a broad risk factor for psychopathology (Watson, Clark, & Carey, 1988). Two measures, the CES-D and SPHERE, were used to create a negative affect
latent variable; however, the combination of measures may have produced a latent variable that could be more accurately described as depression. The findings of this study suggest that both depression and disordered eating behaviors are associated with body dissatisfaction among this sample of Latino women.

**Suitability of a Modified Dual-Pathway Model: Curvaceous-Ideal Internalization**

A modified dual-pathway model including internalization of a curvaceous ideal in place of thin-ideal internalization was not supported. There may be two explanations for these findings. One reason for these findings is that these women may not identify with a curvaceous body ideal. Indeed, only 28.3% of the sample identified as first generation and the majority of those women (93.5%) had immigrated to the United States prior to age 10. Thus, it is likely that the majority of the sample has adopted the mainstream preference for thinness. A second possibility is that the measure’s poor reliability precluded accurate assessment of a curvaceous ideal. Post-hoc elimination of scale items did not improve the reliability of the measure. The assessment tool used in this study was devised by modifying a widely used measure of thin-ideal internalization. Rather than dismissing the relevancy of a more curvaceous body ideal, future studies may benefit from a combined quantitative and qualitative approach to develop a more valid and reliable measure. Furthermore, assessing this construct in a larger sample of first generation women may result in different outcomes.

**Culture-specific Moderators: Acculturative Status, Acculturative Stress, and Marianismo**

Acculturative status, acculturative stress, and *marianismo* were three variables that were examined as potential moderators of the pathway from sociocultural pressures
to thin-ideal internalization. Although it had been thought that the relationship between sociocultural pressures and internalization of body ideals would be a function of their familiarity and exposure to Western cultural values, the stress women feel to assimilate or maintain traditional values, or their adherence to cultural ideals of femininity, none of these hypothesized moderations were significant. The lack of moderation may have been due to the relatively homogeneous nature of the sample. The relatively smaller number of 1st generation women may have resulted in a restricted range that precluded identifying moderator variables. A possible theoretical explanation is that perceived sociocultural pressures and negative communication play more salient roles in the development of body ideals than any culture-specific variables.

It is interesting to note the significant bivariate relationships between both measures of marianismo and thin-ideal internalization. These findings suggest that, although marianismo may not act as a mediating variable, it does have a potential impact on women’s body ideals and warrants further attention. The relationship also calls into question the conventional assumption that adherence to cultural values would protect women from adopting a thin-ideal, since women with stronger marianista beliefs endorsed a greater internalization of the thin-ideal.

**Impact of Acculturation**

As was hypothesized, acculturative status was not associated with total scores on any measures of sociocultural pressures, body dissatisfaction, or disordered eating, nor was it a significant moderator. As would be expected, those that had lived in the United States the longest were more acculturated and reported experiencing greater pressures to
speak and understand Spanish. Conversely, less acculturated women reported feeling increased pressure to speak and understand English. Acculturative stress, in contrast, was correlated with perceived sociocultural pressures, body dissatisfaction, depression, and disordered eating behaviors. There was no relationship between acculturative stress and internalization of either body ideal.

Although not a significant moderating variable, acculturative stress appears to be a greater risk factor for psychopathology than low or high acculturative status. These findings are consistent with the diathesis-stress model of psychopathology that suggests that environmental stressors can trigger manifestation of biological predispositions. Research has shown that disordered eating behaviors can arise as maladaptive coping mechanisms in response to environmental stressors (Joiner, Heatherington, Rudd, & Schmidt, 1997). For individuals that may possess a genetic predisposition towards eating disorders, these environmental and behavioral stressors may act as triggers in the subsequent development of an eating disorder. Acculturative stress may act as an additional stressor that places ethnic minority women at greater risk for eating disorders and increased psychopathology overall.

**Impact of Marianismo**

---

1 Acculturative status was negatively correlated with the MASI English Competency Pressures subscale \( r = -.15, p < .05 \) and positively correlated with MASI Spanish Competency Pressures \( r = .53, p < .01 \), suggesting that those who were less acculturated felt pressure to speak and understand English and vice versa.
Women who strongly identified with marianismo reported greater negative communication, a perceived pressure to be thin, internalization of a thin-ideal, body dissatisfaction, acculturative stress, negative affect, and disordered eating behaviors. These findings are consistent with evidence of poorer psychological well-being among women who identify with more rigid feminine values, including lower self-efficacy, helplessness, and poorer coping strategies (Horwitz & White, 1987; Nolen-Hoeksema & Girgus, 1994). Theoretically, woman may adhere to marianista beliefs as a result of pressures from family and friends (Gil & Vazquez, 1996). Subsequently, conflict between cultural values and mainstream ideals could lead to acculturative stress and body dissatisfaction. Disordered eating behaviors may emerge as both a means for achieving a certain body shape and as an emotion regulation strategy (Stice, Presnell, & Spangler, 2002). The results from this study provide impetus and direction for future research.

The concept of marianismo appears to be an important influence in the lives of Latino women and has been documented as an “invisible yoke” (Arredondo, 2002; Gil & Vazquez, 1996), tying women to traditional values of home, patience, and selflessness. Arredondo (2002) noted that the term itself is academic in nature, however Latina women often acknowledge the presence of marianista values in their families. Marianismo also has been identified as a potential barrier to healthcare, especially related to HIV/AIDS prevention in Spanish-speaking countries (e.g., Sabogal & Cantania, 1996). Despite the attention it has received in other fields, marianismo’s impact on body dissatisfaction and eating problems has remained relatively unexamined.
Among this sample of women, however, fewer than 15% of woman reported that they had heard the term marianismo, and fewer than half of those participants were able to provide an accurate description of the term. Despite this fact, the mean score for the LVS-R indicated that women did identify with many marianista beliefs. The discrepancy between identifying with beliefs and being able to identify the term is likely due to the implicit or deeply ingrained nature of marianista values, rather than an effect of acculturation (Cianelli, Ferrer, & McElmurry, 2008). The sample was relatively young and more acculturated, thus perhaps less knowledgeable about such gender roles. Another possibility is that, as with Western gender roles, the behaviors and beliefs that characterize marianismo may be so deeply ingrained in broader societal and family values that it is not discussed explicitly (Cianelli, Ferrer, & McElmurry, 2008). The fact that the construct was associated with multiple outcome and predictor variables suggests that it deserves further attention in this population.

