

LATINX WOMEN'S DISORDERED EATING: CONSIDERING CULTURALLY  
RELEVANT VARIABLES IN THE OBJECTIFICATION THEORY FRAMEWORK

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by  
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ABSTRACT

Using an objectification theory lens, the purpose of this study was to better understand religious/spiritual coping and acculturative stress as moderators in the relationship among sexual objectification, internalization of sociocultural standards of beauty, and disordered eating with a sample of 399 Latinx women. At the bivariate level, results suggested that experiences of sexual objectification were related to more internalization, acculturative stress, negative religious coping, and disordered eating. When examining internalization as a dependent variable, results suggested that, when sexual objectification, acculturation, acculturative stress, enculturation, negative religious coping, and positive religious coping were examined concurrently, acculturative stress and negative religious coping positively predicted internalization; and enculturation significantly negatively predicted internalization. When examining disordered eating as a dependent variable, results suggested that when sexual objectification, internalization, acculturation, acculturative stress, enculturation, negative religious coping, and positive religious coping were examined concurrently, only sexual objectification, internalization, and acculturative stress positively predicted disordered eating; and enculturation negatively predicted disordered eating. Moreover, post-hoc path analyses indicated that internalization predicted disordered eating; both acculturative stress and enculturation directly predicted internalization

and disordered eating; and sexual objectification did not predict internalization. Strengths and limitations as well as implications for future interventions and future research is discussed.

*Keywords:* objectification theory, spirituality, religiosity, internalization, acculturation, acculturative stress, eating disorders, coping, Latinx

## APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Education, have examined a dissertation titled “Latinx Women’s Disordered Eating: Considering Culturally Relevant Variables in the Objectification Theory Framework,” presented by Sara M. Aslan, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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## CHAPTER 1

### LATINX WOMEN’S DISORDERED EATING: CONSIDERING CULTURALLY RELEVANT VARIABLES IN THE OBJECTIFICATION THEORY FRAMEWORK

#### **Literature Review**

Hispanics/Latinxs are among the largest and most quickly growing ethnic minority group in the United States (U.S. Census Bureau, 2014), encompassing 16% of the population and accounting for more than 50% of total population growth between 2000 and 2010 (Ennis, Ríos-Vargas, & Albert, 2011). Furthermore, recent Census Bureau projections anticipate that approximately 30% of the population will consist of Latinxs by the year 2050 (U.S. Census Bureau, 2010). As a result of the growing numbers of Latinxs in the United States, there has been increased attention to their mental health needs, and awareness of marked underutilization of formal mental health services in comparison with non-Latinxs (Alegría et al., 2002). It is first important to understand the differences in how Hispanic and Latinx populations are defined, as well as the intersectionality of the two.

The term Hispanic has been used to categorize a group of people by their use of a common language—Spanish (Santiago-Rivera & Altarriba, 2002). Marín and Marín (1991, p. 20) defined Hispanic as a “person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture of origin.” Furthermore, the term Latinx has been growing in popularity because it represents a political consciousness and a sense of ethnic pride, particularly among those residing in the United States (Santiago-Rivera & Altarriba, 2002). It is comprised of individuals from Latin-American cultures, including such Portuguese speaking countries as Brazil and Portugal (U.S. Census Bureau, 2011). Like other studies in the past (e.g., Santiago-Rivera & Altarriba, 2002), both terms are used interchangeably throughout the current

manuscript. Yet, due to the term Latinx being more inclusive, it is employed throughout the manuscript to represent the identification of the participants in the current study.

The mental health status of Hispanics/Latinxs continues to remain a chief concern, particularly due to their life experiences consistently being marked by such factors as language barriers, poverty, and discrimination in educational and employment settings (Padilla, Ruiz, & Alvarez, 1989; Rogler, Malgady, Costantino, & Blumenthal, 1987). Moreover, negative attitudes toward and stereotypes of Latinxs remain widespread, such that unfair and prejudicial treatment creates an extremely difficult situation to navigate when attempting to integrate into mainstream society (Berry, 2001). As noted by Santiago-Rivera and colleagues (2008), migration alone can be a stressful process for Latinxs, particularly for those who enter the country undocumented. Undocumented immigrants may experience an additional dilemma, due to not having full access to jobs, education, and health benefits, and could be hypervigilant about being discovered (Santiago-Rivera, 2008). These life circumstances are believed to be major sources of psychological distress for this population (e.g., Cuellar, 2002; Cuellar, Bastida, & Braccio, 2004).

Furthermore, adapting to the dominant societal norms can have a significant impact due to the likelihood of experiencing major changes in such areas as gender role expectations, loss of social support, displacement, isolation, and disruption in family functioning (e.g., Hiott, Grzywacz, Arcury, & Quandt, 2006; Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Santisteban & Mitrani, 2003). Moreover, stigmatized groups have lower status and power within a society, which may lead to racialized stereotypes that may be presented by the media (Rivaneneyra, 2011). These stereotypes can portray people with darker skin as having lower socioeconomic status and lower status occupations (Rivaneneyra, 2011). In

fact, Rivaneneyra (2011) argued that stigmatized groups may also be more likely to be objectified due to possessing less power and status in a society. Moreover, in terms of gender, the concepts of *Machismo* and *Marianismo* have remained the prevailing gender constructs in much of Latin America (de la Vega, 1990). *Machismo* refers to the concept that Latinx men are encouraged to be dominant, strong, rational, masculine, and controlling (Raffaelli & Suarez-Al-Adam, 1998). *Marianismo* can be defined as the expectation of Latinx women to be submissive, obedient, self-sacrificing, and chaste (Raffaelli & Suarez-Al-Adam, 1998).

Additionally, cultural constructions of race are not represented as a simple concept, but instead it is complex and wide-ranging across the Western Hemisphere and ingrained in historical events that continue to impact the meaning of race (Rivaneneyra, 2011). Many of these notions are based on each nation's experiences with slavery and colonialism, which have contributed to very different ways of conceptualizing race and racial categories (Wade, 1997). Racial groups are predominantly distinguished by biological and physical characteristics, such as skin color or hair texture, that are common to people from a certain geographical location (Anderson, Flora, Archie, Morgan, & McKenzie, 2014).

Moreover, ethnicity is also a term that is widely used to describe various characteristics among diverse individuals. The term ethnicity is one that is multifaceted, and defines perceived social groupings based on a sense of belonging, place of origin, and other factors such as language, religion, and sometimes race (Betancourt & López, 1993). Although the two terms may be used interchangeably in many cases, racial and ethnic groupings are not mutually exclusive (Anderson et al., 2014). Furthermore, both race and ethnicity may have an impact on such ailments as the duration of untreated psychosis (Anderson et al., 2014). This impact can be attributed to the shared sociocultural factors that influence access to care (Anderson et al., 2014).

Ultimately, the various life stressors in combination with low socioeconomic status make Latinxs particularly vulnerable to psychological problems (Santiago-Rivera, 2008). Thus, with the abundance of individuals who fit this demographic, and the underutilization of mental health services, it is important and necessary to further explore the unique factors that may contribute to and aid in the amelioration of such acute mental health needs, including eating pathology.

In the United States alone, approximately 20 million women and 10 million men suffer from a clinically significant eating disorder during their lifetime, which includes anorexia nervosa, bulimia nervosa, binge eating disorder, or EDNOS<sup>1</sup> (Wade, Keski-Rahkonen, & Hudson, 2011). This rate is assumed to be higher, as many cases are likely underreported (Smink, van Hoeken, & Hoek, 2012). In addition, the rate of new cases of eating disorders has continued to increase since 1950 (Hudson, Hiripi, Pope, & Kessler, 2007; Streigel-Moore & Franko, 2003; Wade et al., 2011). For example, the rates of bulimia alone have tripled between 1988 and 1993 in 10 to 39-year-old women (Hoek & van Hoeken, 2003). Moreover, binge eating disorder continues to hold the least amount of discrepancy across racial/ethnic groups in comparison to other eating disorder diagnoses (Marques et al., 2011). Even more concerning, eating disorders continue to hold the highest mortality rate of any other psychiatric disorder (Arcelus, Mitchell, Wales, & Nielsen, 2011).

These disorders are also significantly more prevalent among Western and industrialized nations in comparison to less developed nations (American Psychiatric Association [APA], 2000; Pate, Pumariega, Hester, & Garner, 1992). There are several theories as to why eating disorders are more prevalent in Westernized countries, one being continuous exposure to the dominant culture's depiction of beauty. The "thin ideal" as proposed by Western cultures, suggests that girls and women should adhere to standards that are unrealistic, depicting women as primarily

thin, young, hypersexual, and White (Scharrer, 2013). Furthermore, several authors have noted that the increased prevalence of eating disorders in Westernized and industrialized nations may be due to Western cultural standards, which promote thinness as an ideal representation of beauty in women (Crandall & Martinez 1996; Stice, 1994; Vandereycken & Hoek, 1992).

An existing stereotypical view is that eating disorders are unique to White women and that various ethnic minority groups endorse less eating disorder symptomology in comparison to White women (e.g., Abrams, Allen, & Gray, 1993; Gluck & Geliebter, 2002; Smolak & Striegel-Moore, 2001). Yet, several studies have suggested that disordered eating among ethnically diverse women is comparable to rates observed among White women (Crago & Shisslak, 2003; Smith & Krejci, 1991). Indeed, the prevalence of eating disorders appears similar among Non-Hispanic White, Hispanic, Black, and Asian individuals in the United States (Hudson et al., 2007; Wade et al., 2011). However, several studies have demonstrated that clinicians are less likely to diagnose Women of Color (WOC) with eating disorders compared to White women, even after controlling for symptom severity (Becker, Franko, Speck, & Herzog, 2003; Gordon, Brattole, Wingate, & Joiner, 2006).

Moreover, some studies have found that rates of disordered eating may be higher among Latinx women (i.e., women from Spanish-speaking cultures who live in the United States; Crago, Shisslak, & Estes, 1996; Grabe & Hyde, 2006; U.S. Census Bureau, 2011) than other racial/ethnic groups (Alegría et al., 2007; Croll, Neumark-Sztainer, Story, & Ireland 2002; Perez, Voelz, Pettit, & Joiner, 2002), including Asian American (Neumark-Sztainer et al., 2002) and African American women (Fitzgibbon et al., 1998; Neumark-Sztainer et al., 2002). For example, Franko and colleagues (2012) compared the prevalence, impairment, and service utilization for eating disorders among Latinxs, Asians, Black, and non-Latinx White individuals residing in the

United States Findings indicated that anorexia nervosa and binge eating disorder were similar across all groups, and bulimia nervosa was actually more prevalent among Latinxs and African Americans in comparison to White participants (Franko et al., 2012). Furthermore, various rates of dieting (Story, French, Resnick, & Blum, 1995), compensatory behaviors (e.g., laxatives or diuretics; Story et al., 1995), and unhealthy weight control behaviors (Croll et al., 2002) often associated with eating disorders, have been found to be the highest among Latinx adolescents in comparison to White, Asian, and Black individuals (e.g., Croll et al., 2002; Story et al., 1995). Despite emergent research exploring disordered eating among diverse populations, there continues to be a lack of research with various ethnic groups, including Latinxs.

Many possible factors may contribute disordered eating. Through the lens of objectification theory, this study seeks to assess potential contributing factors in relation to Latinx women's disordered eating. In doing so, this study will also assess potential protective factors that may aid in buffering Latinx women against disordered eating. With further knowledge of Latinx women's disordered eating, mental health practitioners may better develop culturally relevant interventions to assist their clients who are struggling with disordered eating.

### **Objectification Theory**

Objectification theory (Fredrickson & Roberts, 1997) was created to help explain how sexually objectifying experiences may relate to psychological distress among girls and women, and may provide a useful framework in better understanding the relationship between sexual objectification experiences and disordered eating among Latinx women. Objectification theory suggests that gender role socialization and women and girls' life experiences are regularly marked by experiences of sexual objectification (Fredrickson & Roberts, 1997). Girls and women are subject to routine sexually objectifying experiences, which may include unsolicited

sexual advances, physical touch, leering, sexual remarks, or even vicariously by viewing an objectifying experience happen to someone other than oneself (Kozee, Tylka, Augustus-Horvath, & Denchik, 2007). These experiences reduce women to mere anatomical representations, occurring whenever a woman's body, body parts, or sexual functions are viewed separately from herself, or simply viewed as instruments for pleasure (Fredrickson & Roberts, 1997).

Eventually, these persistent sexually objectifying experiences may become internalized. During this process, girls and women may learn to associate their worth with their bodies. Therefore, as a result of sexually objectifying experiences, girls and women begin to treat themselves as objects to be appraised and evaluated, and view their bodies as an object for others' pleasure (McKinley, 1998); this view of one's self as an object is known as self-objectification (Fredrickson & Roberts, 1997; Noll & Fredrickson, 1998). Self-objectification becomes apparent through the constant checking and monitoring of one's appearance, as well as through the continuous act of comparison of one's body to an internalized or cultural standard of beauty (Moradi, Dirks, & Matteson, 2005); this manifestation of self-objectification is also known as body surveillance.

Additionally, objectification theory postulates that self-objectification leads to greater levels of emotional and experiential effects (Fredrickson & Roberts, 1997). These four emotional and experiential outcomes include body shame, appearance anxiety, decreased peak motivational states, and decreased interoceptive awareness (Fredrickson & Roberts, 1997). Body shame is the emotional experience that occurs when an individual compares their self to an internalized cultural standard, and perceives that their body does not conform to this standard (Moradi et al., 2005). Appearance anxiety includes both the anticipation of danger or threats to one's safety, and fear about when and how one's body will be observed and evaluated (Moradi et al., 2005).

Furthermore, peak motivational states, or flow experiences (Csikszentmihalyi, 1990), can be described as rare optimal occurrences where an individual can fully engage in a task, and may experience joy, creativity, and freedom (Fredrickson & Roberts, 1997). Fredrickson and Roberts (1997) have noted that this peak motivational/flow state may be upset if an individual feels that she is being sexually objectified. Finally, interoceptive awareness is the capability to detect and accurately interpret physiological sensations, such as heartbeat, stomach contractions, and physiological sexual arousal (Fredrickson & Roberts, 1997; Moradi et al., 2005). As a result of self-objectification, women may experience a decrease in awareness of internal body states and a disconnection from their own internal experiences (Fredrickson & Roberts, 1997). In turn, these experiential effects may lead to greater levels of depression, decreased psychosexual functioning, and disordered eating (Fredrickson & Roberts, 1997).

Generally, research has supported tenets of objectification theory among various populations. For example, Moradi and Huang (2008) reviewed a large body of objectification theory related research and noted several important findings. The experimental data they reviewed suggested that heightened self-objectification encouraged body shame in White and racially/ethnically diverse samples of women; heightened self-objectification was shown to increase appearance anxiety and negative affect; and heightened self-objectification was suggested to thwart task performance (Moradi & Huang, 2008). Furthermore, correlational findings provided support for the posited links of self-objectification, body surveillance, and body shame with indicators of women's mental health, including disordered eating, depressive symptoms, and self-esteem (Moradi & Huang, 2008).

Moreover, a plethora of data supported the mediating role of body shame in the relations of self-objectification or body surveillance with disordered eating and depressive symptomology

(Moradi & Huang, 2008). There has been less consistent support for the mediating roles of decreased internal awareness and peak motivational states in the links from self-objectification or body surveillance to disordered eating and depressive symptoms (Moradi & Huang, 2008). Notably, studies that included sexual objectification experiences as a precursor in the objectification theory framework (as opposed to self-objectification) found that internalization of sociocultural standards of beauty was an additional mediating variable in the link from sexual objectification experiences to disordered eating (Moradi & Huang, 2008).

### **The Mediating Role of Internalization of Sociocultural Standards of Beauty**

Standards of beauty vary across cultures, yet there seems to be an evolving conceptualization of how an “ideal” female body should appear. Scholars have suggested that Western standards of beauty - emphasizing a thin body size - also affect the body image concerns of ethnically diverse women (Austin & Smith, 2008). According to Stice (1994), individuals become aware of White dominant standards of beauty through exposure to sociocultural variables, such as the media, friends, family, and peers. For example, Becker, Burwell, Herzog, Hamburg, and Gilman (2002) examined the influence of Western media exposure on rates of disordered eating among Fijian girls. Findings indicated that within one month of the introduction of television, 7.9% of Fijian girls reported engaging in binge eating behaviors (Becker et al., 2002); however, three years after the introduction of television, the percentage had reduced non-significantly to 4.6%. In contrast, the percentage of girls who reported engaging in self-induced vomiting increased significantly from 0% to 11.3% over the same period of time (Becker et al., 2002). Prior to the introduction of Westernized media, only one case of AN had ever been reported in Fiji (Becker et al., 2002).

When it comes to the societal pressures to conform to sociocultural standards of beauty, some scholars have suggested that ethnically diverse women are impervious to pressures to conform to the thin ideal and the development of disordered eating due to their particular cultural standards of beauty that often endorse larger, more curvaceous body types (see Gilbert, 2003, for a review). However, internalization of Westernized sociocultural standards of beauty has been linked to negative body image and body dissatisfaction across heterogeneous samples, including men, women, sorority members, along with White, African American, Hispanic, and Korean individuals (e.g. Cashel, Cunningham, Landeros, Cokley, & Muhammad, 2003; Forbes & Jung, 2008; Thompson & Stice, 2001). In some ways, it appears that WOC may experience even more pressures in comparison to their White counterparts. In fact, researchers have suggested that various skin tones, facial features, and body portions considered beautiful by mainstream society may seem particularly unachievable for minority women, whose physical characteristics are often discrepant from the upheld White standards (Buchanan, Fischer, Tokar, & Yoder, 2008; Evans & McConnell, 2003).

Latinx women may experience conflicting messages regarding standards of beauty; namely, the curvy figure idealized by the traditional Latinx culture and the extremely thin figure touted by mainstream U.S. culture (Cheney, 2010). Several studies to date have examined internalization of sociocultural standards of beauty among Latinx women, in particular. For example, Cashel and colleagues (2003) investigated awareness of sociocultural pressures for thinness and internalization of these attitudes among a sample of 405 diverse college students. Results indicated that White and Hispanic sorority members reported the highest levels of both awareness of pressures to be thin and attractive and thin-ideal internalization, further suggesting that internalization of sociocultural standards of beauty is relevant to diverse women's

experiences (Cashel et al., 2003). In addition, thin-ideal internalization significantly mediated the positive relationship between thin ideal awareness and disordered eating (Austin & Smith, 2008), and the positive relationship between peer influence and disordered eating (Mancilla-Díaz et al., 2012), among Mexican girls. Thus, internalization of sociocultural standards of beauty—particularly the thin ideal—appears especially relevant in understanding Latinx women’s experiences.

Internalization of sociocultural standards of beauty has received increased attention in the objectification theory framework. Moradi et al. (2005) postulated that the majority of research on objectification theory robustly supported the mediating role of body shame in the link between self-objectification and disordered eating; however, actual sexual objectification experiences were infrequently examined as a predictor variable in the objectification theory mediation model. Studies that did examine sexual objectification experiences found that the link between sexual objectification experiences and self-objectification was often mediated by internalization of sociocultural standards of beauty (see Morry & Staska, 2001). As such, objectification theory should be modified and expanded to include internalization of sociocultural standards of attractiveness.

In assessing this expanded objectification theory model among a sample of predominantly White women, Moradi and colleagues’ (2005) found that internalization of sociocultural standards of beauty mediated the positive links from sexual objectification experiences to body surveillance, body shame, and disordered eating. Additionally, body surveillance significantly mediated the positive association between sexually objectifying experiences and body shame, while body shame significantly mediated the positive relationship between internalization of sociocultural standards of beauty and body surveillance (Moradi et al.,

2005). This seminal study provided support for the mediating role of internalization of sociocultural standards of beauty in the objectification theory framework.

Since Moradi and colleagues' (2005) seminal work, several studies have explored internalization of sociocultural standards of beauty in the objectification theory framework. For example, sexual objectification experiences have been directly linked to higher levels of internalization of sociocultural standards of beauty among African American women (Watson, Ancis, White, & Nazari, 2013), sexual minority women (Watson, Grotewiel, Farrell, Marshik, & Schneider, 2015), heterosexual women (Szymanski & Feltman, 2014), sexual minority men (Wiseman & Moradi, 2010), and Muslim American women (Tolaymat & Moradi, 2011). In addition, internalization of sociocultural standards of beauty has been directly linked to more disordered eating among bisexual (Brewster et al., 2014) and undergraduate women (Lokken, Worthy, & Trautmann, 2004), and also significantly mediated the positive link between sexual objectification experiences and disordered eating among African American (Watson et al., 2013), sexual minority (Watson et al., 2015), Italian (Dakanalis et al., 2014), and Muslim American women (Tolaymat & Moradi, 2011). Thus, it is probable that internalization of sociocultural standards of beauty will also mediate the positive relation between sexual objectification experiences and disordered eating among Latinx women. Despite support for the role of internalization of sociocultural standards of beauty in the objectification theory framework, few studies to date have extended the tenets of objectification theory to Latinx women.