Limitations

There are several limitations with regard to the sample in the study. First, Spanish-speaking women were excluded from the study due to the lack of validated Spanish versions for all measures. Adherence to traditional marianista beliefs and a more flexible body ideal may have been more prevalent in a less acculturated, monolingual group of women. There is an urgent need to develop validated Spanish language measures so that these results can be replicated or elaborated upon in a broader sample. Second, only women with access to a computer were able to complete the study. These two limitations may have excluded lower-income, less educated, less acculturated
women (Suarez-Balcazar, Balcazar, & Taylor-Ritzler, 2009). Third, the generalizability of these findings may be limited due to the impact of self-selection. Women who were more educated, had a particular interest in eating disorders or dieting, or with strong ethnic identification may have been more likely to participate. To counter this limitation, we attempted to contact women at both 4-year universities and community colleges. We also contacted non-cultural student organizations in cities with large Hispanic populations, and posted classified ads to attract non-students.

Although the generalizability of the findings may be affected due to these limitations, it should be noted that the sample was diverse with regard to ethnic identification and geographic residence. Furthermore, U.S. Census data for 2005 (U.S. Census Bureau, 2009) reports that, while internet access among Hispanics is markedly lower than among Caucasians (37% versus 65%), young adults use the Internet more than any other age group, regardless of education, ethnicity, gender, or SES. Having acknowledged these limitations, these findings are still a useful springboard for future investigations.

Additional limitations included the self-report nature of the study, which may have been impacted by social desirability. It is possible that the confidential and relatively anonymous nature of online surveys may decrease the impact of social desirability on women’s responses, although no measure of this tendency was included. Also the cross-sectional nature of the study precludes conclusions regarding causal relationships. Prospective research is needed to truly examine the change in eating
behaviors and body ideals that occur as women progress through the acculturation experience.

Conclusions

The results of this study suggest that multiple psychosocial variables may influence the development of disordered eating behaviors among Latino women, including perceived sociocultural pressures, thin-ideal internalization, and body dissatisfaction. The study found reasonable support for the dual pathway model such that internalization of body ideals partially mediated the pathway from sociocultural pressures to body dissatisfaction and body dissatisfaction mediated the pathway from sociocultural pressures to disordered eating behaviors and negative affect. However, negative affect did not act as a secondary pathway to disordered eating behaviors. Our hypothesis that these women would more strongly identify with a curvaceous body ideal was not supported. Indeed, cultural variables, including marianismo, acculturative status, and acculturative stress did not play the moderating roles that had been hypothesized, although marianismo and acculturative stress demonstrated significant relationships with body dissatisfaction and eating problems.

These findings suggest that, among Latino women, the risk for psychopathology, specifically disordered eating behaviors, is impacted by both Hispanic and mainstream American culture, and that the thin-ideal remains a salient risk factor. For immigrant or ethnic minority women, the process of acculturating – learning a new language, navigating unfamiliar social customs, and daily lifestyle changes – can exert unique additional pressures. Those predisposed to maladaptive coping strategies would be at
greater risk, not only for eating disorders, but other types of psychopathology as well. Thus, future studies should incorporate acculturation measures that assess perceived stress in addition to generational status, country of birth, or length of residency, in order to draw more meaningful conclusions about the role of acculturation.

To increase the generalizability of these findings, the study should be replicated with a Spanish speaking population and recruit women in-person to avoid the barrier of computer access. Second, the development of a validated and reliable curvaceous body ideal measure would help to conduct research that supports the notion of less rigid body ideals among this population. Third, further validation of the Latina Values Scale-Revised would help to better understand the relevancy of marianismo in diverse Hispanic groups. Finally, it would be interesting to further explore these findings by recruiting large numbers of women from each ethnic subgroup in order to understand the differences that exist within the Latino/Hispanic population.

*Clinical Implications*

Overall, the findings of this study suggest that the assessment of disordered eating behaviors in this population should include sensitivity to cultural factors, including psychosocial stressors related to acculturation and immigration. Currently, the assessment of eating disorders has been based on research done on homogenous samples of young Caucasian females. Among these women, a preoccupation with physical appearance and weight and a desire for thinness appear to be the salient risk factors in the development of disordered eating behaviors. Perfectionism, negative affect, and poor emotion regulation ability also have been found to be associated with disordered eating
behavior. The evidence emerging for Latino women suggests that disordered eating behaviors are just as prevalent in this group of women, but perhaps associated with slightly different psychosocial influences stemming from their gender role beliefs and cultural family values. The results of this study regarding marianismo and its associations with multiple risk and maintenance factors of disordered eating behaviors underline the importance of cultural competency when working with this population.

Although body dissatisfaction has been demonstrated to be a risk factor for disordered eating behaviors in this population, it is also necessary to consider other non-weight related risk factors including maladaptive emotion regulation. Many Latino women experience psychological stress related to acculturation, immigration, and discrimination. Disordered eating behaviors may arise as unhealthy methods of coping and self-soothing. Thus assessment of maintenance factors for these eating behaviors should include assessment of these stressors.

**Directions for Future Research**

This study revealed several areas for future research, both within the field of body image and eating disorders and beyond. While existing model do appear to provide an adequate framework for explaining eating disorders among Latino women, there is a need for greater understanding of the role of cultural risk factors such as acculturative stress and gender role beliefs. Development of Spanish-language measures for body image and eating disorders are a primary concern, since a significant portion of the Latino population is overlooked due to language barriers. Indeed, the findings from this study may not be generalizable to non-English speaking women who may hold even stronger
marianista beliefs. Second, a greater understanding of body image among this group is warranted. One reason for the difficulty in capturing this construct adequately could be the sheer diversity within the Hispanic culture. It is likely that the body ideals of Mexican women differ from that of Cuban, South American, or Spanish women, perhaps due to the influences of African, indigenous Indian, or colonial culture.

In addition to a better understanding of body image, future research is needed to examine the influences of non-weight-related influences on the development of eating disorders. Perfectionism, low self-esteem, and poor emotion regulation are just a few of the variables that could be examined further. Acculturation and the experience of immigration and discrimination are additional factors that may negatively impact eating behaviors.

Although the current findings suggested that acculturative stress is associated with poorer psychological well-being, these findings would be more conclusive with prospective data. Multiple prospective assessments of stress, body image, and eating behaviors would provide a clearer picture of the potential changes in body image and the impact of these stressors on eating behaviors.
REFERENCES


Appendix A

Demographic Questionnaire

Demographic Information

Age _____ Height _____ Weight _____

Your Ethnic Origin (check all that apply):
___ 1) Mexican
___ 2) Puerto Rican
___ 3) Cuban
___ 4) Dominican
___ 5) South American (please specify): ________________________________
___ 6) Central American (please specify): ________________________________
___ 7) Spanish
___ 8) Caribbean
___ 9) American Indian or Alaskan Native
___ 10) African American/Black
___ 11) European American/Caucasian/White
___ 12) Asian or Asian American
___ Other (Please specify): ____________________________________________

Marital Status
___ Single
___ Married
___ Divorced/Separated
___ Widowed

Number of Children ______

Your Household’s Annual Income: (For example, if you live with your parents)
___ 1) Less than $5,000
___ 2) $5,000 to $9,999
___ 3) $10,000 to $14,999
___ 4) $15,000 to $24,999
___ 5) $25,000 to $34,999
___ 6) $35,000 to $49,999
___ 7) $50,000 to $74,000
8) $75,000 to $99,000
9) $100,000 to $150,000
10) $150,000 or more

Your Annual Income (check one):
1) Less than $5,000
2) $5,000 to $9,999
3) $10,000 to $14,999
4) $15,000 to $24,999
5) $25,000 to $34,999
6) $35,000 to $49,999
7) $50,000 to $74,000
8) $75,000 to $99,000
9) $100,000 to $150,000
10) $150,000 or more

Occupation/Job: _______________________________

Employment status (check one):
1) currently not employed
2) employed part-time
3) employed full-time
4) other (Please specify):_______________________________

Education level (check highest level obtained):
1) less than 8th grade
2) 8th grade
3) some high school
4) high school
5) trade school
6) some college
7) 2-year college
8) 4-year college
9) Master’s level
10) Doctoral level

Where you were born? (Your country of birth):___________________________

If you were not born in the U.S., at what age did you immigrate to the United States?
________________
Your mother's ethnic origin (check all that apply):

___ 1) Mexican  
___ 2) Puerto Rican  
___ 3) Cuban  
___ 4) Dominican  
___ 5) South American (please specify): ________________________________  
___ 6) Central American (please specify): ________________________________  
___ 7) Spanish  
___ 8) Caribbean  
___ 9) American Indian or Alaskan Native  
___ 10) African American/Black  
___ 11) European American/Caucasian/White  
___ 12) Asian or Asian American  
___ Other (Please specify): ____________________________________  

Your mother's nation of origin (where she was born): ____________________________  

Your father's ethnic origin (check all that apply):

___ 1) Mexican  
___ 2) Puerto Rican  
___ 3) Cuban  
___ 4) Dominican  
___ 5) South American (please specify): ________________________________  
___ 6) Central American (please specify): ________________________________  
___ 7) Spanish  
___ 8) Caribbean  
___ 9) American Indian or Alaskan Native  
___ 10) African American/Black  
___ 11) European American/Caucasian/White  
___ 12) Asian or Asian American  
___ Other (Please specify): ____________________________________  

Your father's nation of origin (where he was born): ____________________________  

Circle the generation that best applies to you. Circle only one.  

1. 1st generation = You were born in other country  
2. 2nd generation = You were born in USA; either parent born in other country  
3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in other country  
4. 4th generation = You and your parents born in USA and at least one grandparent born in other country with remainder born in USA  
5. 5th generation = You and your parents born in the USA and all grandparents born in the USA  

Have you ever sought or received treatment for an eating problem?  

___ 1) Yes (please specify: ________________________________)  
___ 2) No
Have you ever been diagnosed with an eating disorder?
___ 1) Yes (please specify: ________________________________)
___ 2) No
Appendix B

Sociocultural Pressures

PSPS

Using the following scale, please circle the response that best captures your own experience.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I've felt pressure from my friends to lose weight. 1 2 3 4 5
2. I've noticed a strong message from my friends to have a thin body. 1 2 3 4 5
3. I've felt pressure from my family to lose weight. 1 2 3 4 5
4. I've noticed a strong message from my family to have a thin body. 1 2 3 4 5
5. I've felt pressure from people I've dated to lose weight. 1 2 3 4 5
6. I've noticed a strong message from people I have dated to have a thin body. 1 2 3 4 5
7. I've felt pressure from the media (e.g., TV, magazines) to lose weight. 1 2 3 4 5
8. I've noticed a strong message from the media to have a thin body. 1 2 3 4 5
Using the scale below, please select a response that reflects your own experience.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. How frequently are you teased about your weight?
   1  2  3  4  5

2. How frequently has your mother encouraged you to lose weight?
   1  2  3  4  5

3. How frequently has your father encouraged you to lose weight?
   1  2  3  4  5

4. How frequently have your siblings (brothers & sisters) encouraged you to lose weight?
   1  2  3  4  5

5. How frequently have your friends encouraged you to lose weight?
   1  2  3  4  5

6. How frequently has your mother made negative comments about your physical appearance.
   1  2  3  4  5

7. How frequently has your father made negative comments about your physical appearance.
   1  2  3  4  5

8. How frequently have your siblings (brothers and sisters) made negative comments about your physical appearance.
   1  2  3  4  5

9. How frequently have your friends made negative comments about your physical appearance?
   1  2  3  4  5
Appendix C

Body Ideals

SATAQ

Please read each of the following items and circle the number that best reflects your agreement with the statement.

<table>
<thead>
<tr>
<th></th>
<th>1 Completely Disagree</th>
<th>2 Neither agree nor disagree</th>
<th>3 Completely Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.) Women who appear in TV shows and movies project the type of appearance that I see as my goal. _____
2.) I believe that clothes look better on thin models. ______
3.) Music videos that show thin women make me wish that I were thin. _____
4.) I do not wish to look like the models in the magazines. ______
5.) I tend to compare my body to people in magazines and on TV. ______
6.) In our society, fat people are not regarded as unattractive. ______
7.) Photographs of thin women make me wish that I were thin. ______
8.) Attractiveness is very important if you want to get ahead in our culture. ______
9.) It's important for people to work hard on their figures/physiques if they want to succeed in today's culture. ______
10.) Most people do not believe that the thinner you are, the better you look. ______
11.) People think that the thinner you are, the better you look in clothes. ______
12.) In today's society, it's not important to always look attractive. ______
13.) I wish I looked like a swimsuit model. ______
14.) I often read magazines like *Cosmopolitan*, *Vogue*, and *Glamour* and compare my appearance to the models. ______
Curvaceous Ideals

Please read each of the following items and circle the number that best reflects your agreement with the statement.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completely Disagree</td>
<td>Neither agree nor disagree</td>
<td>Completely Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I believe that clothes look better on models that are curvaceous (that have curves)._____
2. Music videos that show curvy or voluptuous women make me wish I had curves._____
3. Photographs of curvy or voluptuous women make me wish I had curves._____
4. I don't believe that the curvier or more voluptuous you are, the better you look._____
5. I think the curvier or more voluptuous you are, the better you look in clothes._____
Please read each of the following statements and select the number which best represents your feelings and beliefs.