### **Objectification Theory and Latinx Women**

Fredrickson and Roberts (1997) suggested that sexual objectification may be experienced by all women, regardless of ethnic and racial background. This may be due to the shared experience of being female bodied in a sociocultural context that sexually objectifies women

(Fredrickson and Roberts, 1997). Nevertheless, the authors recognized that the literature they used to formulate the theory included studies conducted primarily on White women, and did not fully address ethnic and racial diversity (Fredrickson and Roberts, 1997). WOC may have unique experiences of sexual objectification that are shaped by both gender and racial oppression.

Although the majority of research conducted on objectification theory has been conducted with primarily White women (e.g. Augustus-Horvath & Tylka, 2009; Calogero, 2004; Roberts & Gettman, 2004), research is beginning to include more culturally and ethnically diverse groups of women. For example, some tenets of objectification theory have been supported in research with WOC, including African American women (e.g., Buchanan et al., 2008; Watson et al., 2013), Muslim American women (Tolaymat & Moradi, 2011), and Korean women (Kim, Seo, & Baek, 2014). Even so, objectification theory's applicability with ethnically and racially diverse groups of women remains under examined.

Moreover, in attempts to extend applicability and adjust the generalizability of objectification theory to more underrepresented groups of people (i.e., WOC), several studies have expanded upon the theory by integrating culturally relevant constructs. For example, Buchanan and colleagues (2008) extended the research on objectification theory by examining skin tone concerns in a survey of 117 African American women, as skin-tone surveillance may be especially relevant to this population. Results indicated that routine skin tone surveillance was related to more skin tone dissatisfaction and body shame. Furthermore, Watson et al. (2013) also extended tenets of objectification theory to a sample of 278 undergraduate African American women. Results suggested that internalized multiculturally inclusive racial identity attitudes (racial identity attitudes characterized by affirmation of one's Black identity and the cultural identities of others) moderated the link between sexually objectifying experiences and

internalization of sociocultural standards of beauty (Watson et al., 2013). That is, at lower levels of internalized multiculturally inclusive racial identity attitudes, the relationship between sexual objectification experiences and internalization of sociocultural standards of beauty was positive, which was then related to more body surveillance, body shame, appearance anxiety, disordered eating, and reduced interoceptive awareness (Watson et al., 2013). However, this indirect effect was non-significant at higher levels of internalized multiculturally inclusive racial identity attitudes, suggesting a buffering effect.

Furthermore, Brewster and colleagues (2014) assessed tenets of objectification theory with 316 bisexual women, while integrating antibisexual discrimination and internalized biphobia into a structural model (Brewster et al., 2014). Results suggested that antibisexual discrimination was positively and indirectly related to body surveillance, body shame, and disordered eating through internalization of sociocultural standards of beauty (Brewster et al., 2014). Moreover, internalization yielded significant positive indirect links disordered eating through body surveillance and body shame (Brewster et al., 2014).

In another extension of objectification theory, Tolaymat and Moradi (2011) explored the role of the hijab in body image and disordered eating with a sample of 118 Muslim women in the United States. Results suggested that more frequent wearing of the hijab was negatively related with sexual objectification experiences (Tolaymat & Moradi, 2011). Moreover, sexual objectification experiences also had significant positive indirect relations with body surveillance, body shame, and disordered eating through the mediating role of internalization of sociocultural standards of beauty (Tolaymat & Moradi, 2011). Furthermore, findings also suggested that internalization of cultural standards of beauty displayed a significant positive direct relationship

with body shame, and a significant positive direct and indirect relationship with disordered eating (Tolaymat & Moradi, 2011).

Moreover, Kim and colleagues (2014) explored tenets of objectification theory, the roles of sexually objectifying media, and culture-specific standards of beauty in body image and disordered eating among 70 college-aged South Korean women. The results suggested that facial characteristics (e.g., size and shape) were a culture-specific standard of beauty relevant to South Korean women (Kim et al., 2014). Moreover, media exposure yielded significant positive indirect relationships with body shame and disordered eating through the mediating roles of internalization of sociocultural standards of beauty, body surveillance, and face surveillance (Kim et al., 2014). Furthermore, internalization of cultural standards of beauty was uniquely positively related to body surveillance and face surveillance, and both were directly and indirectly related to body shame and disordered eating (Kim et al., 2014).

The aforementioned studies shed light on the importance of extending objectification theory to culturally diverse groups, while also integrating culturally relevant variables in the framework. Moreover, these studies highlight the notion that Westernized standards of beauty are not limited to White women as once believed (Grabe & Hyde, 2006). Yet, of the multitude of ethnic groups within the United States, very few have extended these constructs to Latinx women.

Exposure to sexually objectifying media may have a powerful influence on Latinxs' body image and disordered eating (e.g., Schooler & Daniels, 2014). For example, Rivadeneyra, Ward, and Gordon (2007) found that Latinx adolescents who regularly read magazines and viewed primetime television noted less comfort with their body size. Furthermore, many of the relationships that emerged for women, between media use and self-esteem, had a primary focus

on appearance (Rivadeneira et al., 2007). In 2011, Rivadeneira also examined 466 characters on Spanish-language soap operas or *telenovelas* that aired in the United States. Results suggested that characters played by women were sexualized more often than characters played by men, and physical appearance and nurturing roles were also more likely to be the focus for women in *telenovelas* (Rivadeneira, 2011). Furthermore, appearing less “ethnic” (i.e., more White) seemed beneficial to the characters on the shows; that is, the vast majority of characters were light-skinned and characters with darker skin were portrayed in exaggerated and in more sexualized ways (Rivadeneira, 2011).

For example, characters with darker skin were almost four times more likely to be wearing “very sexy” clothing compared to the characters with lighter skin (Rivadeneira, 2011). Furthermore, characters who had lighter skin tones were depicted as being more fit, younger, and more likely to be rated as upper class compared to those with darker skin tones (Rivadeneira, 2011). Moreover, compared to male characters, women characters were also less likely to be shown with gray hair, more likely to wear sexually provocative clothing, more likely to be portrayed as emotional, and more likely to be represented as unemployed, homemakers, or with unknown occupational status (Rivadeneira, 2011). Therefore, Latinx women may experience unique forms of sexually objectifying experiences, as there appears to be particular racialized sexual stereotypes they may internalize that could foster greater sexual objectification related outcomes.

Of note, a few recent studies have extended the objectification theory framework to Latinx women. For example, Boie, Lopez, and Sass (2013) assessed the relationship between internalization of sociocultural standards of beauty and dieting behaviors in a sample of 499 Latinx and White college students. Findings suggested that internalization predicted body

surveillance and body shame, and the relationship between internalization and body shame was partially mediated by body surveillance (Boie et al., 2013). Furthermore, White and Latinx participants reported similar levels of internalization, body surveillance, body shame, body image dysphoria, and dieting behaviors (Boie et al., 2013). Moreover, Latinx individuals indicated greater levels of body shame in comparison to White individuals (Boie et al., 2013).

More recently, among 189 Latinx women, Velez, Campos, and Moradi (2015) extended objectification theory by integrating racist discrimination in the link to disordered eating and depressive symptomatology. Results suggested that internalization of sociocultural standards of beauty were related to more disordered eating and depressive symptomatology in part through the mediating roles of body shame and body surveillance (Velez et al., 2015). Furthermore, the authors noted that body surveillance was related to an increase in disordered eating and depressive symptomatology through the mediating role of body shame (Velez et al., 2015). Contrary to the hypothesis, sexual objectification was not directly linked to internalization of sociocultural standards of beauty (Velez et al., 2015).

Several reasons may explain this non-significant relationship, one being that this study did not take into account how varied levels of acculturation may have played a role in the relationship between sexual objectification and internalization. For example, if participants were less acculturated to the U.S., they may not have internalized dominant Western standards of beauty, or they may have employed culturally specific coping mechanisms that buffered the relationship between sexual objectification and internalization of sociocultural standards of beauty. The limited available research on objectification theory with Latinx women suggests that more research is needed to understand its relevance to Latinx women (Velez et al., 2015). In

addition, the non-significant relation between sexual objectification experiences and internalized sociocultural standards of beauty suggest that moderating variables may explain this link.

### **Acculturation and Enculturation**

WOC may be at particular risk for body dissatisfaction when exposed to images of White women that are upheld as the standard of beauty (Gordon, Castro, Sitnikov, & Holm-Denoma, 2010). Furthermore, the thin body types and small physical features considered to be beautiful by the dominant culture may be unachievable for some ethnically diverse women whose physical attributes often differ (e.g., facial features, skin tone, and body proportions; Evans & McConnell, 2003). Therefore, it is important to understand how cultural factors may play a role in internalization of sociocultural standards of beauty, as well as their potential link to disordered eating.

Acculturation can be defined as the process of cultural transition, in which immigrants' customs, attitudes, behaviors, beliefs, lifestyle, language, habits, and values change as they adapt to their new home country (Graves, 1967); while enculturation can be described as the process of acquiring knowledge, behavioral expectations, attitudes, and values associated with a person's own ethnic culture (Gonzales, Knight, Birman, & Sirolli, 2004). During the acculturation process, an individual can adhere to or reject certain aspects of the dominant/host culture, and retain or reject cultural beliefs and practices of their culture of origin (Cuéllar, Arnold, & Maldonado, 1995). Furthermore, acculturation may take place at the individual psychological level, where a person can be directly affected by the novel culture that they interact with (Berry, 2003).

Acculturation to the United States is often associated with a host of negative mental health concerns. Among Latinx women, acculturation has been linked to alcohol abuse (Lee,

Almeida, Colby, Tavares, & Rohsenow, 2016), depression symptomology (Davila, McFall, Cheng, 2009; Gallagher-Thompson et al., 1997), and anxiety symptoms (de Mendoza, Harville, Theall, Buekens, & Chasan-Taber, 2016). Usually, individuals who are highly acculturated are presumed to adopt the cultural practices of the dominant society in which they live, while those who are less acculturated, or enculturated, tend to preserve many of the traditions practiced in their former country (Hwang & Ting, 2008). In theory, the more acculturated an individual is to the mainstream culture of the United States, the more likely they will be to internalize the Westernized thin ideal, which would effectively increase the likelihood of developing disordered eating (Gordon et al., 2010; Warren, Castillo, & Gleaves, 2010). However, this theory should be simultaneously considered with enculturation, as research on acculturation and mental health has rarely addressed enculturation as a separate factor (Ojeda, Flores, & Navarro, 2011).

Conversely, those who are more enculturated may be more likely to reject the Westernized thin ideal. Historically, acculturation research has focused on a unidirectional hypothesis, assuming that when individuals engage with and internalize a second culture, they are likely to lose connection to their culture of origin (Miller, 2010). Yet, scholars have expanded this unidirectional model of acculturation to include enculturation (Herskovits, 1948), where individuals can maintain and internalize their culture of origin in the midst of a second culture (i.e., acculturation; LaFromboise, Coleman, & Gerton, 1993).

Although limited, research is beginning to examine the role of acculturation in various areas, such as body attitudes, physical health, and disease in Hispanic women (Sussman, Truong, & Lim, 2007). Past research has suggested that acculturation to a dominant norm of thinness may place Latinx women at increased risk for disordered eating (Chamorro & Flores-Ortiz, 2000). Yet, findings on the association of acculturation with body dissatisfaction and disordered eating

in Latinx samples have varied, with some research suggesting significant positive relationships (e.g., Bettendorf & Fischer, 2009; Poloskov & Tracey, 2013) and others suggesting non-significant relationships (e.g., Gordon et al., 2010; Joiner & Kashubeck, 1996).

Poloskov and Tracey (2013) examined the relationships among acculturation, internalization of U.S. sociocultural beauty standards, and body dissatisfaction among 211 Mexican American college women. The positive relationship between acculturation towards the dominant U.S. culture and body dissatisfaction was fully mediated by the internalization of sociocultural standards of beauty (Poloskov & Tracey, 2013). Furthermore, Ayala, Mickens, Galindo, and Elder (2007) found that adolescent girls who were classified as at risk for or being overweight, and who more strongly recognized and endorsed Western sociocultural standards of beauty, were more dissatisfied with their body image (Ayala et al., 2007). Moreover, Cachelin, Phinney, Schug, and Striegel-Moore (2006) investigated acculturation and disordered eating in a community sample of Mexican Americans. Findings suggested that orientation toward White American culture was significantly positively related with disordered eating, while orientation toward Mexican culture and strength of ethnic identity were not connected to eating disorder symptomology (Cachelin et al., 2006).

It is important to note that the aforementioned studies which found positive relationships utilized the most updated version of an acculturation scale, the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuéllar, Arnold, & Maldonado, 1995). The original version of the ARSMA (Cuéllar, Harris, & Jasso, 1980) was updated to better assess acculturation at the individual level (Cuéllar et al., 1995). The original version of the scale measured acculturation linearly, representing Mexican culture at one extreme and American (U.S.) culture at the other extreme, which posed difficulty when being used with bicultural individuals who identify with

both cultures (Cuéllar et al., 1995). Furthermore, the ARSMA-II (Cuéllar et al., 1995) addressed the faulty assumption that there must be a corresponding reduction in one of two cultures for a person to acculturate (Cuéllar et al., 1995). Thus, improvement and refinement in measurement may be one reason for the significant findings between acculturation and disordered eating.

Conversely, other studies have observed non-significant relationships between acculturation and internalization of U.S. sociocultural standards of beauty in Latinx populations (Blow, Taylor, Cooper, & Redfern, 2010; Lester & Petrie, 1995). For example, Lester and Petrie (1995) assessed the influence of acculturation to U.S. society on bulimic symptomatology among 142 Mexican American female college students. Findings suggested that participants' body mass and endorsement of U.S. societal values concerning attractiveness were positively related to bulimic symptomatology (Lester & Petrie, 1995). However, contrary to prediction, acculturation was not significantly related to bulimic symptomatology (Lester & Petrie, 1995). Furthermore, the study only assessed bulimic symptomatology, and did not consider anorexia nervosa or binge eating behaviors, and therefore restricted the sample to only those who identified with bulimia nervosa symptoms. Additionally, the study also utilized the original version of the ARSMA (Cuéllar et al., 1980), and not the updated ARSMA-II (Cuéllar et al., 1995).

Moreover, Blow and colleagues (2010) examined the relationships among acculturation, weight concerns and control, and internalization of sociocultural standards of beauty in a sample of 163 Hispanic college students, utilizing the Short Acculturation Scale for Hispanics (SASH; Marín, Sabogal, Marín, Otero-Sabogal & Perez-Stable, 1987) to measure acculturation. Findings suggested that Hispanic women reported more internalized sociocultural standards of beauty more than Hispanic men, and contrary to the hypotheses, acculturation was unrelated to all outcome variables (Blow et al., 2010). However, one very important factor to consider is the

geographical location of the participants who took part in the study. Participants in the study resided on the U.S./Mexico border (Blow et al., 2010). The participants may have crossed the border regularly and lived in a location where Hispanics were the majority ethnocultural group (Blow et al., 2010). As such, levels of acculturation may not have played an important role in relation to weight concerns and associated behaviors (Blow et al., 2010).

In addition, Joiner and Kashubeck (1996) explored acculturation, body image, self-esteem, and disordered eating among 120 adolescent Mexican American women. Acculturation did not predict disordered eating or body image in the sample (Joiner & Kashubeck, 1996). The researchers suggested that measurement related issues (their measure of acculturation was too broad) may have explained the non-significant findings (Joiner & Kashubeck, 1996). Again, the authors used the original version of the ARSMA (Cuéllar et al., 1980), and not the updated version of the ARSMA-II (Cuéllar et al., 1995), which assessed the acculturation process through an orthogonal, multidimensional approach by measuring cultural orientation toward both Mexican and American culture independently (Cuéllar et al., 1995).

Lastly, Gordon and colleagues (2010) explored body shape ideals and disordered eating among 276 White, Latinx, and Black college women. Their findings suggested that acculturation did not significantly predict disordered eating or body dissatisfaction among Latinx participants (Gordon et al., 2010). The researchers suggested that acculturative stress, not acculturation, may be related to disordered eating (Gordon et al., 2010). Furthermore, the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) was utilized to measure acculturation; this scale does not measure all possible areas related to acculturation, nor does it measure beliefs, norms, and values (Stephenson, 2000).

To date, there is limited research available that examines the role of enculturation in the relation between internalization and disordered eating. Enculturation can be described as maintaining the norms of one's heritage culture, while living within another culture (Castillo & Caver, 2009; Gonzales, Knight, Morgan-Lopez, Saenz, & Sirolli, 2002). One study examined how enculturation may act as a protective factor by buffering the relationship between acculturation to the mainstream U.S. society and eating/body related concerns (e.g., control concerns, restricted eating, and body dissatisfaction) in a sample of 209 Mexican American women (Bettendorf & Fischer, 2009). Findings suggested that enculturation (i.e., Mexican cultural orientation) was not a moderating variable in the relationship between acculturation to mainstream U.S. society and eating/body related concerns (Bettendorf & Fischer, 2009). The authors suggested that the findings may be explained by the possibility that participants could endorse items on the ARSMA-II (Cuellar et al., 1995) that indicate a general connectedness to both Mexican and Anglo orientation, while simultaneously adhering to any combination of Mexican and Anglo beauty-specific ideals (Bettendorf & Fischer, 2009). Additionally, Bettendorf and Fischer (2009) explained that residing in a society where messages and images of thinness are overwhelmingly pervasive may be sufficient in the production of body concerns, regardless of cultural orientation.

Yet, in other capacities, enculturation has been argued to provide protective social and familial support, a shared sense of ethnic identity, and protective traditional values within Latinx adolescents (Barrera, Gonzalez, Lopez, & Fernandez, 2004). Furthermore, Yoon et al.'s (2013) meta-analysis of 325 studies with various racial and gender backgrounds revealed that enculturation was related to only positive psychological outcomes (i.e., self-esteem, life satisfaction, and positive affect).

Historically, acculturation research has focused on a unidirectional hypothesis, assuming that when individuals engage in and internalize a second culture they are likely to lose connection to their culture of origin (Miller, 2010). Scholars have expanded this unidirectional model of acculturation to include enculturation (Herskovits, 1948), in which individuals can maintain and internalize their culture of origin in addition to a second culture (i.e., acculturation; LaFromboise, Coleman, & Gerton, 1993). Divergent from unilinear models that conceptualize acculturation as a movement on a single continuum (i.e., acculturation occurs in expense of enculturation), bilinear models suggest that individuals can develop cultural orientations to both the dominant culture and their culture of origin; and that these two orientations are relatively independent of each other (Cuéllar et al., 1995; Kim & Abreu, 2001; Zea, Asner-Self, Birman, & Buki, 2003).

Research on acculturation and mental health has rarely addressed enculturation as a separate factor (Ojeda, Flores, & Navarro, 2011). Yet, it is important to consider both acculturation and enculturation as important information may be overlooked. For example, in a meta-analysis of 325 diversity related studies, only mainstream language proficiency was negatively associated with negative mental health outcomes on acculturation dimensions and positively related to positive mental health outcomes across enculturation dimensions (Yoon et al., 2013). To date, no studies have analyzed the role of enculturation in the context of objectification theory, and it appears that further research is warranted.

### **Acculturative Stress**

As noted, acculturative stress has been implicated as a variable related to ethnically/culturally diverse individuals' mental health (e.g., Betancourt et al., 2015; Hwang & Ting, 2008; Idemudia, 2011; Knipscheer & Kleber, 2006; Maneze, Salamonson, Attwood, &

Davidson, 2014; Park, 2009), particularly among Latinxs in the United States (Katsiaficas, Suárez-Orozco, Sirin, & Gupta, 2013; Torres, Driscoll, & Voell, 2012). Acculturative stress can be defined as the degree to which a person experiences distress when pressured to adapt to a new culture (Duarte et al., 2008). Acculturative stress includes problems such as linguistic difficulties, loss of social supports, trouble establishing new social connections, disturbances in family dynamics, difficulty finding a job in the new country, discrimination, and non-acceptance by the host culture (Hwang & Ting, 2008).

Acculturative stress can develop when an individual perceives a discrepancy between cultural demands and the available resources to cope with such demands (Smart & Smart, 1995). Furthermore, acculturative stress can lead to psychological maladjustment (Berry, 2006; Escobar, 1998) and health disparities in ethnic minorities (Berry, Kim, Minde, & Mok, 1987). For Latinxs, several factors can intensify acculturative stress, such as language proficiency. For example, higher rates of English proficiency have been associated with lower rates of acculturative stress among Latinxs (Lueck & Wilson, 2011). Moreover, Capielo, Delgado-Romero, and Stewart (2015) assessed the effects of acculturative stress in a sample of 113 individuals of Puerto Rican descent residing in the U.S. Findings indicated that higher levels of acculturative stress were associated with more depression, maladaptive coping strategies, and less adaptive coping utilization (Capielo et al., 2015). Among Latinx women, in particular, acculturative stress has been associated with lower self-esteem (Claudat, White, & Warren, 2016), and more depressive symptomology (Castillo et al., 2015), hopelessness and suicidal ideation (Hovey & Magaña, 2003), anxiety symptoms (Hovey & Magaña, 2002), body dissatisfaction (Perez et al., 2002), and disordered eating (Claudat et al., 2016; Perez et al., 2002).