1 = very untrue  2 = somewhat untrue  3 = somewhat true  4 = very true

_____ 1. My biggest fear is of becoming fat.
_____ 2. I am afraid to gain even a little weight.
_____ 3. I believe there is a real risk that I will become overweight someday.
_____ 4. I don't understand how overweight people can live with themselves.
_____ 5. Becoming fat would be the worst thing that could happen to me.
_____ 6. If I stopped concentrating on controlling my weight, chances are I would become very fat.
_____ 7. There is nothing that I can do to make the thought of gaining weight less painful and frightening.
_____ 8. I feel like all my energy goes into controlling my weight.
_____ 9. If I eat even a little, I may lose control and not stop eating.
_____ 10. Staying hungry is the only way I can guard against losing control and becoming fat.
Appendix D

Body Image and Dissatisfaction

BSQ

We would like to know how you have been feeling about your appearance over the PAST FOUR WEEKS. Please read each question and choose the appropriate number. Please answer all the questions.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

OVER THE PAST FOUR WEEKS:
1. Has feeling bored made you brood (think a lot) about your shape?
   1  2  3  4  5  6
2. Have you ever been so worried about your shape that you have been feeling that you ought to diet?
   1  2  3  4  5  6
3. Have you thought that your thighs, hips or bottom are too large for the rest of you?
   1  2  3  4  5  6
4. Have you been afraid that you may become fat (or fatter)?
   1  2  3  4  5  6
5. Have you worried about your flesh not being firm enough?
   1  2  3  4  5  6
6. Has feeling full (e.g. after a large meal) made you feel fat?
   1  2  3  4  5  6
7. Have you felt so bad about your shape that you have cried?
   1  2  3  4  5  6
8. Have you avoided running because your flesh might wobble?
   1  2  3  4  5  6
9. Has being with thin women made you feel self-conscious about your shape?
   1  2  3  4  5  6
10. Have you worried about your thighs spreading out when sitting down?
    1  2  3  4  5  6
11. Has eating even a small amount of food made you feel fat?
    1  2  3  4  5  6
12. Have you noticed the shape of other women and felt self-conscious about your shape?
    1  2  3  4  5  6
13. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching TV, reading, listening to conversations)?
14. Has being naked such as when taking a bath, made you feel fat?
15. Have you avoided wearing clothes, which make you particularly aware of the shape of your body?
16. Have you imagined cutting off fleshy areas of your body?
17. Has eating sweets, cakes, or other high calorie food made you feel fat?
18. Have you not gone to social occasions (e.g. parties) because you have felt bad about your shape?
19. Have you felt excessively large and rounded?
20. Have you felt ashamed of your body?
21. Has worry about your shape made you diet?
22. Have you felt happiest about your shape when you stomach has been empty (e.g., in the morning)?
23. Have you thought that you are the shape you are because of your lack of self-control?
24. Have you worried about other people seeing rolls of flesh around your waist or stomach?
25. Have you felt that it is not fair that other women are thinner than you?
26. Have you vomited in order to feel thinner?
27. When in company have you worried about taking up too much room (e.g., sitting on a sofa or a bus seat)?
28. Have you worried about your flesh being dimply?
29. Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?
30. Have you pinched areas of your body to see how much fat is there?
31. Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming baths)?
32. Have you taken laxatives in order to feel thinner?
33. Have you been particularly self-conscious about your shape when in the company of other people?
34. Has worry about your shape made you feel you ought to exercise?
Using the scale below, please indicate how positive or negative you feel about each item listed.

<table>
<thead>
<tr>
<th>Have strong negative feelings</th>
<th>Have moderate negative feelings</th>
<th>Have no feelings one way or the other</th>
<th>Have moderate positive feelings</th>
<th>Have strong positive feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1.) Body scent
2.) Appetite
3.) Nose
4.) Physical stamina
5.) Reflexes
6.) Lips
7.) Muscular strength
8.) Waist
9.) Energy level
10.) Thighs
11.) Ears
12.) Biceps
13.) Chin
14.) Body build
15.) Physical coordination
16.) Buttocks
17.) Agility
18.) Width of shoulders
19.) Arms
20.) Chest or breasts
21.) Appearance of eyes
22.) Cheeks/cheekbones
23.) Hips
24.) Legs
25.) Figure or physique
26.) Sex drive
27.) Feet
28.) Sex organs
29.) Appearance of stomach
30.) Health
31.) Sex activities
32.) Body hair
33.) Physical condition
<table>
<thead>
<tr>
<th></th>
<th>Face</th>
<th>1</th>
<th>2</th>
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<tr>
<td>34.)</td>
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<tr>
<td></td>
<td>Weight</td>
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<td>35.)</td>
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</table>
FRS

Please answer the following questions using the appropriate figure scale shown below. Write in your answer choice on the blank provided.

1. Which figure do you believe most resembles your current figure? _____
2. Which figure would you most like to have? _____
3. Which figure do you believe your partner most wants for you? _____
4. Which figure would you most want your partner to have? _____
5. Which figure most resembles your partner's figure? _____
CDRS

Answer the questions below by writing the appropriate number that corresponds with your figure choice in the blank provided.

1. For the figures below, please identify the figure that best resembles your current figure.____
2. For the figures below, please identify the figure that best resembles the figure you would most like to have.____
3. For the figures below, please identify the figure that the opposite sex finds most attractive.____
Appendix E

Eating Problems

EAT-26

Please check a response for each of the following statements:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Am terrified about being overweight.</td>
<td></td>
<td></td>
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<tr>
<td>2. Avoid eating when I am hungry.</td>
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</tr>
<tr>
<td>3. Find myself preoccupied with food.</td>
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</tr>
<tr>
<td>4. Have gone on eating binges where I feel that I may not be able to stop.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. Cut my food into small pieces.</td>
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<tr>
<td>6. Aware of the calorie content of foods that I eat.</td>
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<td>7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)</td>
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<td>8. Feel that others would prefer if I ate more.</td>
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<td>9. Vomit after I have eaten.</td>
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<td>10. Feel extremely guilty after eating.</td>
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<tr>
<td>11. Am preoccupied with a desire to be thinner.</td>
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<td>12. Think about burning up calories when I exercise.</td>
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<td>13. Other people think that I am too thin.</td>
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<td>14. Am preoccupied with the thought of having fat on my body.</td>
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<td>15. Take longer than others to eat my meals.</td>
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<td>16. Avoid foods with sugar in them.</td>
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<td>17. Eat diet foods.</td>
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<tr>
<td>18. Feel that food controls my life.</td>
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<td>19. Display self-control around food.</td>
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<td>20. Feel that others pressure me to eat.</td>
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<td>21. Give too much time and thought to food.</td>
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<td>22. Feel uncomfortable after eating sweets.</td>
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<td>23. Engage in dieting behavior.</td>
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<td>24. Like my stomach to be empty.</td>
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<td>25. Have the impulse to vomit after meals.</td>
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<td>26. Enjoy trying new rich foods.</td>
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EDDS

Please carefully complete all questions.

OVER THE PAST 3 MONTHS . . .

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<th>Question</th>
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</thead>
<tbody>
<tr>
<td>1. Have you felt fat?</td>
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<td>2. Have you had a definite fear that you might gain weight or become fat?</td>
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<td>3. Has your weight influenced how you think about (judge) yourself as a person?</td>
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<td>4. Has your shape influenced how you think about (judge) yourself as a person?</td>
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<td>5. During the past 6 months have there been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g. quart of ice cream) given the circumstances?</td>
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<td>YES NO</td>
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<td>6. During the times when you ate an unusually large amount of food, did you experience a loss of control (feel you couldn't stop eating or control what or how much you were eating?)</td>
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<td>YES NO</td>
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<td>7. How many DAYS per week on average over the past 6 MONTHS have you eaten an unusually large amount of food and experienced a loss of control?</td>
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<tr>
<td>8. How many TIMES per week on average over the past 3 MONTHS have you eaten an unusually large amount of food and experienced a loss of control?</td>
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<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14</td>
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<tr>
<td>During these episodes of overeating and loss of control did you . . .</td>
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<td>9. Eat much more rapidly than normal?   YES NO</td>
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<td>10. Eat until you felt uncomfortably full? YES NO</td>
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</tbody>
</table>
11. Eat large amounts of food when you didn't feel physically hungry? YES NO

12. Eat along because you were embarrassed by how much you were eating? YES NO

13. Feel disgusted with yourself, depressed, or very guilty after overeating? YES NO

14. Feel very upset about your uncontrollable overeating or resulting weight gain? YES NO

15. How many times per week on average over the past 3 months have you made yourself vomit to prevent weight gain or counteract the effects of eating?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

16. How many times per week on average over the past 3 months have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

17. How many times per week on average over the past 3 months have you fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

18. How many times per week on average over the past 3 months have you engaged in excessive exercise specifically to counteract the effects of overeating episodes?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14


20. How tall are you? ___ ft. ___ in.

21. Over the past 3 months, how many menstrual periods have you missed?

1 2 3 4 na

22. Have you been taking birth control pills during the past 3 months? YES NO
Appendix F

Acculturative Experience

ARSMA

Below are statements about your culture, how you feel about it, and how much you identify with it. There are no right or wrong answers. For each statement, please choose from 1-5, how often it applies to you.