Kroon Van Diest and colleagues (2014) assessed the relationship between acculturative stress and disordered eating among various ethnic groups, including Latinxs. Findings suggested that acculturative stress significantly predicted bulimic symptoms among African American, Asian American, and Latinx women, above and beyond the effects of general life stress (Kroon Van Diest et al., 2014). Furthermore, Claudat et al. (2016) assessed acculturative stress and its relationship with self-esteem and disordered eating among 638 Asian American and Latinx women. Findings suggested that, for both groups of women, acculturative stress was positively correlated with disordered eating (Claudat et al., 2016). Furthermore, multigroup structural equation modeling indicated that, for Asian American and Latinx women, self-esteem partially mediated the relationship between acculturative stress and disordered eating (Claudat et al., 2016).

Moreover, Gordon and colleagues (2010) assessed acculturative stress in relation to body shape ideals and disordered eating among 276 White, Latinx, and Black college-aged women. Finding suggested that greater levels of acculturative stress predicted higher levels of drive for thinness among Latinxs (Gordon et al., 2010). Furthermore, White and Latinx women preferred thinner personal body shape ideals in comparison to Black women (Gordon et al., 2010). White and Latinx women also demonstrated comparable levels of body dissatisfaction and drive for thinness (Gordon et al., 2010). Additionally, Latinx women scored significantly higher than Black women in the endorsement of disordered eating (Gordon et al., 2010).

Lastly, Menon and Harter (2012) also assessed acculturative stress and its relation to psychological well-being and body image disturbances among 399 Latinx students. The study also examined internalization of the thin ideal and perceived social support in relation to psychological well-being and body image disturbances (Menon & Harter, 2012). Findings

suggested that acculturative stress was a significant positive predictor of body image disturbances and internalization of sociocultural standards of beauty (i.e., the thin ideal; Menon & Harter, 2012). Furthermore, internalization mediated the relationship between acculturative stress and body image disturbances (Menon & Harter, 2012).

Yet, in the context of objectification theory, there is currently only one study, an unpublished dissertation, that has considered acculturation and acculturative stress when assessing ethnically and culturally diverse populations (Montes de Oca, 2006). This particular study examined the direct and indirect links among acculturation, acculturative stress, internalization of cultural beauty standards, self-objectification, body shame, and disordered eating among a sample of 112 Latinx participants (Montes de Oca, 2006). Findings indicated that internalization of sociocultural standards of beauty, self-objectification, acculturative stress, and body shame were all uniquely positively related to eating disorder symptomology (Montes de Oca, 2006). Furthermore, acculturative stress was positively related to both body shame and disordered eating (Montes de Oca, 2006).

Collectively, available research has implicated both acculturation and acculturative stress in the objectification theory framework. Nevertheless, additional research is further needed to more fully understand these relationships (Velez et al., 2015). Thus, based on existing research, I predict that acculturation and acculturative stress will be related to more internalization of sociocultural standards of beauty and disordered eating.

It is also important to more fully understand culturally-relevant variables that may protect against internalization of sociocultural standards of beauty. For example, among a sample of 209 Mexican American women, Bettendorf and Fischer (2009) observed that *familism* (a deeply ingrained sense of the individual being inextricably rooted in the family; Bacallo & Smokowski,

2007) significantly buffered the links between acculturation to the mainstream U.S. society and body dissatisfaction and disordered eating. An additional culturally relevant variable to Latinx women may be religious and spiritual coping.

### **Religious and Spiritual Coping**

Ethnic and culturally diverse populations often refrain from seeking support from mental health providers in times of distress (Chiang, Hunter, & Yeh, 2004). In fact, research among Latinx populations proposes that this underutilization is attributable to a variety of reasons, including logistical barriers to accessing health care (e.g., Nandi et al., 2008), attitudes toward mental health services (e.g., Berdahl & Torres Stone, 2009; Cabassa, 2007), and levels of acculturation (e.g., Alegría et al., 2007; Sentell, Shumway, & Snowden, 2007). Given the harmful psychosocial outcomes associated with sexually objectifying experiences, it is important to understand coping mechanisms that may assist WOC, specifically Latinx women, manage their distress. Coping mechanisms may be utilized regardless of help-seeking behavior, and for the aforementioned reasons, it is important to understand the specific coping skills that may protect Latinx women against the effects of sexual objectification.

Religion and spirituality are fundamental components in the lives of many individuals around the world. In the United States alone, approximately 88% of adults express a belief in God (Pew Research Center, 2014). Furthermore, women represent a demographic that adheres to religion more frequently than men (Pew Research Center, 2014). For instance, in comparison with men, women attend more religious services on average, utilize prayer more often, have more frequent feelings of spiritual peace and wellbeing, and describe religion as being more important in their lives (Pew Research Center, 2014).

Moreover, various ethnic and cultural groups within the United States also adhere to religious and spiritual practices. For example, over 82% of Latinxs in the United States have reported that they have a religious affiliation, with approximately 19.6 million Latinxs identifying as Catholic and approximately 8 million Latinxs identifying as Protestant (Pew Research Center, 2014). With such a large portion of Latinx populations adhering to religious practices, it is important to further assess the role of religious and spiritual coping in relation to disordered eating with this population.

Furthermore, it is important to note the difference between religiosity and spirituality, and the intersection of the two. Religion is often defined as the following of practices and rituals through an organized system of beliefs (e.g., a group of individuals who share a common notion and or worldview; Cervantes & Parham, 2005; Hill & Pargament, 2008). Spirituality is a construct that is more difficult to define, given the unique meaning for individuals and cultural groups (Fukuyama & Sevig, 1999; Saint-Laurent, 2000), and the fact that many religious individuals also identify as being spiritual (Moreno & Cardemil, 2013). Although there are some overlapping similarities, it has been noted that a difference between religion and spirituality does exist (Hill & Pargament, 2008). Walsh (1999) described spirituality as the primary energy center at which the transcendent or divine dimension of existence is encountered, and as a set of beliefs and practices relative to transformation of self. More simply, spirituality commonly refers to a personal relationship with a supreme being (e.g., God, Jesus, saints, or spirits), and does not include adherence to an organized religion (Cervantes & Parham, 2005).

Within indigenous healing practices, traditional belief systems are synonymous with unique healing protocols specific to a cultural group (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). Indigenous healing methods refer to the unique beliefs and practices that are

designated to treat communities that share these particular values, and whose members are socialized within a select religious and spiritual mindset (Yeh et al., 2004). Through the combination of physical, psychological, cultural, and spiritual ideals, which occurred between the Spaniards and the Indians, a resemblance of two unique cultural perspectives developed a blend of indigenous, Christian, and Spanish world elements (Cervantes, 2008). Through this amalgamation, many values and traditional practices of various Latinx cultures are fused with Old Catholic ideology (Carrasco, 1990). As a result, beliefs in deities or saints, devotional offerings, vows of penance, prayer, pilgrimages to sacred sites, and shrines can be seen throughout numerous Latinx cultures (Cervantes, 2008).

To cope with sexually objectifying experiences and body image concerns, WOC may engage culturally specific values and coping mechanisms - such as religious and spiritual coping - that may provide assistance in the amelioration of psychosocial distress, including disordered eating. For Latinx women, this may include turning to their culture's religious and spiritual practices to seek solace from distress. Folkman, Lazarus, Gruen, and DeLongis (1986) defined coping as an individual's cognitive and behavioral efforts to manage a situation perceived as a threat, and is related to an individual's psychological and physical wellbeing (Taylor & Stanton, 2007).

Various studies have noted the importance of considering culturally specific coping mechanisms, such as religiosity and spirituality, when protecting against harmful discriminatory experiences, such as sexual objectification (e.g., Khan & Watson, 2006; Lazar & Bjorck, 2008; Tarakeshwar, Pargament, & Mahoney, 2003). Tix and Frazier (1998) defined religious coping as the application of cognitive or behavioral techniques derived from one's religious or spiritual beliefs when faced with stressful life events. However, religious and spiritual coping can take

two separate forms: positive religious coping and negative religious coping. Positive religious coping can be described as a person's "sense of connectedness with a transcendent force, a secure relationship with a caring God, and a belief that life has a greater benevolent meaning" (Pargament, Feuille, & Burdzy, 2011, p. 58). Alternatively, negative religious coping can be defined as experiencing spiritual tension, conflict, and struggle with God and others, as demonstrated by negative reevaluations of God's powers (e.g., feeling abandoned or punished by God), demonic reappraisals (i.e., feeling the devil is involved in the stressor), spiritual inquiry and doubting, and interpersonal religious dissatisfaction (Pargament et al., 2011).

Several studies have noted the importance of the utilization of religious and spiritual coping among Latinx communities. For example, religious and spiritual coping has been shown to aid in the following: reduction of drug use and HIV risk behaviors in Latinxs (Amaro et al., 2010); facilitating resilience, management, and coping with the consequences of cancer in Latinx cancer patients (Hunter-Hernández, Costas-Muñiz, & Gany, 2015); coping with substance abuse in Latino-American men (Ai, Lee, Solis, & Yap, 2016); and with the improvement of psychological well-being in Latinxs with arthritis (Abraído-Lanza, Vásquez, & Echeverría, 2004).

Moreover, several studies have noted that positive religious coping may buffer the effects of racism on mental health by assisting individuals in developing feelings of inner peace, power, and support, as well as diminishing negative feelings about the self (Pargament & Koenig, 2000; Pargament, Smith, Koenig, & Perez, 1998). Spirituality is a central aspect of many Latinxs' psyche, and failure to incorporate this understanding is to overlook a substantial dimension to ethical practice with this community (McNeill & Cervantes, 2008). For example, among Latinx breast cancer patients, spiritual coping was a strategy used primarily at the time of diagnosis,

along with other accompanying factors, such as faith, religion, church, God, and/or prayer (Kellison, 2002).

Furthermore, the effects of negative religious coping have also been analyzed. For example, Szymanski and Obiri (2010) looked at the moderating and mediating effects of positive and negative religious coping in the relationship between external and internalized racism and psychological distress among 269 African American participants. Findings suggested that negative religious coping styles partially mediated the links from racist events and internalized racism to psychological distress (Szymanski & Obiri, 2010). Furthermore, a recent study by Ahles, Mezulis, and Hudson (2016) examined religious coping as a moderating variable in the relationship between stress and depressive symptomatology in a sample of 320 undergraduate college students. Findings suggested that negative religious coping moderated (i.e., exacerbated) the positive relationship between stress and depressive symptoms. Additionally, Horton and Loukas (2013) examined the moderating role of religious coping in the relationship between depressive symptomatology and cigarette use among 963 White, Black, and Hispanic participants. Findings suggested that negative religious coping moderated and exacerbated the impact of depressive symptoms on cigarette smoking among participants who identified as women (Horton & Loukas, 2013).

Several studies have examined the relationships among religious coping, acculturation, and acculturative stress. For example, in a sample of 415 Latinx immigrants, higher levels of acculturative stress was associated with more positive and negative religious coping (Sanchez, Dillon, Concha, & De La Rosa, 2015). Moreover, the study also noted that negative religious coping moderated the relationship between acculturative stress and alcohol consumption, whereby negative religious coping exacerbated this relationship (Sanchez et al.,

2015). Furthermore, Sanchez and colleagues (2015) noted that positive religious coping was related to lower alcohol consumption.

Additionally, Mausbach and colleagues (2003) analyzed the role of religious coping among White and Latinx dementia caregivers. In a sample of 147 White women and 100 Latinx women, findings indicated that Latinxs attended religious services more frequently, prayed more often, rated religion as more important in their lives, and used positive religious coping strategies more often than White women (Mausbach et al., 2003). Furthermore, findings also suggested that higher levels of acculturation were related to less frequent utilization of positive religious coping strategies (Mausbach et al., 2003). Due to religious coping buffering and/or exacerbating the harmful effects associated with acculturation and acculturative stress, it may be useful to explore the role of both positive and negative religious coping in the links from sexual objectification experience, acculturation, and acculturative stress to internalized sociocultural standards of beauty.

To date, no research has examined religious/spiritual coping within Latinx populations while utilizing an objectification theory framework. It is important to understand what coping strategies Latinx women incorporate when facing sexual objectification, in order to reduce the possible internalization of Westernized standards of beauty, and prevent the development of life-threatening eating disorders. Since positive religious coping buffered the link between racism and harmful mental health outcomes (Pargament & Koenig, 2000; Pargament et al., 1998), it is also plausible that it will buffer the links from sexual objectification (another form of discrimination), acculturation, and acculturative stress to internalization of sociocultural standards of beauty, thereby relating to less disordered eating. In other words, positive religious coping may protect against internalization of sociocultural standards of beauty in the face of

sexual objectification, acculturation, and acculturative stress; in contrast, negative religious coping may exacerbate these links.

### **Present Study**

The purpose of the current study is to explore the links from sexual objectification, acculturation, enculturation, and acculturation stress to internalized sociocultural standards of beauty and disordered eating among Latinx women. Moreover, I aim to examine how negative and positive religious coping may exacerbate or buffer the links from these cultural stressors to internalized sociocultural standards of beauty, respectively. To date, no published research has examined religiosity/spirituality acculturation, enculturation, and acculturative stress in the objectification theory framework. Researchers have, however, suggested that the use of religion and spirituality to cope with a variety of stressors may be particularly beneficial to Latinx women. Objectification theory (Fredrickson & Roberts, 1997) provides a lens through which to conceptualize Latinx women's experiences of sexual objectification and disordered eating.

Specific hypotheses are as follows:

- 1) Positive correlations are predicted among experiences of sexual objectification, internalization, acculturation, acculturative stress, negative religious/spiritual coping, and disordered eating. Enculturation and positive religious coping will be negatively correlated with internalization of sociocultural standards of beauty and disordered eating.
- 2) Sexual objectification, acculturation, acculturative stress, and negative religious/spiritual coping will predict more internalization of sociocultural standards of beauty and disordered eating. In contrast, positive religious/spiritual coping and enculturation will significantly negatively predict internalization of sociocultural

standards of beauty and disordered eating. Results from this analysis will be used to inform a path analysis. Should all relations be significant, I predict the following:

2a) Internalization of sociocultural standards of beauty will mediate the links from sexual objectification experiences, acculturation, enculturation, and acculturative stress to disordered eating among Latinx women. However, this indirect effect will be conditional on the following:

2b: Religious and spiritual coping). Negative religious/spiritual coping will strengthen (i.e., exacerbate) the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to more disordered eating.

2c: In contrast, positive religious/spiritual coping will buffer or render the aforementioned links non-significant.

2d. Negative religious/spiritual coping will render the negative relationship between enculturation and internalization non-significant or weaken this relation. That is, the protective benefits of enculturation will be elided at higher levels of negative religious/spiritual coping.

2e. Positive religious/spiritual coping will strengthen the negative relation between enculturation and internalized sociocultural standards of beauty. Specifically, the protective benefits of enculturation will be strengthened when used in conjunction with positive religious/spiritual coping.

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## Footnotes

<sup>1</sup>Per the DSM-5, EDNOS is now recognized as OSFED, other specified feeding or eating disorder.

## CHAPTER 2

### LATINX WOMEN'S DISORDERED EATING: CONSIDERING CULTURALLY RELEVANT VARIABLES IN THE OBJECTIFICATION THEORY FRAMEWORK

In the United States, approximately 20 million women and 10 million men suffer from a clinically significant eating disorder during their lifetime, which includes anorexia nervosa, bulimia nervosa, binge eating disorder, or EDNOS<sup>1</sup> (Wade, Keski-Rahkonen, & Hudson, 2011). This rate is assumed to be higher, as many cases are likely underreported (Smink, van Hoeken, & Hoek, 2012). In addition, the rate of new cases of eating disorders has continued to increase since 1950 (Hudson, Hiripi, Pope, & Kessler, 2007; Streigel-Moore & Franko, 2003; Wade et al., 2011). For example, the rates of bulimia alone have tripled between 1988 and 1993 in 10 to 39-year-old women (Hoek & van Hoeken, 2003). Moreover, binge eating disorder continues to hold the least amount of discrepancy across racial/ethnic groups in comparison to other eating disorder diagnoses (Marques et al., 2011). Even more concerning, eating disorders continue to hold the highest mortality rate of any other psychiatric disorder (Arcelus, Mitchell, Wales, & Nielsen, 2011).

These disorders are also significantly more prevalent among Western and industrialized nations in comparison to less developed nations (American Psychiatric Association [APA], 2000; Pate, Pumariega, Hester, & Garner, 1992). There are several theories explaining this trend, one being continuous exposure to the dominant culture's depiction of beauty. The "thin ideal," as proposed by Western cultures, suggests that girls and women should adhere to standards that are unrealistic, depicting women as primarily thin, young, hypersexual, and White (Scharrer, 2013).

An existing stereotypical view is that eating disorders are unique to White women and that various ethnic minority groups endorse less eating disorder symptomology (e.g., Abrams,

Allen, & Gray, 1993; Gluck & Geliebter, 2002; Smolak & Striegel-Moore, 2001). Yet, several studies have suggested that disordered eating in ethnically diverse women is comparable to rates observed among White women (Crago & Shisslak, 2003; Smith & Krejci, 1991). In addition, some studies have found that rates of disordered eating may be higher among Latinx women (i.e., women from Spanish-speaking cultures who live in the United States; Crago, Shisslak, & Estes, 1996; Grabe & Hyde, 2006; U.S. Census Bureau, 2011;) than other racial/ethnic groups (Alegría et al., 2007; Croll, Neumark-Sztainer, Story, & Ireland 2002; Perez, Voelz, Pettit, & Joiner, 2002), including Asian American (Neumark-Sztainer et al., 2002) and African American women (Fitzgibbon et al., 1998; Neumark-Sztainer et al., 2002).

Currently, there is a lack of research with Latinx populations which is concerning due to Hispanics/Latinxs being among the largest and most quickly growing ethnic minority group in the United States (U.S. Census Bureau, 2014), encompassing 16% of the population and accounting for more than 50% of total population growth between 2000 and 2010 (Ennis, Ríos-Vargas, & Albert, 2011). As a result of the growing numbers of Latinx in the United States, there has been increased attention to their mental health needs and awareness of marked underutilization of formal mental health services in comparison with non-Latinxs (Alegría et al., 2002). With the abundance of individuals who fit this demographic, and the underutilization of mental health services, it is important and necessary to further explore the unique factors that may contribute to and aid in the amelioration of acute mental health needs, including disordered eating.

### **Objectification Theory**

Objectification theory (Fredrickson & Roberts, 1997) was created to help explain how sexually objectifying experiences may relate to psychological distress among girls and women,

and may help to provide a useful framework in better understanding the relationship between sexual objectification experiences and disordered eating among Latinx women. Objectification theory suggests that gender role socialization and women and girls' life experiences are regularly marked by experiences of sexual objectification (Fredrickson & Roberts, 1997). Girls and women are subject to routine sexually objectifying experiences, which may include unsolicited sexual advances, physical touch, leering, sexual remarks, or even vicariously by viewing an objectifying experience happen to someone other than oneself (Kozee, Tylka, Augustus-Horvath, & Denchik, 2007).

Eventually, these persistent sexually objectifying experiences may become internalized, and girls and women may begin to treat themselves as objects to be appraised and evaluated, and view their bodies as an object for others' pleasure (McKinley, 1998); also known as self-objectification (Fredrickson & Roberts, 1997; Noll & Fredrickson, 1998). Self-objectification manifests through the constant checking and monitoring of one's appearance, as well as through the continuous act of comparison of one's body to an internalized or cultural standard (Moradi, Dirks, & Matteson, 2005); this is known as body surveillance. Additionally, objectification theory postulates that self-objectification leads to greater levels of body shame, appearance anxiety, decreased peak motivational states, and decreased interoceptive awareness, which in turn may lead to greater levels of depression, decreased psychosexual functioning, and disordered eating (Fredrickson & Roberts, 1997).

Generally, research has supported tenets of objectification theory, and scholars have suggested that Western standards of beauty - emphasizing a thin body size - also affect the body image concerns of ethnically diverse women (Austin & Smith, 2008). For example, Moradi and Huang (2008) reviewed a large body of objectification theory related research and noted several

important findings. Correlational findings provided support for the posited links of self-objectification, body surveillance, and body shame with indicators of women's mental health, including disordered eating, depressive symptoms, and self-esteem (Moradi & Huang, 2008). Moreover, a plethora of data supported the mediating role of body shame in the relations of self-objectification or body surveillance with disordered eating and depressive symptomology (Moradi & Huang, 2008). Notably, studies that included sexual objectification experiences as a precursor in the objectification theory framework (as opposed to self-objectification) found that internalization of sociocultural standards of beauty was an additional mediating variable in the link from sexual objectification experiences to disordered eating (Moradi & Huang, 2008).

Indeed, sexual objectification experiences have been directly linked to higher levels of internalization of sociocultural standards of beauty among African American women (Watson, Ancis, White, & Nazari, 2013), sexual minority women (Watson, Grotewiel, Farrell, Marshik, & Schneider, 2015), heterosexual women (Szymanski & Feltman, 2014), sexual minority men (Wiseman & Moradi, 2010), and Muslim American women (Tolaymat & Moradi, 2011). In addition, internalization of sociocultural standards of beauty has been directly linked to more disordered eating among bisexual (Brewster et al., 2014) and undergraduate women (Lokken, Worthy, & Trautmann, 2004), and also significantly mediated the positive link between sexual objectification experiences and disordered eating among African American (Watson et al., 2013), sexual minority (Watson et al., 2015), Italian (Dakanalis et al., 2014), and Muslim American women (Tolaymat & Moradi, 2011).