What is your religious preference?:

```
What is your religious preference?:

<table>
<thead>
<tr>
<th>1. I speak Spanish.</th>
<th>2. I speak English.</th>
<th>3. I enjoy speaking Spanish.</th>
<th>4. I associate with Anglos.</th>
<th>5. I associate with Hispanics and/or Hispanic Americans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. I enjoy Spanish language movies</td>
<td>12. I enjoy reading (e.g. books in Spanish)</td>
<td>13. I enjoy reading (e.g. books in English)</td>
<td>14. I write (e.g. letters in Spanish)</td>
<td>15. I write (e.g. letters in English)</td>
</tr>
<tr>
<td>16. My thinking is done in the English language</td>
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1 2 3 4 5
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<table>
<thead>
<tr>
<th>1. I speak Spanish.</th>
<th>2. I speak English.</th>
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<tr>
<td>16. My thinking is done in the English language</td>
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</tbody>
</table>
17. My thinking is done in the Spanish language
18. My contact with Hispanic countries has been...
19. My contact with the USA has been...
20. My father identifies or identified himself as "Hispanic."
21. My mother identifies or identified herself as "Hispanic."
22. My friends, while I was growing up, were of Anglo origin.
23. My friends, while I was growing up were of Hispanic origin.
24. My family cooks Hispanic foods.
25. My friends now are of Anglo origin
26. My friends now are of Hispanic origin
27. I like to identify myself as an Anglo American
28. I like to identify myself as a Hispanic American
29. I like to identify myself as Hispanic
30. I like to identify myself as an American

SCALE 2

<table>
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<tr>
<th></th>
<th>Not at all</th>
<th>Very little/Not very often</th>
<th>Moderately</th>
<th>Much/Very often</th>
<th>Extremely often/Almost always</th>
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1. I have difficulty accepting some ideas held by Anglos.
2. I have difficulty accepting certain attitudes held by Anglos.
3. I have difficulty accepting some behaviors exhibited by Anglos.
4. I have difficulty accepting some values held by some Anglos.
5. I have difficulty accepting certain practices and customs commonly found in some Anglos.
6. I have, or think I would have, difficulty accepting Anglos as close personal friends.
7. I have difficulty accepting ideas held by some Hispanics.
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<tbody>
<tr>
<td>8. I have difficulty accepting certain attitudes held by Hispanics.</td>
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<td>9. I have difficulty accepting some behaviors exhibited by Hispanics.</td>
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<td>10. I have difficulty accepting some values held by some Hispanics.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>11. I have difficulty accepting certain practices and customs commonly found in some Hispanics.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>12. I have, or think I would have, difficulty accepting Hispanics as close personal friends.</td>
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<tr>
<td>13. I have difficulty accepting ideas held by some Hispanic Americans.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>14. I have difficulty accepting certain attitudes held by Hispanic Americans.</td>
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<td>15. I have difficulty accepting some behaviors exhibited by Hispanic Americans.</td>
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<tr>
<td>18. I have, or think I would have, difficulty accepting Hispanic Americans as close personal friends.</td>
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MASI

Below is a list of situations that as a Hispanic/Latina you may have experienced. Read each item carefully and first decide whether or not you have experienced that situation during the past 3 months. If you have experienced the situation during the past 3 months, circle YES. Then circle the number that best represents HOW STRESSFUL the situation has been for you. If you have not experienced the situation during the past 3 months, circle NO, and go to the next item.

1. I have a hard time understanding others when they speak English
   YES   NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #2.)

   1 Not At All Stressful
   2 A Little Stressful
   3 Somewhat Stressful
   4 Very Stressful
   5 Extremely Stressful

2. I have a hard time understanding others when they speak Spanish.
   YES   NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to question #3.)

   1 Not At All Stressful
   2 A Little Stressful
   3 Somewhat Stressful
   4 Very Stressful
   5 Extremely Stressful

3. I feel pressure to learn Spanish.
   YES   NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #4.)

   1 Not At All Stressful
   2 A Little Stressful
   3 Somewhat Stressful
   4 Very Stressful
   5 Extremely Stressful

4. It bothers me that I speak English with an accent.
   YES   NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered no, go to #5.)
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<tr>
<td>Not At All</td>
<td>A Little</td>
<td>Somewhat</td>
<td>Very Stressful</td>
<td>Extremely Stressful</td>
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5. It bothers me that I speak Spanish with an accent.
   YES  NO

   If you answered YES, how stressful has this situation been **during the past 3 months**? (If you answered NO, go to #6.)

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6. Since I don't speak English well, people have treated me rudely or unfairly.
   YES  NO

   If you answered YES, how stressful has this situation been **during the past 3 months**? (If you answered NO, go to #7.)

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7. I have been discriminated against because I have difficulty speaking English.
   YES  NO

   If you answered YES, how stressful has this situation been **during the past 3 months**? (If you answered NO, go to #8.)

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8. I don't speak English or I don't speak it well
   YES  NO

   If you answered YES, how stressful has this situation been **during the past 3 months**? (If you answered NO, go to #9.)

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</table>
9. I don't speak Spanish or don't speak it well.
   YES          NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #10.)

   
   
   1  2  3  4  5
   Not At All Stressful A Little Stressful Somewhat Stressful Very Stressful Extremely Stressful

10. I feel pressure to learn English.
   YES          NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #11.)

   
   
   1  2  3  4  5
   Not At All Stressful A Little Stressful Somewhat Stressful Very Stressful Extremely Stressful

11. I feel uncomfortable being around people who only speak English.
   YES          NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #12.)

   
   
   1  2  3  4  5
   Not At All Stressful A Little Stressful Somewhat Stressful Very Stressful Extremely Stressful

12. I feel uncomfortable being around people who only speak Spanish.
   YES          NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #13.)

   
   
   1  2  3  4  5
   Not At All Stressful A Little Stressful Somewhat Stressful Very Stressful Extremely Stressful

13. It bothers me when people assume that I speak English.
   YES          NO
If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #14.)

1  Not At All Stressful
2  A Little Stressful
3  Somewhat Stressful
4  Very Stressful
5  Extremely Stressful

14. It bothers me when people assume that I speak Spanish.

YES  NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #15.)

1  Not At All Stressful
2  A Little Stressful
3  Somewhat Stressful
4  Very Stressful
5  Extremely Stressful

15. Since I don’t speak Spanish well, people have treated me rudely or unfairly.

YES  NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #16.)

1  Not At All Stressful
2  A Little Stressful
3  Somewhat Stressful
4  Very Stressful
5  Extremely Stressful

16. I have been discriminated against because I have difficulty speaking Spanish.

YES  NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #17.)

1  Not At All Stressful
2  A Little Stressful
3  Somewhat Stressful
4  Very Stressful
5  Extremely Stressful

17. It bothers me when people pressure me to assimilate to the American ways of doing things.

YES  NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #18.)
18. It bothers me when people don't respect my Hispanic/Latino values (e.g., family).

YES \hspace{1cm} NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #19.)

19. It bothers me when people don't respect my American values (e.g., independence).

YES \hspace{1cm} NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #20.)

20. I am self-conscious about my Hispanic/Latino background.

YES \hspace{1cm} NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #21.)


YES \hspace{1cm} NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #22.)
22. Because of my cultural background, I have a hard time fitting in with Americans.
YES      NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #23.)

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<tr>
<td>Not At All</td>
<td>A Little</td>
<td>Somewhat</td>
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</table>

23. Because of my cultural background, I have a hard time fitting in with Mexicans/Latinos.
YES      NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #24.)

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<td>Stressful</td>
<td>Stressful</td>
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</table>

24. I don't feel accepted by Hispanics/Latinos.
YES      NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #25.)

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</table>

25. I don't feel accepted by Americans.
YES      NO

If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #26.)

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<td>Stressful</td>
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</table>
26. I have had conflicts with others because I prefer American customs (e.g., celebrating Halloween, Thanksgiving) over Hispanic/Latino ones (e.g., celebrating Dia de los Muertos, Quinceañeras).

   YES     NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #27.)


27. I have had conflicts with others because I prefer Hispanic/Latino customs (e.g., celebrating Dia de los Muertos, Quinceañeras) over American ones (e.g., celebrating Halloween, Thanksgiving).

   YES     NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #28.)


28. People look down upon me if I practice Hispanic/Latino customs.

   YES     NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #29.)


29. People look down upon me if I practice American customs.

   YES     NO

   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #30.)

30. I feel uncomfortable when I have to choose between Hispanic/Latino and American ways of doing things.
   YES     NO
   
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #31.)

   1  2  3  4  5
   Not At All    A Little Somewhat Very Stressful Extremely
   Stressful     Stressful Stressful Stressful Stressful Stressful

31. I feel uncomfortable because my family does not know American ways of doing things.
   YES     NO
   
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #32.)

   1  2  3  4  5
   Not At All    A Little Somewhat Very Stressful Extremely
   Stressful     Stressful Stressful Stressful Stressful Stressful

32. I feel uncomfortable because my family does not know the Hispanic/Latino ways of doing things.
   YES     NO
   
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #33.)

   1  2  3  4  5
   Not At All    A Little Somewhat Very Stressful Extremely
   Stressful     Stressful Stressful Stressful Stressful Stressful

33. I feel uncomfortable when others expect me to know American ways of doing things.
   YES     NO
   
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #34.)

   1  2  3  4  5
   Not At All    A Little Somewhat Very Stressful Extremely
34. I feel uncomfortable when others expect me to know Hispanic/Latino ways of doing things.
   YES  NO
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #35.)
   1 Not At All Stressful 2 A Little Stressful 3 Somewhat Stressful 4 Very Stressful Stressful 5 Extremely Stressful Stressful

35. At times, I wish that I were more American.
   YES  NO
   If you answered YES, how stressful has this situation been during the past 3 months? (If you answered NO, go to #36.)
   1 Not At All Stressful 2 A Little Stressful 3 Somewhat Stressful 4 Very Stressful Stressful 5 Extremely Stressful Stressful

36. At times, I wish that I were more Hispanic/Latino.
   YES  NO
   If you answered YES, how stressful has this situation been during the past 3 months?
   1 Not At All Stressful 2 A Little Stressful 3 Somewhat Stressful 4 Very Stressful Stressful 5 Extremely Stressful Stressful
Appendix G

Marianismo

STSS

Please circle the number that best describes how you feel about each of the statements listed below. If you are not currently in an intimate relationship, please indicate how you felt and acted in your previous intimate relationships.

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<th>Neither agree nor disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
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1. I think it is best to put myself first because no one else will look out for me.
   1 2 3 4 5

2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.
   1 2 3 4 5

3. Caring means putting the other person's needs in front of my own.
   1 2 3 4 5

4. Considering my needs to be as important as those of the people I love is selfish.
   1 2 3 4 5

5. I find it is harder to be myself when I am in a close relationship than when I am on my own.
   1 2 3 4 5

6. I tend to judge myself by how I think other people see me.
   1 2 3 4 5
7. I feel dissatisfied with myself because I should be able to do all the things people are
supposed to be able to do these days.
   1 2 3 4 5

8. When my partner's needs and feelings conflict with my own, I always state mine
clearly.
   1 2 3 4 5

9. In a close relationship, my responsibility is to make the other person happy.
   1 2 3 4 5

10. Caring means choosing to do what the other person wants, even when I want to do
something different.
    1 2 3 4 5

11. In order to feel good about myself, I need to feel independent and self-sufficient.
    1 2 3 4 5

12. One of the worst things I can do is to be selfish.
    1 2 3 4 5

13. I feel I have to act in a certain way to please my partner.
    1 2 3 4 5

14. Instead of risking confrontations in close relationships, I would rather not rock the
boat.
    1 2 3 4 5

15. I speak my feelings with my partner, even when it leads to problems or
disagreements.
    1 2 3 4 5

16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.
    1 2 3 4 5

17. In order for my partner to love me, I cannot reveal certain things about myself to
him/her.
    1 2 3 4 5
18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.
   1   2   3   4   5

19. When I am in a close relationship I lose my sense of who I am.
   1   2   3   4   5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.
   1   2   3   4   5

21. My partner loves and appreciates me for who I am.
   1   2   3   4   5

22. Doing things just for myself is selfish.
   1   2   3   4   5

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.
   1   2   3   4   5

24. I rarely express my anger at those close to me.
   1   2   3   4   5

25. I feel that my partner does not know my real self.
   1   2   3   4   5

26. I think it's better to keep my feelings to myself when they do conflict with my partner's.
   1   2   3   4   5

27. I often feel responsible for other people's feelings.
   1   2   3   4   5

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.
   1   2   3   4   5

29. In a close relationship I don't usually care what we do, as long as the other person is happy.
   1   2   3   4   5
30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

   1  2  3  4  5

*31. I never seem to measure up to the standards I set for myself.

   1  2  3  4  5

* If you answered the last question with a 4 or 5, please list up to three standards you feel you don't measure up to.

1. 
2. 
3.
LVS-R

Please circle the number that best describes how you feel. Please note, that each sentence has two parts.

1 2 3 4 5
Strongly disagree Somewhat disagree Do not agree Somewhat agree Strongly agree

1. I find myself doing things for others that I prefer not to do.
   1b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

2. I feel guilty when I ask others to do things for me.
   2b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

3. I feel proud when others praise me for the sacrifices I have made.
   3b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

4. I often take on responsibilities having to do with my family.
   4b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

5. I often find myself doing things that will make my family happy even when I know it's not what I want to do.
   5b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

6. I have difficulty expressing my anger.
   6b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

7. I often take on responsibilities with my family that I'd rather not take, because it makes me feel like a better person.
   7b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5

8. I often feel inferior in comparison to men.
   8b. Has the response to this question caused problems or conflicts in your life?
       1 2 3 4 5
9. I consider my family a great source of support.
   1 2 3 4 5
   9b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

10. I find it difficult to say "no" to people even when it is clear that "no" is what I should be saying.
   1 2 3 4 5
   10b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

11. Family is very important to me.
   1 2 3 4 5
   11b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

12. I feel guilty when I go against my parent's wishes.
   1 2 3 4 5
   12b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

13. I have difficulty asserting myself to figures of authority.
   1 2 3 4 5
   13b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

   1 2 3 4 5
   14b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

15. I try to make others happy at all costs.
   1 2 3 4 5
   15b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

16. I try to make my family happy at all costs.
   1 2 3 4 5
   16b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

17. I believe sacrificing yourself for others makes you a better person.
   1 2 3 4 5
   17b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

18. I find myself putting others' needs in front of my own.
   1 2 3 4 5
   18b. Has the response to this question caused problems or conflicts in your life?
   1 2 3 4 5

19. Being seen as a "good" person by others is very important to me.
19b. Has the response to this question caused problems or conflicts in your life?

20. I find myself putting my family's needs in front of my own.
   1 2 3 4 5
   20b. Has the response to this question caused problems or conflicts in your life?

21. I find myself believing that any criticism or conflict is caused by my own faults.
   1 2 3 4 5
   21b. Has the response to this question caused problems or conflicts in your life?

22. I believe that sacrificing for others will eventually be rewarded.
   1 2 3 4 5
   22b. Has the response to this question caused problems or conflicts in your life?

23. Making my partner happy makes me feel good about myself.