### **Objectification Theory, Internalization, and Latinx Women**

Exposure to sexually objectifying media may have a powerful influence on Latinxs' body image and disordered eating (e.g., Schooler & Daniels, 2014). In 2011, Rivadeneyra examined

466 characters on Spanish-language soap operas or *telenovelas* that aired in the United States. Results suggested that characters played by women were sexualized more often than characters played by men, and physical appearance and nurturing roles were also more likely to be exhibited by women in *telenovelas* (Rivadeneira, 2011). Furthermore, appearing less “ethnic” seemed beneficial to the characters on the shows; that is, the vast majority of characters were light-skinned and characters with darker skin were portrayed in exaggerated and in more sexualized ways (Rivadeneira, 2011).

To date, few studies have extended the objectification theory framework to Latinx women. Boie, Lopez, and Sass (2013) assessed the relationship between internalization of sociocultural standards of beauty and dieting behaviors in a sample of 499 Latinx and White college students. Findings suggested that internalization predicted body surveillance and body shame, and the relationship between internalization and body shame was partially mediated by body surveillance (Boie et al., 2013). Moreover, Latinx individuals indicated greater levels of body shame in comparison to White individuals (Boie et al., 2013).

More recently, among 189 Latinx women, Velez, Campos, and Moradi (2015) extended objectification theory by integrating racist discrimination in the links to disordered eating and depressive symptomatology. Results suggested that internalization of sociocultural standards of beauty were related to more disordered eating and depressive symptomatology in part through the mediating roles of body shame and body surveillance (Velez et al., 2015). Furthermore, the authors noted that body surveillance was related to an increase in disordered eating and depressive symptomatology through the mediating role of body shame (Velez et al., 2015). Contrary to hypothesis, sexual objectification was not directly linked to internalization of sociocultural standards of beauty (Velez et al., 2015). Several reasons may explain this non-

significant relationship, one being that this study did not take into account how varied levels of acculturation may have played a role in the relationship between sexual objectification and internalization (Velez et al., 2015).

### **Acculturation and Enculturation**

Acculturation can be defined as the process of cultural transition, in which immigrants' customs, attitudes, behaviors, beliefs, lifestyle, language, habits, and values change as they adapt to their new home country (Graves, 1967). During the acculturation process, an individual can adhere to or reject certain aspects of the dominant/host culture, and retain or reject cultural beliefs and practices of their culture of origin (Cuéllar, Arnold, & Maldonado, 1995). Latinx women, in particular, may experience the effects of acculturation in numerous ways. For example, among Latinx women, acculturation has been linked to various ailments including alcohol abuse (Lee, Almeida, Colby, Tavares, & Rohsenow, 2016), depressive symptomology (Davila, McFall, Cheng, 2009; Gallagher-Thompson et al., 1997), and symptoms of anxiety (de Mendoza, Harville, Theall, Buekens, & Chasan-Taber, 2016). Usually, individuals who are highly acculturated are presumed to adopt the cultural practices of the dominant society in which they live, while those who are less acculturated tend to preserve many of the traditions practiced in their former country (i.e., enculturated; Hwang & Ting, 2008). In theory, the more acculturated an individual is to the mainstream culture of the United States, the more likely they will be to internalize the Westernized thin ideal, which would effectively increase the likelihood of developing disordered eating (Gordon, Castro, Sitnikov, & Holm-Denoma, 2010; Warren, Castillo, & Gleaves, 2010).

Notably, there is limited research that has examined the role of enculturation (i.e., maintaining the norms of one's heritage culture while living within another culture [Castillo &

Caver, 2009]) in body image and disordered eating research. One study posited that enculturation may act as a protective factor by buffering the relationship between acculturation to mainstream U.S. society and eating/body related concerns (e.g., control concerns, restricted eating, and body dissatisfaction) in a sample of 209 Mexican American women (Bettendorf & Fischer, 2009). Findings suggested that enculturation (i.e., Mexican cultural orientation) did not directly predict eating/body related concerns, and was not a moderating variable in the relationship between acculturation to mainstream U.S. society and eating/body related concerns (Bettendorf & Fischer, 2009). To my knowledge, this is the only study to date that has analyzed the role of enculturation in this context, warranting further research on this potential protective factor.

Yet, in other capacities, enculturation has been argued to provide protective social and familial support, a shared sense of ethnic identity, and protective traditional values within Latinx adolescents (Barrera, Gonzalez, Lopez, & Fernandez, 2004). Furthermore, Yoon et al.'s (2013) meta-analysis of 325 studies with various racial and gender backgrounds revealed that enculturation was only related to positive psychological outcomes (i.e., self-esteem, life satisfaction, and positive affect). Historically, acculturation research has focused on a unidirectional hypothesis, assuming that when individuals engage and internalize in a second culture, they are likely to lose connection to their culture of origin (Miller, 2010). Research on acculturation and mental health has rarely addressed enculturation as a separate factor (Ojeda, Flores, & Navarro, 2011). Yet, it is important to consider both acculturation and enculturation as important information may be overlooked. For example, in a meta-analysis of 325 diversity related studies, only mainstream language proficiency was negatively associated with negative mental health outcomes on acculturation dimensions and positively related to positive mental health outcomes across enculturation dimensions (Yoon et al., 2013).

Findings on the association of acculturation with body dissatisfaction and disordered eating in Latinx samples have varied, with some research suggesting significant positive relationships (e.g., Bettendorf & Fischer, 2009; Poloskov & Tracey, 2013) and others suggesting non-significant relationships (e.g., Gordon et al., 2010; Joiner & Kashubeck, 1996). For example, Poloskov and Tracey (2013) found that internalization of sociocultural standards of beauty mediated the positive relationship between acculturation and body dissatisfaction among 211 Mexican American college women. It is important to note that the aforementioned studies, which found positive relationships, utilized the most updated version of an acculturation scale, the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuéllar et al., 1995).

In contrast, other studies have observed non-significant links from acculturation to internalization of sociocultural standards of beauty (Blow, Taylor, Cooper, & Redfern 2010) and disordered eating (Gordon et al., 2010; Lester & Petrie, 1995) among Latinx women. This may be due to measurement related concerns and model specificity (i.e., some of these studies did not examine internalization of sociocultural standards of beauty in relation to disordered eating). For example, Lester and Petrie (1995) restricted the sample to only those who identified with bulimia nervosa symptoms, and utilized the original version of the ARSMA (Cuéllar, Harris, & Jasso, 1980) and not the updated ARSMA-II (Cuéllar et al., 1995). Joiner and Kashubeck (1996) also used the original version of the ARSMA (Cuéllar et al., 1980) in their study. Furthermore, Blow and colleagues (2010) utilized the Short Acculturation Scale for Hispanics (SASH; Marín et al., 1987) to measure acculturation, and participants in the study resided on the U.S./Mexico border (Blow et al., 2010). The participants may have crossed the border regularly and lived in a location where Hispanics were the majority ethnocultural group, where levels of acculturation

may not have played an important role in relation to weight concerns and associated behaviors (Blow et al., 2010).

Moreover, Gordon and colleagues (2010) utilized the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) to measure acculturation, which does not measure all possible areas related to acculturation or beliefs, norms, and values (Stephenson, 2000). Additionally, acculturative stress, rather than acculturation, has been implicated as a variable related to ethnically/culturally diverse individuals' mental health (e.g., Betancourt et al., 2015; Hwang & Ting, 2008; Idemudia, 2011; Knipscheer & Kleber, 2006; Maneze, Salamonson, Attwood, & Davidson, 2014; Park, 2009), particularly among Latinxs in the United States (Katsiaficas, Suárez-Orozco, Sirin, & Gupta, 2013; Torres, Driscoll, & Voell, 2012).

### **Acculturative Stress**

Acculturative stress can be defined as the degree to which a person experiences distress when pressured to adapt to a new culture (Duarte et al., 2008). Acculturative stress includes problems such as linguistic difficulties, loss of social supports, trouble establishing new social connections, disturbances in family dynamics, difficulty finding a job in the new country, discrimination, and non-acceptance by the host culture (Hwang & Ting, 2008). Acculturative stress can develop when an individual perceives a discrepancy between cultural demands and the available resources to cope with such demands (Smart & Smart, 1995). Furthermore, acculturative stress can lead to psychological maladjustment (Berry, 2006; Escobar, 1998) and health disparities in ethnic minorities (Berry, Kim, Minde, & Mok, 1987).

Among Latinx women, in particular, acculturative stress has been associated with lower self-esteem (Claudat, White, & Warren, 2016), more depressive symptomology (Castillo et al., 2015), hopelessness and suicidal ideation (Hovey & Magaña, 2003), anxiety symptoms (Hovey

& Magaña, 2002), body dissatisfaction (Perez et al., 2002), and disordered eating (Claudat et al., 2016; Perez et al, 2002). Menon and Harter (2012) also assessed acculturative stress and its relation to psychological well-being and body image disturbances among 399 Latinx students. Findings suggested that acculturative stress was a significant positive predictor of body image disturbances and heightened internalization of sociocultural standards of beauty (i.e., the thin ideal; Menon & Harter, 2012). Furthermore, internalization significantly mediated the relationship between acculturative stress and body image disturbances (Menon & Harter, 2012). These findings suggest that acculturative stress, rather than acculturation/enculturation, may be a more reliable predictor of body image and eating disturbances among Latinx women.

In the context of objectification theory, there is currently only one study, an unpublished dissertation, that has considered acculturation and acculturative stress in the objectification theory framework (Montes de Oca, 2006). In a sample of 112 Latinx participants, findings suggested that internalization of sociocultural standards of beauty, self-objectification, acculturative stress, and body shame were all positively uniquely related to eating disorder symptomology (Montes de Oca, 2006). Furthermore, acculturative stress was significantly related to more body shame and disordered eating (Montes de Oca, 2006). Thus, extant studies assessing the links of acculturation and acculturative stress with disordered eating have supported the relevance of these variables in the objectification theory framework, although acculturative stress appears to be a more reliable predictor of body image disturbances and disordered eating. However, additional research is necessary to further understand these links, as well as potential protective factors. For Latinx women, religiosity and spirituality may protect against the harmful effects of sexual objectification.

## **Religious and Spiritual Coping**

Religion and spirituality are fundamental components in the lives of many individuals around the world. In the United States alone, approximately 88% of adults express a belief in God (Pew Research Center, 2014). Furthermore, women represent a demographic that adheres to religion more frequently than men (Pew Research Center, 2014), as they attend more religious services on average, utilize prayer more often, have more frequent feelings of spiritual peace and wellbeing, and describe religion as being more important in their lives (Pew Research Center, 2014). Moreover, various ethnic and cultural groups within the U.S. also adhere to religious and spiritual practices. For example, over 82% of Latinxs in the United States have reported that they have a religious affiliation, with approximately 19.6 million Latinxs identifying as Catholic, and approximately 8 million Latinxs identifying as Protestant (Pew Research Center, 2014). With such a large portion of Latinx populations adhering to religious practices, it is important to further assess the role of religious and spiritual coping in relation to disordered eating with this population.

Religion is often defined as the following of practices and rituals through an organized system of beliefs (Cervantes & Parham, 2005; Hill & Pargament, 2008). Walsh (1999) described spirituality as the primary energy center at which the transcendent or divine dimension of existence is encountered, and as a set of beliefs and practices relative to transformation of self. More simply, spirituality commonly refers to a personal relationship with a supreme being (e.g., God, Jesus, saints, or spirits), and does not include adherence to an organized religion (Cervantes & Parham, 2005).

To cope with sexually objectifying experiences, WOC may endorse culturally specific values and coping mechanisms - such as religious and spiritual coping - that may reduce

pressures to internalize sociocultural standards of beauty in the face of distressing experiences. For Latinx women, this may include turning to their culture's religious and spiritual practices to seek solace from distress. Various studies have noted the importance of considering religious and spiritual coping when protecting against harmful discriminatory experiences, such as sexual objectification (e.g., Khan & Watson, 2006; Lazar & Bjorck, 2008; Tarakeshwar, Pargament, & Mahoney, 2003;).

Tix and Frazier (1998) defined religious coping as the application of cognitive or behavioral techniques derived from one's religious or spiritual beliefs when faced with stressful life events. These coping methods may include prayer, confessionals, and pursuing strength and comfort from God (Tix & Frazier, 1998). However, religious and spiritual coping can take two separate forms: positive religious coping and negative religious coping. Positive religious coping can be described as a person's "sense of connectedness with a transcendent force, a secure relationship with a caring God, and a belief that life has a greater benevolent meaning" (Pargament, Feuille, & Burdzy, 2011, p. 58). Alternatively, negative religious coping can be defined as experiencing spiritual tension, conflict, and struggle with God and others, as demonstrated by negative reevaluations of God's powers (e.g., feeling abandoned or punished by God), demonic reappraisals (i.e., feeling the devil is involved in the stressor), spiritual inquiry and doubting, and interpersonal religious dissatisfaction (Pargament et al., 2011). Latinx populations may find comfort in utilizing culturally relevant coping mechanisms, such as positive religious and spiritual coping (Cervantes, 2010).

Several studies have noted the importance of religious and spiritual coping among Latinx communities. For example, religious and spiritual coping is related to lower levels of drug use and HIV risk behaviors in Latinxs (Amaro et al., 2010); more resilience, management, and

coping with cancer among Latinx cancer patients (Hunter-Hernández, Costas-Muñíz, & Gany, 2015); more coping with substance abuse in Latino-American men (Ai, Lee, Solis, & Yap, 2016); and greater levels of psychological well-being among Latinxs with chronic arthritis (Abraído-Lanza, Vásquez, & Echeverría, 2004).

To date, no research has examined religious/spiritual coping within Latinx populations while utilizing an objectification theory framework. It is important to understand what coping strategies Latinx women incorporate when facing sexual objectification, in order to reduce the possible internalization of Westernized standards of beauty and prevent the development of life-threatening eating disorders. Since positive religious coping was found to buffer the link between racism and harmful mental health outcomes (Pargament & Koenig, 2000; Pargament, Smith, Koenig, & Perez, 1998), it is also plausible that it will buffer the link between sexual objectification (another form of discrimination) and internalization of sociocultural standards of beauty.

Alternatively, negative religious coping may exacerbate harmful mental health outcomes. For example, negative religious coping partially mediated the links from external and internalized racism and psychology distress (Szymanski & Obiri, 2010), and moderated (i.e., exacerbated) the relationship between racial/ethnic discrimination and cigarette smoking among Mexican American students (Horton & Loukas, 2013). Furthermore, negative religious coping exacerbated the positive relationship between stress and depression in a sample of 320 undergraduate college students (Ahles, Mezulis, & Hudson, 2016). In other words, positive religious coping may buffer the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, while negative religious coping may exacerbate these links.

Several studies have explored the relationships among acculturative stress, acculturation, and religious coping. For example, among 415 Latinx immigrants, higher levels of acculturative stress was associated with more positive and negative religious coping (Sanchez, Dillon, Concha, & De La Rosa, 2015). Moreover, negative religious coping moderated the relationship between acculturative stress and alcohol consumption in a sample of 415 Latinx immigrants (Sanchez et al., 2015); that is, negative religious coping exacerbated the relationship, while positive religious coping was related to lower alcohol consumption when dealing with acculturative stress (Sanchez et al., 2015).

Additionally, Mausbach and colleagues (2003) examined religious coping among a sample of White and Latinx dementia caregivers. Findings indicated that, among Latinx participants, higher degrees of acculturation were related to less frequent utilization of positive religious coping strategies (Mausbach, Coon, Cardenas, & Thompson, 2003). Due to religious coping buffering and/or exacerbating the harmful effects associated with acculturation and acculturative stress, it may be useful to further explore these relationships in an expanded objectification theory model.

### **Present Study**

The purpose of the current study is to explore the links from sexual objectification, acculturation, enculturation, and acculturation stress to internalized sociocultural standards of beauty and disordered eating among Latinx women. Moreover, I aim to examine how negative and positive religious coping may exacerbate or buffer the links from these cultural stressors to internalized sociocultural standards of beauty, respectively. To date, no published research has examined religiosity/spirituality acculturation, enculturation, and acculturative stress in the objectification theory framework. Researchers have, however, suggested that the use of religion

and spirituality to cope with a variety of stressors may be particularly beneficial to Latinx women. Objectification theory (Fredrickson & Roberts, 1997) provides a lens through which to conceptualize Latinx women's experiences of sexual objectification and disordered eating.

Specific hypotheses are as follows:

1) Positive correlations are predicted among experiences of sexual objectification, internalization, acculturation, acculturative stress, negative religious/spiritual coping, and disordered eating. Enculturation and positive religious/spiritual coping will be negatively correlated with internalization of sociocultural standards of beauty and disordered eating.

2) Sexual objectification, acculturation, acculturative stress, and negative religious/spiritual coping will predict more internalization of sociocultural standards of beauty and disordered eating. In contrast, positive religious/spiritual coping and enculturation will significantly negatively predict internalization of sociocultural standards of beauty and disordered eating. Results from this analysis will be used to inform a path analysis. Should all relations be significant, I predict the following:

2a) Internalization of sociocultural standards of beauty will mediate the links from sexual objectification experiences, acculturation, enculturation, and acculturative stress to disordered eating among Latinx women. However, this indirect effect will be conditional on the following:

2b: Religious and spiritual coping). Negative religious/spiritual coping will strengthen (i.e., exacerbate) the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to more disordered eating.

2c: In contrast, positive religious/spiritual coping will buffer or render the aforementioned links non-significant.

2d. Negative religious/spiritual coping will render the negative relationship between enculturation and internalization non-significant or weaken this relation. That is, the protective benefits of enculturation will be elided at higher levels of negative religious/spiritual coping.

2e. Positive religious/spiritual coping will strengthen the negative relation between enculturation and internalized sociocultural standards of beauty. Specifically, the protective benefits of enculturation will be strengthened when used in conjunction with positive religious/spiritual coping.

## Method

### Participants

The suggested sample size for a hierarchical regression analysis is ascertained by collecting data from 10-15 participants per predictor variable (Field, 2013). The current model consisted of 7 predictor variables, four covariates (i.e., age, language, BMI, generational status), and 8 interaction terms; which would indicate the need for approximately 170 to 255 participants in order to obtain a reliable regression model. Given the difficulty finding interaction effects, and to control for anticipated errors in data collection, such as unfinished questionnaires, data was collected from 638 participants prior to data cleaning and analyses.

A total of 638 self-described Latinx women responded to the survey (English version [ $n = 556$ ]; Spanish version [ $n = 82$ ]). Of these, 52 cases were removed from the English version of the questionnaire, and 3 cases were removed from the Spanish version of the questionnaire for missing four or more of the validity check questions. Furthermore, 120 cases from the English version, and 50 cases from the Spanish version were removed for excessive missing data. Additionally, 2 cases were removed from the English version for being univariate outliers, and 12 cases were removed from the English version for being multivariate outliers. The final sample used in the analyses consisted of 399 participants (English [ $n = 374$ ; 93.7%]; Spanish [ $n = 25$ ; 6.3%]).

The ages of participants in this study ranged from 18 to 64 years ( $SD = 9.71$ ), with the mean age of participants being 29.07 years ( $SD = 9.71$ ). Most participants ( $n = 365$ ; 91.5%) indicated that they have been living in the United States for an average of 26.09 years ( $SD = 10.81$ ), with years living in the United States ranging from 1 to 62 years; 34 (8.5%) participants did not reply. Of the sample, 308 (77.2%) identified as Latinx/Hispanic; 60 (15%) identified as

Latinx/Hispanic/White; 5 (1.3%) identified as Latinx/Hispanic/Black; 11 (2.7%) identified as Bi/Multiracial; 1 (.3%) participant identified as American Indian or Alaska Native; and 14 (3.5%) participants identified as Other (Chicana [ $n = 4$ ]; Multiracial/Italian-American [ $n = 1$ ]; Hispanic-American [ $n = 1$ ]; Biracial Latina [ $n = 1$ ]; Latina/Chicana/Mexican [ $n = 1$ ]; Latina/Mexican [ $n = 2$ ]; Mexican-American [ $n = 1$ ]; Mexican-American/Tejana [ $n = 1$ ], Mexicana [ $n = 1$ ]; Pacific Islander [ $n = 1$ ]).

The majority of participants were born in the United States ( $n = 302$ ; 75.7%), with the remainder of the participants indicating various birth places, such as Mexico ( $n = 60$ ; 15%); Puerto Rico ( $n = 13$ ; 3.3%); Cuba ( $n = 1$ ; .3%); Central America (.8%; Costa Rica [ $n = 1$ ]; Guatemala [ $n = 1$ ]; Nicaragua [ $n = 1$ ]); South America (4%; Argentina [ $n = 2$ ]; Colombia [ $n = 4$ ]; Peru [ $n = 4$ ]; Venezuela [ $n = 6$ ]); Other Countries (.8%; China [ $n = 1$ ]; Dominican Republic [ $n = 1$ ]; Ecuador [ $n = 1$ ]); and 1 (.1%) participant did not reply.

Moreover, the majority of participants indicated that their parents were born in Mexico ( $n = 189$ ; 47.4%); United States ( $n = 117$ ; 29.3%); Puerto Rico ( $n = 18$ ; 4.5%); Cuba ( $n = 2$ ; .5%); Dominican Republic ( $n = 2$ ; .5%); Central America (5.3%; Costa Rica [ $n = 1$ ]; El Salvador [ $n = 5$ ]; Guatemala [ $n = 7$ ]; Honduras [ $n = 2$ ]; Nicaragua [ $n = 3$ ]; Panama [ $n = 2$ ]; South America (6.3%; Argentina [ $n = 2$ ]; Bolivia [ $n = 1$ ]; Brazil [ $n = 1$ ]; Chile [ $n = 1$ ]; Colombia [ $n = 7$ ]; Ecuador [ $n = 1$ ]; Peru [ $n = 5$ ]; Uruguay [ $n = 2$ ]; Venezuela [ $n = 6$ ]); 3 (.8%) participants did not reply and 1 (.3%) participant indicated that it was unknown where her parents were born due to being adopted. Additionally, 21 (5.1%) participants indicated that each of their parents were born in separate countries including the United States and Mexico ( $n = 11$ ); the United States and Canada ( $n = 1$ ); Croatia and Chile ( $n = 1$ ); Guatemala and Mexico ( $n = 1$ ); Mexico and Costa

Rica ( $n = 1$ ); Mexico and El Salvador ( $n = 2$ ); Mexico and Chile ( $n = 1$ ); Columbia and Venezuela ( $n = 1$ ); El Salvador and Guatemala ( $n = 1$ ); and the United States and Spain ( $n = 1$ ).

Participants' generational status was reported, with the majority of participants ( $n = 155$ ; 38.8%) being 1<sup>st</sup> generation (born in the United States); 82 (20.6%) participants being 2<sup>nd</sup> generation American (U.S.-born children of at least one foreign-born parent); 59 (14.8%) participants being 3<sup>rd</sup> generation American (U.S.-born children of at least one U.S.-born parent, where at least one grandparent is foreign-born); 52 (13%) participants being other/family has been in the U.S. for more than three generations; and 51 (12.8%) participants did not reply.

Participants' spiritual and religious affiliation consisted of 271 participants identifying with a form of Christianity (221 [55.5%] Christian/Catholic; 13 [3.3%] Christian/Protestant; 37 [9.3%] Christian/Other); 34 (8.5%) Agnostic; 3 (.8%) Buddhist/Taoist; 1 (.3%) Jewish; 52 (13%) Spiritual, but not Religious; 24 (5.8%) Atheist; and 9 (2.2%) indicating Other Spiritual/Religious Affiliation (Pagan [ $n = 1$ ]; Old Gods [ $n = 1$ ]; Indigenous Traditions/Beliefs [ $n = 2$ ], Jehovah's Witness [ $n = 1$ ]; Christian/Baptist [ $n = 1$ ]; Questioning Religion/Spirituality [ $n = 1$ ]; Mormon [ $n = 1$ ]; Not Religious/Spiritual [ $n = 1$ ]); and 5 (1.3%) participants did not reply.

Participants largely identified as Cisgender Women ( $n = 378$ ; 94.7%); 1 (.3%) Transgender Woman; 1 (.3%) Non-Binary Transgender; 2 (.5%) Gender Queer; 1 (.3%) Gender Fluid; 3 (.8%) Questioning; and 13 (3.1%) did not provide an answer. Additionally, participants also largely identified as heterosexual/straight ( $n = 329$ ; 82.5%); 34 (8.5%) bisexual; 10 (2.5%) gay/lesbian; 9 (2.3%) pan/omnisexual; 4 (1%) queer; 4 (1%) questioning; 3 (.8%) other [2 asexual; 1 asexual andro-romantic]; and 6 (1.5%) did not provide an answer.

Education levels were measured using highest level of education. Based on this, 8 (2%) participants stated that they had some high school/no diploma; 35 (8.8%) high school diploma; 5

(1.3%) GED; 7 (1.8%) vocational or trade school; 97 (24.3%) some college/no degree; 45 (11.3%) associates degree; 91 (22.8%) Bachelor's Degree; 65 (16.3%) Master's Degree; 45 (11.3%) Doctorate Degree; and 1 (.3%) did not respond. Participants reported income included \$25,000 or below ( $n = 96$ ; 24.1%); \$25,001-\$35,000 ( $n = 48$ ; 12%); \$35,001-\$45,000 ( $n = 38$ ; 9.5%); \$45,001-\$55,000 ( $n = 47$ ; 11.8%); \$55,001-\$65,000 ( $n = 25$ ; 6.3%); \$65,001-\$75,000 ( $n = 30$ ; 7.5%); \$75,001-\$85,000 ( $n = 18$ ; 4.5%); \$85,001-\$95,000 ( $n = 15$ ; 3.8%); \$95,001-\$105,000 ( $n = 27$ ; 6.8%); \$105,001 and above ( $n = 54$ ; 13.5%); and 1 (.3%) participant did not answer.

Furthermore, participant BMI scores ranged from 14 to 51.21, with a mean score of 26.52 ( $SD = 6.6$ ). Additionally, 8 (2%) participants fell within the underweight range; 149 (37.3%) participants fell within the normal weight range; 110 (27.6%) participants fell within the overweight range; 120 (30.1%) participants fell within the obese weight range; and 12 (3%) participants did not report height and/or weight data, and therefore, BMI could not be calculated.

## **Procedure**

After approval was received by the Social Sciences Institutional Review Board (SSIRB) of the University of Missouri-Kansas City, recruitment took place through university email listserves and a snowball sampling method using personal contacts and distribution through social media sites, such as Facebook and Reddit. Some specific Latinx groups, such as those within the trans community and from different cultural groups (e.g., Mexican, Brazilian, Venezuelan, Puerto Rican, etc.), were also targeted to provide a wide variety of demographic information to the current study. To take part in the study, participants were required to be at least 18 years of age or older, identify as a Latinx woman, currently live in the United States, and speak English or Spanish (both English and Spanish versions of the study's questionnaire were offered to

participants). There was no cap on the age range due to body image concerns being salient across a women's life span (Tiggemann, 2004). Participants were informed that the purpose of this study was to further understand social experiences and eating patterns for Latinx women. Interested participants then had the opportunity to complete an online survey. The study was administered online due to research indicating that it provides anonymity, and results in less social desirability (Joinson, 1999; Richman, Kiesler, Weisband, & Drasgow, 1999).

To ensure that potential participants met the inclusion criteria, preliminary questions were asked prior to administration of the full survey. Those who did not meet the criteria for the survey were informed that they are ineligible to participate. The online survey was administered using Qualtrics software, a secure web application for building and managing online surveys and databases. The survey took approximately 30 minutes to complete. Survey questions were presented in a randomized order. Five additional items were added to the survey questions to serve as validity checks. For example, a sample validity check item was "To make sure you are paying attention, please select 'almost always' for your response." Participants who did not get four out of the five items correct were eliminated from the study.

Participants had the ability to discontinue the survey at any time without penalty by clicking on a specified button to exit the survey, which took participants to the debriefing page, or by closing the web browser. Participants were also provided with a list of counseling and health care resources, which were accessible at the beginning and end of the survey. Following their participation, participants were eligible to enter a raffle to win one of 15, \$25 Amazon gift cards. This link to the raffle was independent from the participant's survey responses.

All measures were obtained in Spanish from research articles and with permission from the authors. All other materials, such as instructions and confidentiality information, underwent a

translation process. Translation of all measures from English to Spanish, were completed by adhering to guidelines established by the World Health Organization (WHO; 2007). The process involved (a) forward translation into Spanish using a bilingual expert committee approach, (b) blind back translation into English by a professional translator working in the mental health field, (c) ongoing review by a bilingual team to help detect and resolve any inadequate language and concepts of the forward translation and original version, and (d) further restatements of the Spanish versions.

## **Measures**

**Demographics.** Participants were asked to report their ethnic/racial identification, country of origin, age, body mass index, level of education, socioeconomic status (SES) as reflected by average annual household income, gender, sexual orientation, religious affiliation, number of years in the United States, age of arrival to the United States, and generational status; as generation status is an important factor to consider in research with acculturation variables, as each succeeding generation is associated with increased acculturation (Velez & Ungemack, 1995). Participants had the opportunity to take complete the survey in the English or Spanish language. Language was coded in a dichotomous fashion: 0 = English, 1 = Spanish.

**Body mass index (BMI).** Participants were asked to report their height and weight, as greater BMI scores have been linked with poorer body image and greater eating disorder symptoms (e.g., Stice, 2002). BMI has been reported as a reliable and valid assessment of body size (Garrow & Webster, 1985). BMI was calculated as weight in kilograms/height<sup>2</sup> in meters (Cachelin, Monreal, & Juarez, 2006). Thus, weight is first converted to kilograms and height is converted to meters, then weight is divided by height<sup>2</sup>. Research suggests that self-reports are highly correlated with actual heights and weights for Hispanic individuals, and are appropriate to

use in epidemiological and survey studies (Davis & Gergen, 1994). Weight categories for BMI scores were defined as: Underweight, BMI < 18.5; Normal weight, BMI = 18.6-24.9; Overweight, BMI = 25-29.9; and Obese, BMI > 30 (NIH/NHLBI, 1998).

**Sexual objectification.** The Interpersonal Sexual Objectification Scale (ISOS; Kozee et al., 2007) assessed sexually objectifying experiences that participants endured within the past year. The ISOS is a 15-item scale consisting of two subscales: Body Evaluation and Unwanted Explicit Sexual Advances; however, consistent with prior research (i.e., Brewster et al., 2014; Kozee et al., 2007; Velez et al., 2015; Watson et al., 2013), the overall total score was used. Exploratory factor analysis uncovered the two aforementioned factors, and confirmatory factor analysis supported this factor structure (Kozee et al., 2007). The results of this analysis were 15 items, with Factor 1 containing 11 items and Factor 2 containing 4 items, with all items loading on their intended factor (Kozee et al., 2007). The first factor accounted for 41.72% of the total variance, and the second factor accounted for 8.61% of the total variance (Kozee et al., 2007). Through factor analysis, Body Evaluation accounted for 46.68% of the variance; its factor loadings ranged from .51 to .85 (Kozee et al., 2007). The second factor, Unwanted Explicit Sexual Advances, accounted for 9.48% of the variance; its factor loadings ranged from .44 to .71 (Kozee et al., 2007). These factors were significantly positively correlated ( $r = .62$ ) with each other, suggesting a strong positive correlation.

Body evaluation refers to experiences of other people evaluating the participants' bodies, and unwanted explicit sexual advances refers to participants experiencing unsolicited advances from other people. An example question from the Body Evaluation subscale is “How often have you noticed someone staring at your breasts when you are talking to them?” An example question from the Unwanted Explicit Sexual Advances subscale is “How often has someone

made a degrading sexual gesture towards you?” The items are rated on a 5-point Likert scale ranging from 1 (*never*) to 5 (*almost always*) and are averaged to achieve subscale and total scale scores, with higher scores indicating higher levels of interpersonal sexual objectification.

The ISOS has demonstrated strong test–retest reliability over a 3-week period ( $r = .90$ ), as well as convergent and incremental validity with the Schedule of Sexist Events Scale (Klonoff & Landrine, 1995; Kozee et al., 2007). Furthermore, the Cronbach’s alpha in a sample of Latinx women was .94 (Velez et al., 2015). In this study, the ISOS demonstrated excellent internal consistency ( $\alpha = .92$ ).

**Internalization of sociocultural standards of beauty.** The Sociocultural Attitudes Towards Appearance Questionnaire - Internalization (SATAQ-I; Heinberg, Thompson, & Stormer, 1995) was used to measure the level acceptance of standards of appearance endorsed by society. This subscale is derived from the 14-item Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ; Heinberg et al., 1995). The SATAQ-I is comprised of eight items that are rated on a 5-point scale, ranging from 1 (*completely disagree*) to 5 (*completely agree*). Items are summed to attain a total scale score, with higher scores indicating greater levels of internalization. An example question is, “I often read magazines like *Cosmopolitan*, *Vogue*, and *Glamour* and compare my appearance to the models.” Previous factor analyses have indicated that all 8 items load highly on one factor, supporting its unidimensionality (Heinberg et al., 1995; Tylka & Subich, 2004). The subscale has demonstrated good internal consistency among undergraduate women ( $\alpha = .88$ ; Heinberg et al., 1995), and moderate convergent validity with the Eating Disorder Inventory (EDI; Cashel, Cunningham, Landeros, Cokley, & Muhammad, 2003; Garner, 1991). Among a sample of Latinx women, the Cronbach’s alpha was .87 (Velez et al., 2015). In this study, the SATAQ-I demonstrated good internal consistency ( $\alpha = .87$ ).

**Disordered eating behaviors.** The Eating Disorder Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008) is a 28-item measure that assesses a broad range of eating behaviors, feelings, and attitudes, including bulimia nervosa, anorexia nervosa, and binge eating disorder symptomatology. The EDE-Q is derived from the investigator-based Eating Disorder Examination interview (EDE; Fairburn & Cooper, 1993), which is considered the “gold standard” for assessing eating disorders (Guest, 2000, p. 71). The EDE-Q was also selected over other widely used questionnaires because it addresses a particular time frame and specifically assesses the frequency of eating behaviors. Six items recognize the behavioral features of eating disorders by assessing frequency or days the behavior occurred, and 22 items assess the core features of eating disorder symptomatology occurring in the past 28 days. Items are rated on a 7-point Likert-type scale, ranging from 0 (*No days; None of the times; Not at all*) to 6 (*Every day; Every time; Markedly*); with higher scores indicating more eating disturbances. The EDE-Q consists of four clinically derived subscales, each of which encompass five to eight items: dietary restraint, eating concern, weight concern and shape concern; a global score (mean of all subscale scores); and pathogenic behaviors (i.e., binge eating, vomiting, diuretics use, laxative use).

Two studies have examined the factor structure of the EDE-Q (i.e., Hrabosky et al., 2008; Peterson et al., 2007). Peterson and colleagues (2007) conducted an exploratory factor analysis with a sample of 203 adults with full- and sub-threshold BN. Furthermore, Hrabosky and colleagues (2008) conducted both exploratory and confirmatory factor analyses in a sample of 337 adult obese bariatric surgery candidates. Results of both studies also supported the initial four-factor model. The four subscales can be used separately to view specific areas of disordered eating, or can be used to calculate the global score, with higher scores indicating greater pathology (Fairburn & Beglin, 2008). In accordance with other studies (i.e., Darby, Hay, Mond,

Rodgers, & Owen, 2007; Lavender, & Anderson, 2010; Pernick et al., 2006; Rauh, Nichols, & Barrack, 2010; Smith, Hawkeswood, Bodell, & Joiner, 2011), the global score was utilized in the current study to assess disordered eating and was not used for diagnostic purposes. Sample items include “Over the past 28 days, on how many days have you eaten in secret?” and “Over the past 28 days, how dissatisfied have you been with your weight?”

The EDE-Q has been used with a wide variety of populations including Japanese women (Nakai et al., 2014), Persian women (Mahmoodi et al., 2016), undergraduate women (Villarroel, Penelo, Portell & Raich, 2011), high school and college aged men (Reas, Øverås, & Rø, 2012), and Turkish adolescents (Yucel et al., 2011). The scale has demonstrated excellent internal consistency in community members ( $\alpha = .94$ ; Rø, Reas & Stedal, 2015) and eating disorder patients ( $\alpha = .93$ ; Rø et al., 2015). Among undergraduate women, test-retest correlations ranged from .81 to .94 for the four subscales and from .57 to .70 for the frequency of key behavioral features, including binge eating, self-induced vomiting, and laxative misuse (Luce, Crowther, & Pole, 2008). Furthermore, in a sample of 708 Spanish college women, aged 18–30 years, Cronbach’s  $\alpha$  values for the Dietary Restraint subscale yielded .81, the Eating Concern subscale yielded a .82, .92 was found for the Shape Concern subscale, the Weight Concern subscale yielded at .83, and a .95 was reported for the Global Score (Villarroel et al., 2011). In this study, the Cronbach’s  $\alpha$  values for the Dietary Restraint subscale yielded a .81, the Eating Concern subscale yielded a .78, the Shape Concern subscale yielded a .91, the Weight Concern subscale yielded a .82, and the EDE-Q Global Score demonstrated excellent internal consistency ( $\alpha = .94$ ).

In a sample of 5, 255 adult women, with ages ranging from 18–42 years of age, normative data was derived for the four subscales and global score (Mond, Hay, Rodgers, & Owen, 2006).

Mean scores (*SDs*) for the Restraint, Eating Concern, Weight Concern and Shape Concern subscales were, respectively, 1.30 (1.40), 0.76 (1.06), 1.79 (1.51), 2.23 (1.65), and the mean global score was 1.52 (1.25; Mond et al., 2006). Furthermore, in a sample of 723 undergraduate women, with ages ranging from 18-25, normative scores were also collected for all subscale scores and the global score (Luce et al., 2008). Mean scores (*SDs*) for the Restraint, Eating Concern, Weight Concern and Shape Concern subscales were, respectively, 1.62 (1.54), 1.11 (1.11), 1.97 (1.56), 2.27 (1.54), and the global score was 1.74 (1.30; Luce et al., 2008). In the current sample, normative scores for the Restraint, Eating Concern, Weight Concern Shape Concern subscales, and global scores were 2.64 (1.50), 2.07 (1.13), 3.68 (1.59), 3.94 (1.70), and 3.08 (1.27), respectively.

**Acculturation and enculturation.** The Acculturation Rating Scale for Mexican Americans - II (ARSMA-II; Cuéllar et al., 1995) separately measures one's acculturation to mainstream American culture and enculturation to traditional Hispanic culture by assessing four domains: (a) language use and preference, (b) ethnic identity and classification, (c) cultural heritage and ethnic behaviors, and (d) ethnic interaction. There is general consensus among acculturation/enculturation researchers that the ARSMA-II is one of the most advanced acculturation/enculturation scales, both conceptually and methodologically (Kim & Abreu, 2001; Ponterotto, Baluch, & Carielli, 1998). It has two subscales: The 17-item Mexican Orientation Scale (MOS), measuring enculturation, and the 13-item Anglo Orientation Scale (AOS), measuring acculturation, which were both used in this study. Sample items from the AOS include "I like to identify myself as an American," and sample items from the MOS include "I enjoy Spanish language movies." Items are scored on a 5-point Likert-type scale ranging from 1 (*not at all*) to 5 (*extremely often or almost always*) and averaged to achieve subscale scores, with

higher scores indicating higher affiliation/acculturation to mainstream American (Anglo) and Hispanic culture, respectively. The AOS and MOS scores are calculated by averaging the items.

This scale has been used with non-Mexican Latinxs, with items on the MOS being adapted by substituting the word Hispanic/Latinx for the word Mexican (e.g., Haack, Gerdes, & Lawton, 2014); the word Hispanic/Latinx for the word Mexican was also substituted in the current study. The ARSMA-II has shown good internal consistency ( $\alpha = .87$ ) in a sample of Mexican American female college students (Castillo, Conoley, & Brossart, 2004) and good test-retest reliability (.96) over a 1-week period, in a sample of Mexican, Mexican American, and White American college students (Cuéllar et al., 1995). Furthermore, the ARSMA-II has shown good concurrent validity ( $r = .89$ ) with the original ARSMA (Cuéllar, Harris, & Jasso, 1980), and the two cultural orientation subscales were found to have good internal reliabilities, Cronbach's Alphas were .86 and .88 for AOS and MOS, respectively (Cuéllar et al., 1995). In the current study, the AOS yielded an alpha of .75, the MOS yielded an alpha of .89, and the overall ARSMA-II scale score yielded acceptable internal consistency ( $\alpha = .75$ ).

**Acculturative stress.** Acculturative stress was measured using the Multidimensional Acculturative Stress Inventory (MASI; Rodriguez, Myers, Mira, & Garcia-Hernandez, 2002). The MASI scale consists of 36 items that measure acculturative stress. It was developed to assess acculturative stress among those of Mexican origin who are residing in the United States. Participants taking the MASI are first asked to decide whether the stressful event had occurred during the past 3 months, and second to evaluate the stressfulness of that event (Lazarus & Folkman, 1984a). If an event had not been experienced during the past 3 months, participants were asked to indicate 0 (*does not apply*). If an event was experienced during the past 3 months, participants were instructed to rate the stressfulness of that event using a 5-point scale ranging

from 1 (*not at all stressful*) to 5 (*extremely stressful*). Items were averaged to obtain an overall score that ranges from 0 to 5, with higher scores indicating greater acculturative stress.