   1 2 3 4 5
   23b. Has the response to this question caused problems or conflicts in your life?

24. I feel like a terrible person when I know someone is upset or disappointed with me.
   1 2 3 4 5
   24b. Has the response to this question caused problems or conflicts in your life?

25. I find myself accepting maltreatment from a partner (i.e. cheating, physical abuse, emotional, etc.)
   1 2 3 4 5
   25b. Has the response to this question caused problems or conflicts in your life?

26. I can express my needs to my partner.
   1 2 3 4 5
   26b. Has the response to this question caused problems or conflicts in your life?

27. I have allowed partners to take sexual liberties with me even when I did not want to.
   1 2 3 4 5
   27b. Has the response to this question caused problems or conflicts in your life?

28. I have allowed partners to take sexual liberties with me because: (check all that apply)
   a. They will leave me?
   b. I will hurt their feelings?
   c. I will be seen in a negative light?
   d. I will be hurt physically?
   e. They will cheat on me?
   f. Other
Have you ever heard the term Marianismo? If yes, please describe it below in your own words:

ADDITIONAL COMMENTS: Please feel free to expand on any of the above answers or to include any reactions/feelings/thoughts that you may have after completing the above responses.
Appendix H

Negative Affect

CES-D

Below is a list of the ways you might have felt or behaved. Using the following scale, please indicate how often you have felt this way during the past week.

1-Rarely or none of the time (less than one day)
2-Some or a little of the time (1-2 days)
3-Occasionally or a moderate amount of time (3-4 days)
4-Most of all of the time (5-7 days)

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<tr>
<th>Item</th>
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<th>2</th>
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<tbody>
<tr>
<td>1. I was bothered by things that usually don’t bother me.</td>
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<tr>
<td>2. I did not feel like eating; my appetite was poor.</td>
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<tr>
<td>3. I felt that I could not shake off the blues even with help from my family or friends.</td>
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<td>4. I felt I was just as good as other people.</td>
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<td>5. I had trouble keeping my mind on what I was doing.</td>
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<tr>
<td>6. I felt depressed.</td>
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<tr>
<td>7. I felt that everything I did was an effort.</td>
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<td>8. I felt hopeful about the future.</td>
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<td>9. I thought my life had been a failure.</td>
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<td>10. I felt fearful.</td>
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<tr>
<td>11. My sleep was restless.</td>
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<tr>
<td>12. I was happy.</td>
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<tr>
<td>13. I talked less than usual.</td>
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<tr>
<td>15. People were unfriendly.</td>
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<tr>
<td>16. I enjoyed life.</td>
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<tr>
<td>17. I had crying spells.</td>
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<tr>
<td>18. I felt sad.</td>
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<tr>
<td>19. I felt that people dislike me.</td>
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<tr>
<td>20. I could not get “going.”</td>
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123
SPHERE

Please indicate how often you have felt this way in general using the following scale.

1 Never or some of the time; 2 A good part of the time; 3 Most of the time.

1. Feeling nervous or tense? __
2. Feeling unhappy and depressed? __
3. Feeling constantly under strain? __
4. Everything getting on top of you? __
5. Losing confidence? __
6. Being unable to overcome difficulties? __
7. Muscle pain after activity? __
8. Needing to sleep longer? __
9. Prolonged tiredness after activity? __
10. Poor sleep? __
11. Poor concentration? __
12. Tired muscles after activity? __
Table 1. *Means, Standard Deviations, and Cronbach’s alpha.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>SD</th>
<th>α</th>
<th>Measure</th>
<th>Mean</th>
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Note. NCS=Negative Communications Scale; PSPS=Perceived Sociocultural Pressures Scale; FFS=Fear of Fat Scale; BES=Body Esteem Scale; FRS=Figure Rating Scale; CDRS=Contour Drawing Rating Scale; SATAQ=Sociocultural Attitudes Towards Appearance Questionnaire; SATINT=SATAQ Internalization; CI=Curvaceous Ideal Internalization; BSQ=Body Shape Questionnaire; EAT-26=Eating Attitudes Test; ACCScore=Acculturation Status Score; SPHERE=Somatic Psychological Health Report; CESD=Center for Epidemiological Studies Depression Scale; STSS=Silencing the Self Scale; LVSR=Latina Values Scale Revised; MASI-R=Multidimensional Acculturative Stress Inventory Revised; EDDS=Eating Disorder Diagnostic Scale (Symptoms).
Table 2. Bivariate Correlations.

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* p < .05, ** p < .01.

Note. NCS=Negative Communications Scale; PSPS=Perceived Sociocultural Pressures Scale; FFS=Fear of Fat Scale; BES=Body Esteem Scale; FRS=Figure Rating Scale; CDRS=Contour Drawing Rating Scale; SATAQ=Sociocultural Attitudes Towards Appearance Questionnaire; SATINT=SATAQ Internalization; CI=Curvaceous Ideal; BSQ=Body Shape Questionnaire; EAT-26=Eating Attitudes Test; ACCScore=Acculturation Score; MAR=Marginalization; SPHERE-12=Somatic Psychological Health Report; CESD=Center for Epidemiological Studies Depression Scale; STSS=Silencing the Self Scale; LVSR=Latina Values Scale Revised; MASI-R=Multidimensional Acculturative Stress Inventory Revised; EDDS=Eating Disorder Diagnostic Scale (Symptoms subscale).
Table 3. **Covariate correlations.**

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* * p < .05, ** p < .01

Note. BMI = Body-mass index; Tx = Eating disorder treatment; Dx = Eating disorder diagnosis; HH = Household Income; OI = Personal Income
Table 4. *Summary of Regression Analyses Testing Mediation*

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*p < .01, **p < .001

Note: SP = Sociocultural Pressures; TII = Thin-ideal Internalization; BD = Body Dissatisfaction; EDDS = Eating Disorder Symptoms; MA = Marianismo; NA = Negative Affect.
Table 5. Summary of regression analyses testing moderation of the sociocultural pressures to thin-ideal internalization pathway.

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Note. *p < .05; SP = Sociocultural Pressures; MA = Marianismo.
Figure 1. Dual-pathway model.

Note. INT = thin-ideal internalization; PP = perceived pressure to be thin; BD = body dissatisfaction.
Figure 2. Measurement Model for Thin-Ideal Internalization

Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; Status = Acculturative Status; Stress = Acculturative Stress; SP = Sociocultural Pressures; SATAQ = Sociocultural Attitudes Towards Appearance Scale; FFS = Fear of Fat Scale; BI = Body Image; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EP = Eating Problems; EAT-26 = Eating Attitudes Test-26; EDDS = Eating Disorder Diagnostic Scale.
Figure 3. Measurement Model for Curvaceous Ideal Internalization

Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; Status = Acculturative Status; Stress = Acculturative Stress; SP = Sociocultural Pressures; SATAQ = Sociocultural Attitudes Towards Appearance Scale; CI = Curvaceous Ideal; FFS = Fear of Fat Scale; BI = Body Image; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EP = Eating Problems; EAT-26 = Eating Attitudes Test-26; EDDS = Eating Disorder Diagnostic Scale.
Figure 4. Negative affect as a partial mediator of the relationship between Marianismo and eating problems.
Figure 5. Revised measurement model for thin-ideal internalization.

Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; SP = Sociocultural Pressures; SATInt = SATAQ Internalization Subscale; BD = Body Dissatisfaction; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EDDS = Eating Disorder Diagnostic Scale; CESD = Center for Epidemiological Studies – Depression Scale; SPHERE-12 = Somatic and Psychological Health Report-12.
Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; SP = Sociocultural Pressures; CI = Curvaceous Ideal Internalization; BD = Body Dissatisfaction; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EDDS = Eating Disorder Diagnostic Scale; CESD = Center for Epidemiological Studies–Depression Scale; SPHERE-12 = Somatic and Psychological Health Report-12.
Figure 7. Final Model of Thin-Ideal Internalization with Standardized Values.

Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; SP = Sociocultural Pressures; SATAQInt = SATAQ Internalization Subscale; BD = Body Dissatisfaction; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EDDS = Eating Disorder Diagnostic Scale; CES-D = Center for Epidemiological Studies – Depression Scale; SPHERE-12 = Somatic and Psychological Health Report-12.
Figure 8. Final Curvaceous-Ideal Internalization Model with Standardized Values.

Note. PSPS = Perceived Sociocultural Pressures Scale; NCS = Negative Communication Scale; SP = Sociocultural Pressures; BD = Body Dissatisfaction; BSQ = Body Shape Questionnaire; BES = Body Esteem Scale; FRS = Figure Rating Scale; CDRS = Contour Drawing Rating Scale; NA = Negative Affect; EDDS = Eating Disorder Diagnostic Scale; CESD = Center for Epidemiological Studies – Depression Scale; SPHERE-12 = Somatic and Psychological Health Report-12.