Principal-components analyses with varimax rotations yielded four stable and internally consistent factors: Spanish Competency Pressures accounted for 28.3% of the variance (7 items; e.g., “I don’t speak Spanish or don’t speak it well”), English Competency Pressures accounted for 20.9% of the variance (7 items; e.g., “It bothers me that I speak English with an accent”), Pressure to Acculturate accounted for 9.4% of the variance (7 items; e.g., “It bothers me when people pressure me to assimilate to the American ways of doing things”), and Pressure Against Acculturation accounted for 5.8% of the variance (4 items; e.g., “I feel uncomfortable because my family members do not know Mexican/Latino ways of doing things”). These four factors accounted for 64.4% of the variance and correlated in the expected directions with criterion measures of acculturation and/or psychological adjustment, providing evidence of construct validity (Rodriguez et al., 2002). The authors suggest averaging all items to obtain an overall score, where higher MASI scores correspond to greater acculturative stress (Rodriguez et al., 2002). Subsequently, the majority of acculturative stress related research also uses an overall score to determine levels of acculturative stress (i.e., Driscoll & Torres, 2013; Sarmiento & Cardemil, 2009; Torres et al., 2012).

The MASI incorporated items that considered pressures originating from the Anglo-American culture and competency in the English language (e.g., “It bothers me that I speak English with an accent”), that were derived from scales developed specifically to assess acculturative (Gil, Vega, & Dimas, 1994; Padilla, Wagatsuma, & Lindholm, 1985;) and psychosocial stresses (Cervantes, Padilla, & Salgado de Snyder, 1991) among those of Mexican origin and other Latino/as. Additional items reflect other acculturative stresses originating from

both the Anglo-American culture (e.g., “I am self-conscious about my American background”) and Mexican culture (e.g., “I am self-conscious about my Mexican/Latino background”), as well as from Spanish language competency (e.g., “I feel pressure to learn Spanish”).

Both the English and Spanish versions of the MASI have been validated with Mexican-origin Latinxs (Rodriguez et al., 2002) and showed excellent internal consistency (Torres, Driscoll, & Voell, 2012). For example, among a sample of 174 Mexican-origin adults, subscales were shown to be reliable for the entire sample (Cronbach’s  $\alpha$ s ranged from .77 to .93), the English subsample (Cronbach’s  $\alpha$ s ranged from .77 to .94), and the Spanish subsample (Cronbach’s  $\alpha$ s ranged from .74 to .91; Rodriguez et al., 2002). Furthermore, within the same sample, test-retest reliability was conducted over a two-week period. Findings indicated that all correlation coefficients were significant, ranging between .53 and .84, indicating acceptable test-retest reliabilities for three of the four subscales (Rodriguez et al., 2002). The only subscale that demonstrated a modest reliability was the Pressure to Acculturate subscale ( $r = .53$ ; Rodriguez et al., 2002). Additionally, among a sample of 469 Latinx adult community members residing in the Midwest, the MASI demonstrated excellent internal consistency (coefficient alpha = .92; Driscoll & Torres, 2013). Furthermore, in the greater metropolitan Los Angeles area, an internal consistency coefficient of .90 was found with 174 adults (117 women, 57 men) of Mexican origin (Rodriguez et al., 2002). In the current study, the overall MASI score demonstrated good internal consistency ( $\alpha = .83$ ).

**Religious and spiritual coping.** Religious and spiritual coping was assessed using the Brief Measure of Religious Coping Styles (Brief RCOPE; Pargament et al., 1998). The Brief RCOPE is a 14-item rating scale composed of two subscales: The Positive Religious Coping subscales assesses religious/spiritual coping that reflects benevolent religious involvement in the

search for significance (Pargament, 1999), whereas the Negative Religious Coping subscale reflects a religious struggle in coping (Pargament, 1999). In development of the two subscales using a college sample, principal components with oblimin rotations was conducted and constrained to create a two-factor model, expected to capture positive and negative patterns of religious coping (Pargament et al., 1998). A two-factor solution appeared to clearly differentiate between positive and negative items (Pargament et al., 1998).

Thus, Pargament and colleagues (1998) reached an acceptable solution, with the two factors accounting for 38% of the variance. Furthermore, confirmatory factor analysis (CFA) of the 14 items was conducted, with results indicating that a two-factor solution is a reasonable fit for the data (Pargament et al., 1998). Pargament and colleagues (1998) also replicated the aforementioned steps with a sample of hospital patients, and results were highly similar to those obtained in college sample (Pargament et al., 1998).

A sample item from the positive religious/spiritual coping subscale is “Looked for spiritual support from my church in this crisis”, and a sample item from the negative religious/spiritual coping subscale is “Wondered whether God had abandoned us”. Items are rated on a 1 (*not at all*) to 4 (*a great deal*) scale, and items are summed to create separate subscale scores, with higher scores indicating more frequent use of the particular coping strategy. Both subscale scores were used in this study.

Among a sample of Hispanic students, negative religious/spiritual coping was strongly associated with negative affect ( $r = .61$ ), psychological distress ( $r = .41$ ), depression ( $r = .42$ ), anxiety ( $r = .32$ ), and somatization ( $r = .28$ ), providing evidence of concurrent validity (Van Dyke, Glenwick, Cecero, & Kim, 2009). Also, with a sample of Hispanic students, the internal consistency of the Positive Religious Coping subscale was .81, and the internal consistency of

the Negative Religious Coping subscale was .71 (Van Dyke et al., 2009). It is important to note that the alpha values obtained in the Van Dyke et al. (2009) study were comparable to the values reported in the initial validation study (i.e., Pargament et al., 1998). In the current study, the Positive Religious Coping subscale demonstrated excellent internal consistency ( $\alpha = .95$ ), and the Negative Religious Coping subscale demonstrated good internal consistency ( $\alpha = .87$ ).

## **Results**

### **Data Cleaning Procedures and Preliminary Analyses**

Preliminary data screening consisted of screening for multicollinearity, nonnormal distribution, nonlinearity, heteroscedasticity, and univariate and multivariate outliers, and missing values (Warner, 2013). Multicollinearity was inspected in order to see if correlations were highly related, which has been suggested to take place at a value greater than the absolute value of .85 (Kline, 2011). In the current study, none of the variables reached the specified correlation value, indicating that multicollinearity was not present. To assess for skew and kurtosis among study variables, skewness values were expected to be in the range of  $|\lt 3|$  and kurtosis values were expected in the range of  $|\lt 10|$ . Moreover, histograms were visually inspected on each variable to examine the shape of the distributions among study variables. In the current study, none of the endogenous variables demonstrated skew or kurtosis; therefore, no corrections for normality were made.

Furthermore, to assess for the assumption of linearity and homoscedasticity between variables, scatterplots were employed. A scatterplot of the residuals against the outcome values predicted by the model, also known as a *zpred vs. zresid* plot (Field, 2013), were created in order to locate potential violations of assumptions. Based on the scatterplots, violations of linearity and homoscedasticity were not observed; therefore, no corrections were made to the dataset.

Moreover, extreme scores were also evaluated. To locate extreme univariate outliers, all scores were converted to  $z$ -score values to standardize the scores for comparison. This ensured that each score had a  $M$  of 0 and a  $SD$  of 1.  $Z$ -score values with absolute values of 3  $SD$  above or below the mean with a 99% confidence level;  $p < .001$ . Once identifying these outliers, they were visually inspected in order to attempt to determine the reason behind the extreme score (e.g., inattentive responding suggested by scoring 1 across all items). In the current study, two cases met criteria for being univariate outliers, both from the EDE-Q measure. These cases were removed from the dataset. Data was also screened for multivariate outliers using the Mahalanobis test to see which values were within acceptable limits (Barnett & Lewis, 1978, as cited in Field, 2009). In the current study, 12 cases were removed due to being outside the acceptable limits, and thus meeting criteria for multivariate outliers.

To handle missing values, cases with excessive missing data at the item level (i.e., missing more than 25% for any given case; Kline, 2011) were removed. In the current study, 120 cases in the English version of the questionnaire were removed, and 50 cases were removed in the Spanish version of the questionnaire for excessive missing data. For cases with less than 25% of the data missing, Little's Missing Completely at Random (MCAR) test was used to assess if values were missing at random or missing completely at random (a significant  $p$ -value suggests that data are not missing completely at random) (Kline, 2011; Little & Rubin, 2002). If these criteria are met, missing values will then be imputed through an imputation procedure, expectation maximization (Kline, 2011). In the current study, The Little's MCAR test resulted in a non-significant chi-square = 7999.02 ( $df = 807984$ ;  $p = .45$ ), indicating that the data was MCAR.

Expectation maximization (EM) was used to replace missing values (Hill, 1997). Each iteration is comprised of an “E” step and an “M” step (Hill, 1997). The E step locates the provisional expectation of the “missing” data, which are within the observed values and the parameter estimates and are then substituted for the “missing” data (Hill, 1997). The M step’s maximum likelihood estimates of the parameters are computed as though the missing data had been filled in (Hill, 1997). New regression equations are then calculated for each variable predicted by all others (Graham, 2009). During the E step, these regression equations are then used to update the best guess for missing values (Graham, 2009). This process then continues until changes from iteration to iteration are so small that they are judged to be trivial; this is when EM is said to have converged (Graham, 2009).

Furthermore, exploratory factor analyses (EFA) for all variables were conducted for English measures. Due to the small number of Spanish speaking participants ( $n = 25$ ), EFAs could not be computed for Spanish measures. Items were restricted to load onto a single factor for their respective scale (Field, 2013). An exception to this is the Brief RCOPE and the ARMSA-II, in which it is expected that items will load onto their respective positive and negative religious coping and Mexican orientation and Anglo orientation subscales, respectively.

Sampling adequacy was observed by utilizing the Kaiser-Meyer-Olkin (KMO; Kaiser, 1970). The KMO was calculated for each scale and is representative of the ratio of the squared correlation between variables to the squared partial correlation between variables (Field, 2013). The KMO statistic varies between 0 and 1, with 0 indicating that the sum of partial correlations is large relative to the sum of correlations. A score of 0 indicates diffusion in the pattern of correlations (Field, 2013). A value close to 1 indicates that patterns of correlations are relatively compact, and thus factor analysis should yield distinct and reliable factors (Field, 2013).

It is recommended that values below .5 should not be accepted, and changes should be made to the data (i.e., collecting more data, changing the inclusion variables; Kaiser, 1974). Recommended guidelines for interpreting values include “miserable” (values in the .50s), “mediocre” (values in the .60s), “middling” (values in the .70s), “meritorious” (values in the .80s), and “marvelous” (values in the .90s; Hutcheson & Sofroniou, 1999). In the current study, all individual KMO values for each English measure were above the recommended value of .5 (see Table 1).

Bartlett’s test of sphericity was also examined. Bartlett’s test examines whether the variance-covariance matrix is proportional to an identity matrix (i.e., covariances are zero and variances are roughly equal; Field, 2013). Thus, if the value is significant (i.e.,  $p < .05$ ), the correlations between variables are, overall, significantly different from zero (Field, 2013). Items were restricted to load onto a single factor, and factor loadings of each item were examined, and items with values greater than or equal to .32 were retained.

The majority of the scales did not appear to lack evidence of construct validity within this sample, as most items were greater or equal to .32. Therefore, no modifications were made to the following scales/subscales: ISOS, SATAQ, EDE-Q, PosRCOPE, and NegRCOPE. In contrast, the following scales/subscales did not meet the aforementioned requirements: AOS, MOS, and MASI. Because these pre-existing scales/subscales have demonstrated evidence of unidimensionality and/or are recommended to be used as total scale scores (i.e., MASI), no modifications were made (see Measures section).

Table 1. *Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) and Bartlett's test of sphericity*

Variable	KMO	Bartlett's	Range of Factor Loadings
1. ISOS	.91	3316.89***	.51 - .80
2. SATAQ	.91	1356.03***	.50 - .83
3. AOS	.77	1235.07***	.25 - .69
4. MOS	.90	2624.55***	.18 - .81
5. MASI	.83	4098.81***	-.08 - .67
6. EDE-Q	.93	5866.50***	.39 - .82
7. PosRCOPE	.92	2779.09***	.71 - .95
8. NegRCOPE	.86	1260.56***	.42 - .84

*Note.*  $N = 374$ . ISOS = Interpersonal Sexual Objectification Scale; SATAQ = Sociocultural Attitudes Towards Appearance Questionnaire—Internalization; AOS = Anglo Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Acculturation; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; MASI = Multidimensional Acculturative Stress Inventory; EDE-Q = Eating Disorder Examination Questionnaire; PosRCOPE = Positive religious coping subscale of the Brief Measure of Religious Coping Styles; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles. Statistical significance: \*\*\* $p < .001$ .

Next, bivariate correlations were examined. Benchmarks were used to describe correlations as being small ( $r = .10$ ), medium ( $r = .30$ ), or large ( $r = .50$ ; Cohen, 1992). Most significant correlations were in the expected direction. Experiences of sexual objectification were significantly positively related to: internalization of sociocultural standards of beauty, demonstrating a small effect ( $r = .14, p < .01$ ); acculturative stress, demonstrating a medium effect ( $r = .33, p < .01$ ); negative religious coping, demonstrating a small effect ( $r = .21, p < .01$ );

and to disordered eating, demonstrating a small effect ( $r = .24, p < .001$ ). However, sexual objectification and acculturation were not significantly related ( $p = .21$ ).

Internalization of sociocultural standards of beauty was significantly positively related to: acculturative stress, demonstrating a small effect ( $r = .23, p < .01$ ); negative religious coping, demonstrating a small effect ( $r = .18, p < .01$ ); and to disordered eating, demonstrating a large effect ( $r = .49, p < .01$ ). However, internalization and acculturation were not significantly related ( $p = .39$ ). Acculturation and acculturative stress were significantly negatively related, demonstrating a small effect ( $r = -.11, p < .05$ ); and acculturation was significantly positively related to disordered eating, demonstrating a small effect ( $r = .11, p < .05$ ). However, acculturation was not significantly related to negative religious coping ( $p = .16$ ). Acculturative stress was significantly positively related to negative religious coping and disordered eating, demonstrating small effect ( $r = .15, p < .01$ ) and medium effect ( $r = .34, p < .01$ ) sizes, respectfully. Negative religious coping was significantly positively related to disordered eating, demonstrating a small effect ( $r = .17, p < .01$ ). Furthermore, as predicted, significant negative correlations were found between enculturation and internalization of sociocultural standards of beauty, demonstrating a small effect ( $r = -.14, p < .01$ ); and between enculturation and disordered eating, demonstrating a small effect ( $r = -.18, p < .01$ ). Alternatively, correlations between positive religious coping and internalization ( $p = .32$ ), and among positive religious coping and disordered eating ( $p = .65$ ), were non-significant.

Additionally, bivariate correlations between control variables (i.e., age, language, generational status, and BMI) and the variables under investigation were examined. Age was significantly negatively correlated with sexual objectification, demonstrating a small effect ( $r = -.23, p < .01$ ); internalization, demonstrating a small effect ( $r = -.26, p < .01$ ); acculturative stress,

demonstrating a small effect ( $r = -.26, p < .01$ ); and negative religious coping, demonstrating a small effect ( $r = -.12, p < .05$ ). Alternatively, age was significantly positively correlated with acculturation, demonstrating a small effect ( $r = .12, p < .05$ ).

Language was significantly negatively related to sexual objectification, demonstrating a small effect ( $r = -.15, p < .01$ ); internalization, demonstrating a small effect ( $r = -.16, p < .01$ ); acculturation, demonstrating a small effect ( $r = -.27, p < .01$ ); and significantly positively related to positive religious coping, demonstrating a small effect ( $r = -.14, p < .01$ ). BMI was significantly negatively related to sexual objectification, demonstrating a small effect ( $r = -.11, p < .05$ ); significantly positively related to acculturation, demonstrating a small effect ( $r = .12, p < .05$ ); and disordered eating, demonstrating a small effect ( $r = .29, p < .01$ ). Lastly, generational status was only significantly positively correlated with acculturation, demonstrating a small effect ( $r = .24, p < .01$ ; see Table 2). These results informed two hierarchical regression.

Table 2. *Bivariate correlations*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	<i>M</i>	<i>SD</i>
1. ISOS													2.30	.69
2. SATAQ	.14**												2.86	.88
3. AOS	-.06	.04											3.74	.53
4. MASI	.33**	.23**	-.11*										2.03	.81
5. PosRCOPE	-.04	-.05	-.02	-.09									2.50	1.04
6. NegRCOPE	.21**	.18**	-.07	.15**	.29**								1.50	.63
7. EDE-Q	.24**	.47**	.11*	.34**	-.02	.17**							3.08	1.27
8. Age	-.23**	-.26**	.12*	-.26**	.03	-.12*	-.05						29.07	9.71
9. Language	-.15**	-.16**	-.27**	-.08	.14**	.02	-.06	.16**					.06	.24
10. GenStatus	-.06	-.02	.24**	-.01	.07	-.01	.08	.10	-.14*				2.02	1.10
11. BMI	-.11*	-.05	.12*	.01	-.09	-.01	.29**	.30**	.00	.03			27.78	6.65
12. MOS	.02	-.14**	-.29**	-.05	.19**	.03	-.18**	-.08	.27**	-.43**	-.09		3.66	.70

*Note.* *N* = 399. ISOS = Interpersonal Sexual Objectification Scale; SATAQ = Sociocultural Attitudes Towards Appearance

Questionnaire—Internalization; AOS = Anglo Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Acculturation; MASI = Multidimensional Acculturative Stress Inventory; PosRCOPE = Positive religious coping subscale of the Brief Measure of Religious Coping Styles; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; EDE-Q = Eating Disorder Examination Questionnaire; Age = Measuring age in years; Language = Coded 1 for Spanish, 0 for English; GenStatus = Generational Status; BMI = Body Mass Index; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; *M* = mean; *SD* = standard deviation. Statistical significance: \**p* < .05, \*\**p* < .01

## Data Analytic Plan

**Moderation analysis.** Moderation occurs when the strength of the relationship between two variables is dependent on a third variable (Preacher, Rucker, & Hayes, 2007). According to Frazier, Tix, and Barron (2004), hierarchical multiple regression is a suitable method for examining moderation effects. The current examined the moderating effects of positive and negative religious/spiritual coping in the links from sexual objectification experiences, acculturation, enculturation, and acculturative stress to internalization of sociocultural standards of beauty.

To test for moderation, several interaction terms were created. Prior to creating the interaction terms, all predictor variables were centered around the grand mean (Field, 2013), in order to provide a meaningful zero point for the interpretations (Frazier et al., 2004). The interaction terms were created by multiplying the appropriate mean centered variables together to create the moderating variables. The following interaction terms were created:

Objectification X Positive Religious Coping, Objectification X Negative Religious Coping, Acculturation X Positive Religious Coping, Acculturation X Negative Religious Coping, Acculturative Stress X Positive Religious Coping, Acculturative Stress X Negative Religious Coping, Enculturation X Positive Religious Coping, and Enculturation X Negative Religious Coping.

After creating the interaction terms, two separate hierarchical multiple regression models were conducted, one for each outcome variable (i.e., internalization and disordered eating). The first model examined internalization as the dependent variable. Age and language use were entered in the first stage of the regression since they were significantly correlated with internalization in the aforementioned bivariate correlations. The first block was statistically

significant,  $R = .28$ ,  $R^2 = .08$ , adjusted  $R^2 = .08$ ,  $F(2, 396) = 17.05$ ,  $p < .001$ . The variables entered in block 1 explained 7.9% of the variance in internalization. Specifically, both covariates were uniquely statistically significant and had small effect sizes: age ( $\beta = -.24$ ,  $p < .001$ ) and language ( $\beta = -.12$ ,  $p < .05$ ).

In the second block, sexual objectification, acculturation, acculturative stress, enculturation, positive religious coping, and negative religious coping terms were entered. Block 2 was also statistically significant,  $R = .38$ ,  $R^2 = .15$ , adjusted  $R^2 = .13$ ,  $F(8, 390) = 8.27$ ,  $p < .001$ . The variables entered in block 2 explained 13% of the variance in internalization. The change in  $R^2$  from block 1 to block 2 was  $.07$  ( $p < .001$ ), with the significant predictor variables in block 2 explaining half of the variance in internalization. Specifically, four of the eight predictor variables were uniquely statistically significant and had small effect sizes: age ( $\beta = -.20$ ,  $p < .001$ ), negative religious coping ( $\beta = .15$ ,  $p < .05$ ), acculturative stress ( $\beta = .15$ ,  $p < .05$ ), and enculturation ( $\beta = -.12$ ,  $p < .05$ ). Each interaction term was also tested separately in block 3; however, each interaction term was still non-significant. Specifically, ISOSXPosRCOPE ( $B = -.05$ ,  $SE = .06$ ,  $\beta = -.04$ ,  $p = .43$ ), ISOSXNegRCOPE ( $B = -.05$ ,  $SE = .09$ ,  $\beta = -.03$ ,  $p = .56$ ), AOSXPosRCOPE ( $B = -.037$ ,  $SE = .08$ ,  $\beta = -.02$ ,  $p = .64$ ), AOSXNegRCOPE ( $B = .21$ ,  $SE = .13$ ,  $\beta = .08$ ,  $p = .10$ ), MOSXPosRCOPE ( $B = .05$ ,  $SE = .06$ ,  $\beta = .04$ ,  $p = .35$ ), MOSXNegRCOPE ( $B = .02$ ,  $SE = .09$ ,  $\beta = .01$ ,  $p = .84$ ), MASIXPosRCOPE ( $B = -.06$ ,  $SE = .05$ ,  $\beta = -.06$ ,  $p = .12$ ), and MASIXNegRCOPE ( $B = -.03$ ,  $SE = .09$ ,  $\beta = -.01$ ,  $p = .78$ ).

Thus, no evidence was found to support negative religious/spiritual coping strengthening (i.e., exacerbating) the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to more disordered eating (Hypothesis 2b). Thus, Hypothesis 2b was not supported. Results also revealed

that no evidence was found to support positive religious/spiritual coping buffering or rendering the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to less disordered eating (Hypothesis 2c). Thus, Hypothesis 2c was not supported. In addition, no evidence was found to support negative religious/spiritual coping rendering the negative relationship between enculturation and internalization non-significant or weakening this relation (Hypothesis 2d). And, no evidence was found to support positive religious/spiritual coping strengthening the negative relation between enculturation and internalized sociocultural standards of beauty (Hypothesis 2e). Rather, results of this regression analysis suggested that age, language, negative religious coping, acculturative stress, and enculturation were statistically significant predictors of internalization of sociocultural standards of beauty. Regression statistics are reported in Table 3.

Table 3. Summary of Hierarchical Regression Predicting Internalization of Sociocultural Standards of Beauty

Step	Variables	B	SE	$\beta$	<i>t</i>	<i>R</i>	<i>R</i> <sup>2</sup>	<i>R</i> <sup>2</sup> Change
1	Main Effects					.28	.08***	
	Language	-.43	.18	-.12*	-2.41			
	Age	-.02	.00	-.24***	-4.86			
2	Main Effects					.38	.15***	.07***
	Language	-.24	.19	-.07	-1.25			
	Age	-.02	.01	-.20***	-3.96			
	ISOS	.01	.07	.01	.20			
	MOS	-.15	.06	-.12*	-2.28			
	AOS	.07	.09	-.04	.84			
	MASI	.16	.06	.15**	2.84			
	PosRCOPE	-.04	.04	-.04	-.83			
	NegRCOPE	.22	.07	.15**	3.03			

*Note.* *N* = 399. Age = Measuring age in years; Language = Coded 1 for Spanish, 0 for English; ISOS = Interpersonal Sexual Objectification Scale; AOS = Anglo Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Acculturation; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring

Enculturation; MASI = Multidimensional Acculturative Stress Inventory; PosRCOPE = Positive religious coping subscale of the Brief Measure of Religious Coping Styles; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; SATAQ = Sociocultural Attitudes Towards Appearance Questionnaire—Internalization.  $\beta$  reflects values for the final regression equation. Statistical significance: \* $p < .05$ .; \*\* $p < .01$ ; \*\*\* $p < .001$

Next, a second two-step hierarchical multiple regression was conducted with disordered eating as the dependent variable. BMI was entered at stage one of the regression since this variable was significantly positively related to disordered eating in the bivariate correlations. The first block was statistically significant,  $R = .29$ ,  $R^2 = .08$ , adjusted  $R^2 = .08$ ,  $F(1, 389) = 35.50$ ,  $p < .001$ . BMI was statistically significant, with a near-moderate effect size ( $\beta = .29$ ,  $p < .001$ ), and explained 8.4% of the variance in disordered eating. In the second block, sexual objectification, internalization, acculturation, acculturative stress, enculturation, positive religious coping, and negative religious coping terms were entered. The second block was also statistically significant,  $R = .65$ ,  $R^2 = .42$ , adjusted  $R^2 = .41$ ,  $F(8, 382) = 34.77$ ,  $p < .001$ . The variables entered in block 2 explained 41% of the variance in disordered eating. The change in  $R^2$  from block 1 to block 2 in the regression analysis was .34 ( $p < .001$ ), with the significant predictor variables explaining half of the variance in disordered eating. Specifically, five of the eight predictor variables were statistically significant, with internalization demonstrating stronger effects ( $\beta = .42$ ,  $p < .001$ ) than BMI ( $\beta = .32$ ,  $p < .001$ ), acculturative stress ( $\beta = .19$ ,  $p < .001$ ), sexual objectification ( $\beta = .16$ ,  $p < .001$ ), and enculturation ( $\beta = -.08$ ,  $p < .05$ ). Regression statistics are reported in Table 4.

Table 4. *Summary of Hierarchical Regression Predicting Disordered Eating*

Step	Variables	B	SE	$\beta$	<i>t</i>	<i>R</i>	<i>R</i> <sup>2</sup>	<i>R</i> <sup>2</sup> Change
1	Main Effects					.29	.08***	
	BMI	-.06	.01	.29***	5.96			
2	Main Effects					.65	.42***	.34***
	BMI	.06	.01	.32***	7.99			
	MOS	-.15	.08	-.08*	-2.00			
	AOS	.14	.10	.06	1.36			
	ISOS	.29	.08	.16***	3.69			
	SATAQ	.61	.06	.42***	10.20			
	MASI	.30	.07	.19***	4.50			
	PosRCOPE	.07	.05	-.04	-.83			
	NegRCOPE	.04	.09	.02	.44			

*Note.*  $N = 399$ . BMI = Body Mass Index; SATAQ = Sociocultural Attitudes Towards Appearance Questionnaire—Internalization; ISOS = Interpersonal Sexual Objectification Scale; AOS = Anglo Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Acculturation; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; MASI = Multidimensional Acculturative Stress Inventory; PosRCOPE = Positive religious coping subscale of the Brief Measure of Religious Coping Styles; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; EDE-Q = The Eating Disorder Examination Questionnaire.  $\beta$  reflects values for the final regression equation. Statistical significance: \* $p < .05$ .; \*\* $p < .01$ ; \*\*\* $p < .001$

**Path analysis.** The path analysis was conducted in AMOS, using maximum likelihood estimation, means and intercepts were not estimated, and multiple fit indices were observed, as suggested by Kline (2011). For example, Model chi-square is a badness-of-fit model, indicating that lower values demonstrate better fit. Therefore, a non-significant chi-square indicates that the data was a good fit to the theoretical model (Kline, 2011). Furthermore, Root Mean Square Error of Approximation (RMSEA) is an additional badness-of-fit model, with appropriate values for this index ranging between .00 and .05 (Kline, 2011). Standardized Root Mean Square Residual (SRMR) measures the difference between observed and predicted correlations of a model. In SRMR, adequate values range between .00 and .08 (Kline, 2011). Moreover, the comparative fit index (CFI) is a goodness of fit index, and a threshold of .95 is recommended for model fit. All possible paths were examined in order to see which reach statistical significance, and to determine if the pattern of results is consistent with hypotheses.

To determine effect sizes (i.e., the strength of a relationship between variables), standardized beta ( $\beta$ ) values were also examined. Cohen's  $d$  values can be used to determine effect sizes (Cohen, 1992), and will be used in the current study to gauge the size of the beta weights. Cohen's  $d$  can be utilized to describe the standardized mean difference of an effect, which can be used to compare effects across studies; even when the dependent variables are measured in different ways (Lakens, 2003). Cohen (1988, 1992) suggested the following benchmarks:  $d = 0.2$  (small),  $d = 0.5$  (medium),  $d = 0.8$  (large). Lastly, variance (i.e.,  $R^2$ ) was examined among endogenous variables in order to consider the practical significance of the findings. Bootstrapping procedures with 5,000 (bias-corrected and accelerated) samples were also utilized to adjust standard errors and provide robust and conservative estimates for direct and indirect effects. Precisely, bias-corrected 95% confidence intervals (CI) that do not contain

zero indicate significant indirect effects. Maximum likelihood (ML) estimation was also utilized in the current analysis.

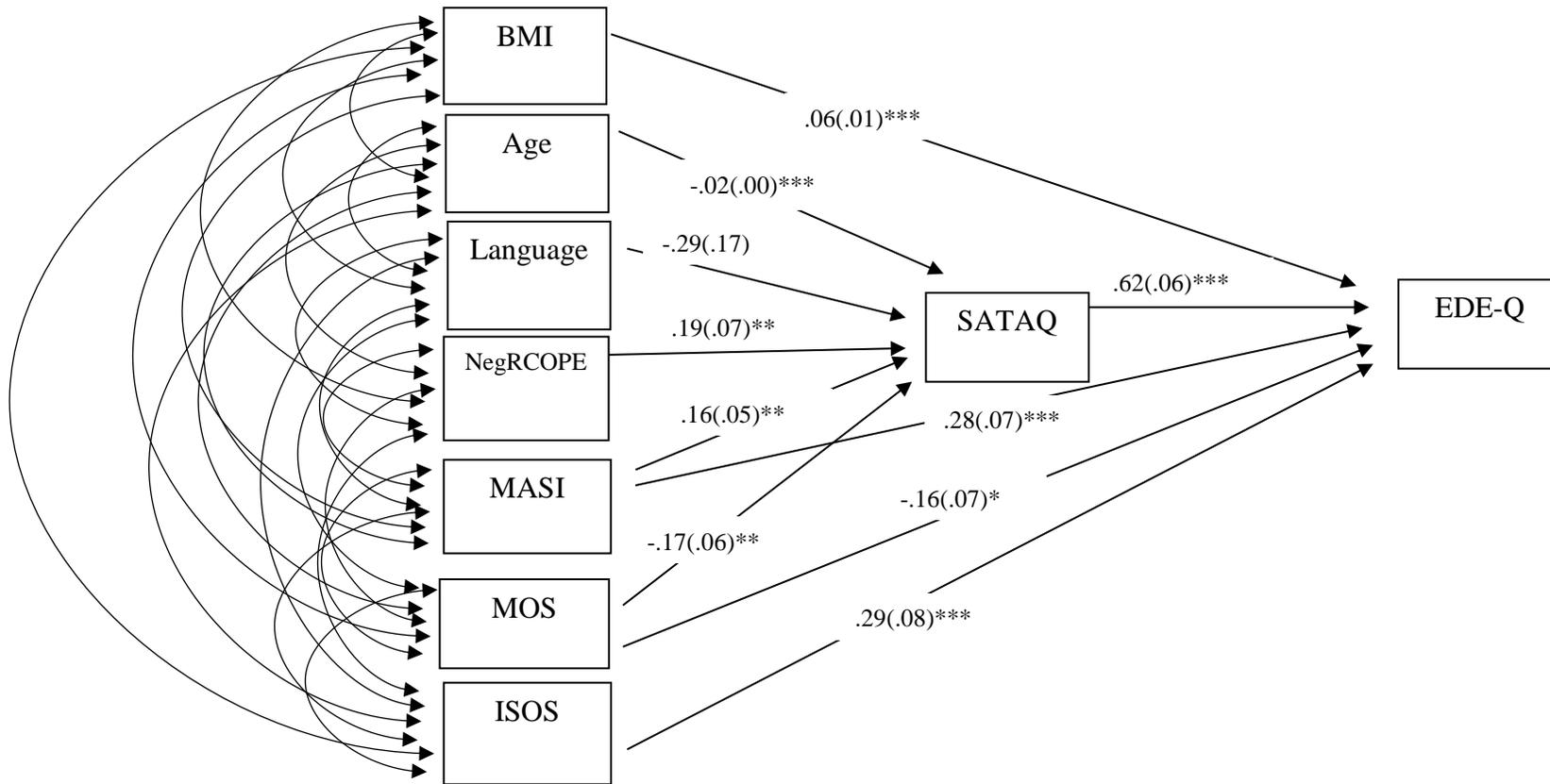
The present model is theoretically identified, as it is recursive in nature (uncorrelated disturbances, all causal effects are unidirectional, no feedback loops) and has degrees of freedom greater than zero ( $df = 5$ ). In the current study, results of the mediation path analysis suggested excellent data to model fit:  $\chi^2 = 5.34$  (non-significant [ $p = 0.37$ ]), CFI = .99, RMSEA = .01, 90% CI [.00, .07], and SRMR = .01. No standardized residual values for the model surpassed |2.00|, demonstrating good local-fit of the data. Since the proposed model produced adequate model fit, modification indices were not consulted to assess for respecification, and the model was not respecified based on theoretical rationale.

Combined, all of the predictors in the model appear to account for approximately 42% of the variance in disordered eating, and 14% of the variance in internalization. Paths from enculturation, acculturative stress, negative religious coping, and age to internalization were all statistically significant, and in the expected directions,  $p < .05$ . Yet, the path from language to internalization was nonsignificant,  $p > .05$ , indicating that language does not appear to directly predict internalization when examined with the additional independent variables (see Figure 1 for direct path coefficients, and Table 6 for bootstrapped standard errors). Paths from sexual objectification, internalization, enculturation, acculturative stress, and BMI to disordered eating behaviors were also significant and in the expected directions,  $p < .05$ .

Furthermore, correlations from BMI, negative religious coping, age, and language with sexual objectification were statistically significant,  $p < .05$ . Correlations from sexual objectification, negative religious coping, and age with acculturative stress were statistically significant,  $p < .05$ . Enculturation and language were significantly positively correlated,  $p < .05$ .

BMI and age were significantly positively correlated,  $p < .05$ . Negative religious coping and age were significantly negatively correlated,  $p < .05$ . Finally, age and language were significantly positively correlated,  $p < .05$ .

Results revealed that internalization of sociocultural standards of beauty partially mediated the relationship between enculturation to disordered eating (Hypothesis 2a:  $b = 0.04$ ; 95% CI = -0.18 to -0.03,  $p = .01$ ,  $\beta = 0.02$ ) the relationship between acculturative stress to disordered eating (Hypothesis 2a:  $b = 0.03$ ; 95% CI = 0.03 to 0.17,  $p = .01$ ,  $\beta = 0.02$ ). Furthermore, internalization of sociocultural standards of beauty also fully mediated the relationship between negative religious/spiritual coping and disordered eating ( $b = 0.05$ ; 95% CI = 0.03 to 0.22,  $p = .01$ ,  $\beta = 0.02$ ). Some hypotheses were not examined since the relations were non-significant in the preceding regression analyses; therefore, no evidence was found to support internalization of sociocultural standards of beauty mediating the relationship between sexual objectification to disordered eating (Hypothesis 2a), or internalization of sociocultural standards of beauty mediating the relationship between acculturation to disordered eating (Hypothesis 2a). Thus, Hypothesis 2a was partially supported.



*Figure 1. Standardized estimates of model. Note. N = 399. BMI = Body Mass Index; SATAQ = Sociocultural Attitudes Towards Appearance Questionnaire—Internalization; ISOS = Interpersonal Sexual Objectification Scale; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; MASI = Multidimensional Acculturative Stress Inventory; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; EDE-Q = The Eating Disorder Examination Questionnaire; Age = Measuring age in years; Language = Coded 1 for Spanish, 0 for English. Standardized regression weights reported, with unstandardized regression weights in parentheses. Statistical significance: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$*

Table 5. *Correlations among variables.*

Variable	1	2	3	4	5	6	7	<i>M</i>	<i>SD</i>
1. NegRCOPE								1.49	.63
2. BMI	-.01							27.78	6.65
3. Age	-.12*	.29**						29.07	9.71
4. Language	.02	.00	0.16**					.06	.24
5. MOS	0.03	-0.08	-0.07	0.27**				3.66	.70
6. ISOS	0.21**	-0.11*	-0.23**	-0.15**	0.02			2.30	.69
7. MASI	0.15**	0.01	-0.26**	-0.08	-0.05	0.33**		2.03	.81

*Note.* *N* = 399. ISOS = Interpersonal Sexual Objectification Scale; MASI = Multidimensional Acculturative Stress Inventory; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; Age = Measuring age in years; BMI = Body Mass Index; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; *M* = mean; *SD* = standard deviation; Language = Coded 1 for Spanish, 0 for English. Statistical significance: \**p* < .05, \*\**p* < .01

Table 6. *Bootstrapped Standard Errors.*

Variable	SATAQ	EDE-Q
1. NegRCOPE	.07**	
2. BMI		.01***
3. Age	.00***	
4. Language	.17	
5. MOS	.06**	.07*
6. ISOS		.08***
7. MASI	.05**	.07***
8. SATAQ		.06***

*Note.*  $N = 399$ . ISOS = Interpersonal Sexual Objectification Scale; MASI = Multidimensional Acculturative Stress Inventory; NegRCOPE = Negative religious coping subscale of the Brief Measure of Religious Coping Styles; Age = Measuring age in years; BMI = Body Mass Index; MOS = Mexican Orientation Scale of The Acculturation Rating Scale for Mexican Americans – II, measuring Enculturation; SATAQ = Sociocultural Attitudes Towards Appearance Questionnaire—Internalization; Language = Coded 1 for Spanish, 0 for English. Statistical significance: \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

## Discussion

### Hypothesis 1

At the bivariate level, results suggested that experiences of sexual objectification were related to more internalization of sociocultural standards of beauty, acculturative stress, negative religious coping, and disordered eating. These findings indicate that as sexually objectifying experiences increase, so does internalization, acculturative stress, negative religious coping, and disordered eating, and vice versa. Furthermore, the findings explaining that sexual objectification experiences were positively correlated with disordered eating is consistent with some of the tenets of objectification theory (Fredrickson & Roberts, 1997), as well as prior research (i.e., Velez et al., 2015). However, contrary to predictions, no significant relationship was found between sexual objectification and acculturation (Hypothesis 1).

To date, objectification theory has yet to attend to the role of acculturation in its framework. Instead, acculturation has been examined in relation to body image variables, but not within the objectification theory framework. An example of this area of research can be seen predominantly focusing on the role of body dissatisfaction, and disordered eating in women's lives (e.g., Bettendorf & Fischer, 2009; Gordon et al., 2010; Joiner & Kashubeck, 1996; Lester & Petrie, 1995; Poloskov & Tracey, 2013), and acculturation with internalization of sociocultural standards of beauty (e.g., Blow, Taylor, Cooper, & Redfern, 2010). In future research, utilizing bilinear models may help provide a more accurate reflection of the role of acculturation within in the lives of Latinx women. Thus, exploring the development of cultural orientations to both the dominant culture and the culture of origin, as opposed to unilinear models that conceptualize acculturation and enculturation as movement on a single continuum (i.e., acculturation occurs in expense of enculturation (Cuéllar et al., 1995; Kim & Abreu, 2001; Zea, Asner-Self, Birman, & Buki, 2003)).

Moreover, a positive correlation was noted between sexual objectification and negative religious/spiritual coping. This correlation suggests that as sexually objectifying experiences increase, so does negative religious/spiritual coping. To our knowledge, the current study is one of the first to incorporate religious/spiritual coping into the objectification theory framework, though the findings are comparable to similar research findings. For example, the current findings align with previous research indicating that negative religious coping has predicted worse overall mental health symptomology (i.e., depression; Hebert, Zdaniuk, Schulz, & Scheier, 2009), while sexually objectifying experiences has also predicted such ailments as depression symptomology (Velez et al., 2015). It is possible that as women experience more sexually objectifying treatment, they may be more inclined to call upon negative religious coping mechanisms in order to deal with the associated distress.

Moreover, acculturative stress was positively correlated with negative religious/spiritual coping, suggesting that as acculturative stress increases, so does negative religious/spiritual coping; and vice versa. Our findings coincide with previous research on the relationship between acculturative stress and negative religious/spiritual coping. For example, among a sample Latinx immigrants, higher levels of acculturative stress was associated with both an increase in positive and negative religious coping strategies (Sanchez, Dillon, Concha, & De La Rosa, 2015). In the current study, only negative religious coping was utilized among the sample comprised of women. This may shed light on the way that women in Latinx cultures are coping with acculturative stress. As acculturative stress has been found to negatively impact the physical and mental health of Latinx immigrants (Sanchez, Dillon, Ruffin, & De La Rosa, 2012), it appears highly important that the relationship between acculturative stress and negative religious coping are further investigated, particularly with Latinx women.

Furthermore, as predicted, enculturation was negatively correlated with internalization of sociocultural standards of beauty and disordered eating, indicating that as enculturation increases, internalization and disordered eating decreases. In contrast, as enculturation levels decrease, internalization and disordered eating behaviors tend to increase (Hypothesis 1). To date, no studies have analyzed the role of enculturation in this context. Typically, highly acculturated individuals tend to adopt the cultural practices of the dominant society where they reside, while less acculturated or enculturated individuals tend to preserve many of the traditions practiced in their former country (Hwang & Ting, 2008). In theory, the more acculturated an individual is to the mainstream culture of the United States, the more likely they will be to internalize the Westernized thin ideal, which would effectively increase the likelihood of developing disordered eating (Gordon et al., 2010; Warren, Castillo, & Gleaves, 2010). Conversely, those who are more enculturated may be more likely to reject the Westernized thin ideal. Thus, enculturation may act as a protective factor in the development and maintenance of internalization of Westernized beauty standards and disordered eating behaviors.

Moreover, contrary to predictions, positive religious coping was not significantly correlated with internalization or disordered eating (Hypothesis 1). To date, objectification theory related research has not explored the relationship between internalization and positive religious coping. The result of no correlation between positive religious coping and internalization may have occurred due to the majority of research supporting the relationship between adverse events and more negative religious coping. For example, research suggests that greater levels of negative religious coping are associated with higher levels of depression, anxiety, obsessive-compulsiveness, somatization, obesity and trauma (Bryant-Davis & Wong 2013; Pirutinsky et al. 2012), all of which possess comorbidity with disordered eating behaviors (Treasure et al. 2010).

Furthermore, these results appear to be consistent with previous literature, suggesting that unlike positive religious coping, a greater use of negative religious coping was associated with higher levels of disordered eating pathology (Latzer et al., 2015; Rider, Terrell, Sisemore, & Hecht, 2014). In comparison, it appears that negative religious coping may be a more salient construct than positive coping in relation with disordered eating (Latzer et al., 2015).

## **Hypothesis 2**

When examining internalization as a dependent variable, results suggested that, when sexual objectification, acculturation, acculturative stress, enculturation, negative religious coping, and positive religious coping were examined concurrently, only acculturative stress and negative religious coping positively predicted internalization of sociocultural standards of beauty, while controlling for language and age (Hypothesis 2). These findings suggest that sexual objectification, acculturation, and positive religious coping may not uniquely predict internalization in the presence of acculturative stress, enculturation, and negative religious coping.

Consistent with prior research with Latinx women, nonsignificant links were also noted between sexual objectification and internalization (e.g., Velez et al., 2015). However, this finding diverges from prior objectification theory research with samples of White (i.e., Kozee et al., 2007; Wiseman & Moradi, 2010), African American (i.e., Mitchell & Mazzeo, 2009; Watson et al., 2013), sexual minority (i.e., Watson et al., 2015), and Muslim American women (i.e., Tolaymat & Moradi, 2011). Within Latinx samples, sexual objectification experiences do not appear to be related to the internalization of the Westernized thin ideal. Instead, other factors, such as acculturative stress and negative religious coping seem to be contributing to this relationship.

Furthermore, also when examining internalization as a dependent variable, results suggested that enculturation significantly negatively predicted internalization of sociocultural standards of beauty (Hypothesis 2). Thus, enculturation may act as a protective factor in this relationship, as an increase in enculturation may decrease the levels of internalization of Westernized beauty standards and the negative outcomes that may result from this relationship. As previously noted, objectification theory research supports the tendency of a positive relationship between internalization of sociocultural standards of beauty and disordered eating (e.g., Brewster et al., 2014; Dakanalis et al., 2014; Tolaymat & Moradi, 2011; Watson et al., 2015). Accordingly, these findings may also suggest that, for Latinx women, higher levels of enculturation may decrease levels of internalization, and consequently decrease disordered eating behaviors; thus, acting as a protective factor in the overall relationship.

Moreover, when examining disordered eating as a dependent variable, results suggested that when all variables were examined concurrently, only sexual objectification, internalization, enculturation, and acculturative stress predicted disordered eating, when controlling for BMI (Hypothesis 2). Furthermore, it is important to note that the change in  $R^2$  from block 1 to block 2 in the regression analysis was .34 ( $p < .001$ ). With the aforementioned predictor variables explaining half of the variance in disordered eating. The predictive nature of sexual objectification, internalization, enculturation, and acculturative stress on disordered eating are of great importance for several reasons. First, our findings suggest that within a sample of Latinx women, sexual objectification directly and positively predicted disordered eating, even after controlling for BMI and the additional variables in the model. This particular finding suggests that as sexually objectifying experiences increase, so do disordered eating behaviors. The direct relationship from sexual objectification to disordered eating coincides with previous

objectification theory related research (e.g., Kozee & Tylka, 2006; Schooler & Daniels, 2014), and helps to further extend this area of research to Latinx women.

Furthermore, the predictive nature of internalization instead diverges from the majority of objectification theory research which explains that internalization most often mediates the relationships between sexual objectification and disordered eating (e.g., Dakanalis et al., 2014; Moradi et al., 2005; Tolaymat & Moradi, 2011; Watson et al., 2015). Although, in the current study, additional variables (i.e., age, language, BMI, generational status) were controlled for, which may have impacted this relationship. However, in the current study, findings suggest that the effects of sexual objectification may have a more direct and detrimental impact on the disordered eating behaviors of Latinx women.

Next, our findings suggest that within a sample of Latinx women, internalization directly predicted disordered eating. This direct positive relationship suggests that as internalization increases, so does disordered eating; and vice versa. These findings coincide with previous objectification theory related research (i.e., Dakanalis et al., 2014; Tolaymat & Moradi, 2011; Watson et al., 2013; Watson et al., 2015), and with objectification theory research involving Latinx women (i.e., Velez et al., 2015). For example, within a sample of 180 Latinx women, Velez and colleagues (2015) noted that internalization also yielded a significant positive direct link with eating disorder symptoms, even after controlling for age and BMI. Our findings help to further indicate that important portions of objectification theory can, and should, be extended to Latinx women. Thus, internalization of Westernized standards of beauty is an important variable to consider when including Latinx women in the objectification theory framework.

Furthermore, our findings also suggest that within this sample of Latinx women, acculturative stress directly predicted disordered eating. The direct positive relationship observed in the current study suggests that as levels of acculturative stress increase, so do disordered

eating behaviors; and vice versa. In terms of the relationship between acculturative stress and disordered eating, our findings appear to coincide with previous studies, and add to the body of research that supports this link. For example, Kroon Van Diest and colleagues (2014) suggested that acculturative stress significantly predicted bulimic symptoms among Latinx women, above and beyond the effects of general life stress. Furthermore, Claudat and colleagues (2016) suggested that, for Latinx women, acculturative stress was positively correlated with disordered eating. Moreover, Gordon and colleagues (2010) assessed acculturative stress in relation to disordered eating, and suggested that Latinx women scored significantly higher than Black women in the endorsement of disordered eating.

These findings are particularly worrisome as they suggest that the effects of acculturative stress that Latinx women are experiencing may be increasing their vulnerability to the development of disordered eating. In various cultures, there is a difference in beauty standards in comparison to the Westernized thin ideal. For example, for Latinx women, there is a cultural duality that exists between curvy figures idolized by traditional Latino culture and the tremendously thin figure that is glorified in mainstream U.S. culture (Cheney, 2010; Gordon et al., 2010). The endorsement of these beauty standards, along with various cultural values, may vary according to acculturation level, suggesting that acculturation is an important variable to consider in relation to Latinx women's disordered eating.

Franko and colleague's (2012) qualitative study which examined risk factors for body dissatisfaction, eating disorders, and obesity in college-aged Latinx women identified four main themes, including cultural disparities in body-ideal (including media and acculturation issues), and body weight and shape messages received by family, peers, and society. The authors noted the ease of confusion due to the contrast in views about what Latinx women's bodies are expected to look like (Franko et al., 2012). One participant noted that she is "still trying to come

to terms with the difference between the White standard and then the Hispanic standard”, as both are wanted (Franko et al., p. 383). Furthermore, the participant noted that she “wants both...I want to be thin, but at the same time I want the curves from the Latina side. It’s almost like I’m stuck with both” (Franko et al., 2012, p. 383). Moreover, another participant noted that there are contrasting views in various geographical regions, and “where you live matters” (Franko et al., 2012, p. 383). For example, the participant noted that when she travels to places like Puerto Rico or Argentina, “it’s okay to be big/curvy...here in the U.S. curvy is not good” (Franko et al., 2010, p. 383).

Aside from contrasting societal perceptions of beauty, the cultural importance of family and the connection to food may also be impacting these views. One of the primary aspects in Latinx cultures is the focus on family and respect (Franko et al., 2012). As this may be a positive aspect of the culture, this combination of values may also create conflict regarding the way that food is conceptualized. Franko and colleagues (2012) noted that within Latin cultures, food is a connection to gender roles and often represents a demonstration of love and affection in the family. One participant in their study even expressed how her attempt to eat healthier was perceived as an insult by her mother and that her mother became “offended” when the participant decreased food portions (Franko et al., 2010, p. 384).

As the importance of the family remains salient in Latin cultures, various interrelated concepts may also need to be explored in future research (i.e., family, food, affection, acculturative stress). With conflicting societal, cultural, and family messages, it is also plausible that Latinx women may be engaging in disordered eating behaviors to cope with these cumulative pressures. Future research may want to explore these variables simultaneously, as there may be an interconnectedness between them. In the context of objectification theory, the current study is one of the few to explore the role of acculturative stress on disordered eating

behaviors among Latinx women. Within an objectification theory context, scarce amounts of previous research findings indicated that acculturative stress was positively related to disordered eating among Latinx women (i.e., Montes de Oca, 2006). Our findings not only align with previous findings, but also underscore the importance of examining acculturative stress in the objectification theory framework with Latinx women.

Additionally, results suggest when sexual objectification, internalization, acculturation, acculturative stress, enculturation, negative religious coping, and positive religious coping were examined concurrently, enculturation negatively predicted disordered eating, while controlling for BMI (Hypothesis 2). In the context of disordered eating, past research has only examined enculturation as a moderating variable, hypothesizing that enculturation would buffer such relationships as adherence to the mainstream U.S. society and eating/body-related concerns (i.e., Bettendorf & Fischer, 2009). However, findings from this study revealed that enculturation (i.e., Mexican cultural orientation) did not moderate the relationship between acculturation to mainstream U.S. society and eating/body related concerns (Bettendorf & Fischer, 2009). Bettendorf and Fischer (2009) explained that simply residing in a society where messages and images of thinness are overwhelmingly pervasive may be sufficient in the production of body concerns, regardless of cultural orientation.

However, when viewing enculturation as a possible protective factor, instead of a moderating variable, current findings suggest that enculturation directly negatively predicted disordered eating. Thus, enculturation may act as a protective factor in the development of disordered eating behaviors. Past research has supported the notion that ethnic identity may support Latinx women's (i.e., Mexican American) resilience, in that the focus is more on being a member of a cultural group than on one's personal identity with a particular appearance (Cachelin et al., 2006). Theorists have also proposed that cultural factors (i.e., accepting attitudes

toward larger bodies, broader definitions of beauty, and more multifaceted senses of self-esteem), which women with stronger ethnic identities may endorse to a greater extent, are, in fact, protective in nature (Gray, Ford, & Kelly, 1987).

For several reasons, these findings are of great importance to the body of literature concerning disordered eating and WOC. For example, eating disorders continue to hold the highest mortality rate of any other psychiatric disorder (Arcelus et al., 2011), they are significantly more prevalent among Western and industrialized nations in comparison to less developed nations (American Psychiatric Association [APA], 2000; Pate et al., 1992), and many studies have found that rates of disordered eating may be higher among Latinx women (Crago et al., 1996; Grabe & Hyde, 2006; U.S. Census Bureau, 2011) in comparison to other racial/ethnic groups (Alegría et al., 2007; Croll et al., 2002; Perez et al., 2002).

This is concerning for several reasons, one being that Hispanics/Latinxs are among the largest and most quickly growing ethnic minority group in the United States (U.S. Census Bureau, 2014) and display marked underutilization of formal mental health services in comparison with non-Latinxs (Alegría et al., 2002). Furthermore, several studies have demonstrated that clinicians are less likely to diagnose WOC with eating disorders compared to White women, even after controlling for symptom severity (Becker et al., 2003; Gordon et al., 2006). Moreover, there has been concern and push for more culturally relevant treatment procedures to be utilized with WOC (i.e., Villegas-Gold & Yoo, 2014), and this finding may be the preliminary push that is needed to not only place importance on culture within therapeutic settings, but also to indicate that future research in the area of enculturation appears warranted.

Last, several variables did not predict disordered eating behaviors. For example, when examining disordered eating as a dependent variable, results suggested that acculturation, positive religious coping, and negative religious coping did not predict disordered eating. These

findings suggest that acculturation, positive religious coping, and negative religious coping may not uniquely predict disordered eating in the presence of BMI, sexual objectification, internalization, acculturative stress, and enculturation.

### **Hypothesis 2a**

Furthermore, the current study posited that internalization of sociocultural standards of beauty would mediate the links from sexual objectification experiences, acculturation, enculturation, and acculturative stress to disordered eating among Latinx women. As previously noted, through the use of hierarchical regression, sexual objectification did not predict internalization. Thus, in the post-hoc structural equation modeling procedures used, a path from sexual objectification to internalization was not created. In other words, internalization did not mediate the links between sexually objectifying experiences and disordered eating (Hypothesis 2a). Our findings coincide with previous research that utilized objectification theory with Latinx women (e.g., Velez et al., 2015), indicating that internalization does not appear to be a significant mediating variable in the relationship between sexual objectification and disordered eating.

As previously noted, much of the objectification theory related research has supported the mediating role of internalization in the relationship between sexually objectifying experiences and disordered eating (e.g., Dakanalis et al., 2014; Moradi et al., 2005; Tolaymat & Moradi, 2011; Watson et al., 2013; Watson et al., 2015). The lack of mediation from internalization within the current study sheds light on just how harmful the residual effects of sexually objectifying experiences may be for Latinx women. This direct relationship between sexual objectification and disordered eating is concerning, particularly due to the pervasiveness of sexual objectification in westernized cultures (Kozee et al., 2007) and the mortality rate of eating disorders (Arcelus et al., 2011). Velez and colleagues (2015) suggested that research should begin including such variables as ethnic identity as a possible protective factor, as research has

supported the notion that ethnic identity may play an important moderating role in the relationship between sexual objectification and internalization (e.g., Watson et al., 2013). For example, having a stronger ethnic identity may enable individuals to identify experiences of discrimination and conceptualize such experiences in an oppressive context, rather than internalizing them (Watson et al., 2016). Furthermore, the ability to maintain ethnic identity strength in the face of such discriminatory experiences may also help to reduce harmful psychosocial outcomes (Noh & Kaspar, 2003; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Umaña-Taylor, Toomey, Tynes, Williams, & Mitchell, 2015; Yip, Gee, & Takeuchi, 2008).

Moreover, as previously noted, there were nonsignificant relationships observed between acculturation and internalization, as well as between acculturation and disordered eating. Thus, acculturation was not included in the path model, indicating that internalization did not mediate the links between acculturation and disordered eating (Hypothesis 2a). There may be several reasons for this result. One reason may be that participants in this study were less acculturated to American culture in general, as enculturation was a variable in the current study that retained statistical significance throughout each statistical analysis. Another possible reason for the nonsignificant relationship between acculturation and internalization is that various levels of biculturalism were not tested in the current study. The degree of acculturation may vary in individuals and may not have been properly captured in the current study. For example, biculturalism was found to be one of the cultural aspects associated with fewer internalizing problems and higher self-esteem in 323 Latinx adolescents (Smokowski, & Bacallao, 2007). Also, perceived bicultural self-efficacy (i.e., perceived ability to function competently in two cultures) has been associated with bicultural college students' psychological well-being and mental health (David, Okazaki, & Saw, 2009). Biculturalism may be an area of interest for future

objectification theory related research, and appears particularly important to incorporate with Latinx populations.

Furthermore, another possibility for the nonsignificant relationship between acculturation and internalization may be that the stress associated with acculturation is more salient than acculturation itself. For instance, as previously noted, among Latinx women, acculturative stress has been associated with body dissatisfaction (Gordon et al., 2010; Menon & Harter, 2012; Perez et al., 2002) and disordered eating (Claudat et al., 2016; Kroon Van Diest et al., 2014; Perez et al., 2002). Thus, acculturative stress may more adequately account for body image and disordered eating disturbances in comparison to levels of acculturation. Future objectification theory related research may want to attend to this relationship, particularly due to previous research findings suggesting that acculturative stress was also a significant positive predictor of internalization of sociocultural standards of beauty (Menon & Harter, 2012), and internalization mediated the relationship between acculturative stress and body image disturbances (Menon & Harter, 2012).

Alternatively, as predicted, internalization of sociocultural standards of beauty mediated the links between enculturation and disordered eating (Hypothesis 2a). Due to the link between enculturation and internalization being significantly negative, results indicated that increased enculturation may act as a protective factor in the aforementioned relationship. Moreover, a direct and significantly negative path was revealed between enculturation and disordered eating, further indicating the protective role of enculturation. To date, only one other study incorporated enculturation as a possible protective factor for Latinx women (e.g., Bettendorf & Fischer, 2009), and no other studies have utilized enculturation in the objectification theory framework. For instance, Bettendorf and Fischer (2009) examined how enculturation may act as a protective factor by buffering the relationship between acculturation to the mainstream U.S. society and eating/body related concerns. However, their findings noted that within a sample of 209 Mexican

American women, enculturation (i.e., Mexican cultural orientation) did not directly predict eating/body related concerns, and was not a moderating variable in the relationship between acculturation to mainstream U.S. society and eating/body related concerns (Bettendorf & Fischer, 2009). Our findings may have differed for several reasons, one being that the current study examined enculturation as a direct predictor of internalization and disordered eating, rather than a moderating variable (i.e., Bettendorf & Fischer, 2009), suggesting that enculturation may have a more direct relation with these outcome variables.

Moreover, as predicted, internalization of sociocultural standards of beauty mediated the links between acculturative stress and disordered eating. In other words, acculturative stress is related to more internalization of sociocultural standards of beauty, which in turn is related to more disordered eating. Our findings coincide with previous research indicating that acculturative stress significantly predicted disordered eating symptomology, such as bulimic symptoms, among Latinx women (Kroon Van Diest et al., 2014). Yet, acculturative stress has not been extensively examined in the context of objectification theory. Currently, only one study, an unpublished dissertation, considered acculturative stress when assessing ethnically and culturally diverse populations (Montes de Oca, 2006). The results of this particular study indicated that internalization of sociocultural standards of beauty, self-objectification, acculturative stress, and body shame were all uniquely positively related to eating disorder symptomology among a sample of 112 Latinx women (Montes de Oca, 2006).

### **Hypothesis 2b & Hypothesis 2d**

The current study also aimed to analyze the moderating role of religious/spiritual coping in the relations from sexual objectification, acculturation, acculturative stress, enculturation internalization, and enculturation to internalization and disordered eating. Hypothesis 2b posited that negative religious/spiritual coping would strengthen (i.e., exacerbate) the links from sexual

objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to more disordered eating. Furthermore, Hypothesis 2d posited that negative religious/spiritual coping would weaken the negative relationship between enculturation and internalization, or render it non-significant. That is, the protective benefits of enculturation will be elided at higher levels of negative religious coping. Findings from a hierarchical regression analysis revealed that negative religious/spiritual coping did not moderate the aforementioned relations, and thus both Hypothesis 2b and Hypothesis 2d were not supported.

However, due to significant direct effects revealed in the hierarchical regressions, a direct path between negative religious/spiritual coping and internalization was retained in the path model. Results of the post-hoc path analysis revealed that the relationship between negative religious/spiritual coping and internalization was statistically significant and positive. This relationship indicated that as negative religious/spiritual coping increases, so does internalization, which is then related to greater levels of disordered eating. Thus, negative religious/spiritual coping may directly relate to internalization versus playing a more moderating role. It appears that negative religious/spiritual coping may already be utilized among Latinx women, and its presence in the lives of Latinx women may be a factor that is worth attending to, particularly due to the positive relationship observed between negative religious/spiritual coping, internalization of sociocultural standards of beauty, and disordered eating behaviors.

For example, it appears that religious/spiritual coping techniques are being utilized within the current populations on a more regular basis. Within Latinx populations in the United States, over 82% have reported a religious affiliation, with approximately 19.6 million Latinxs identifying as Catholic, and approximately 8 million Latinxs identifying as Protestant (Pew Research Center, 2014). Furthermore, women represent a demographic that adheres to religion

more frequently than men (Pew Research Center, 2014), as women attend more religious services on average, utilize prayer more often, have more frequent feelings of spiritual peace and wellbeing, and describe religion as being more important in their lives (Pew Research Center, 2014). These rates appear to coincide with the current sample of Latinx women, as the overwhelming majority of participants also identified as being religious and/or spiritual.

Though several studies have noted the importance of considering culturally specific coping mechanisms, such as religiosity and spirituality, when protecting against harmful discriminatory experiences (e.g., Khan & Watson, 2006; Lazar & Bjorck, 2008; Tarakeshwar et al., 2003), the negative aspects of religious/spiritual coping seems to play a crucial role in relation to adverse outcomes. Experiences of spiritual tension, conflict, and struggle with God and others, as demonstrated by negative reevaluations of God's powers (e.g., feeling abandoned or punished by God), demonic reappraisals (i.e., feeling the devil is involved in the stressor), spiritual inquiry and doubting, and interpersonal religious dissatisfaction (Pargament et al., 2011), may be detrimental and relate to the development and maintenance of disordered eating among Latinx women by way of internalization.

### **Hypothesis 2c & Hypothesis 2e**

Additionally, the current study posited that positive religious/spiritual coping would buffer or render the links from sexual objectification experiences, acculturation, and acculturative stress to internalization of sociocultural standards of beauty, relating to less disordered eating (Hypothesis 2c), and would strengthen the negative relation between enculturation and internalized sociocultural standards of beauty (Hypothesis 2e). However, as indicated through the use of hierarchical regressions, no significant relationships were revealed between interaction terms involving positive religious coping and internalization. Thus, positive

religious/spiritual coping was not a moderating variable, and was not retained in the path model. Therefore, both Hypothesis 2c and Hypothesis 2e were not supported.

### **Strengths, Limitations, and Future Directions**

There are several notable strengths of the current study. The first being that this study expanded on objectification theory framework with the inclusion of acculturation, enculturation, acculturative stress, and religious/spiritual coping within a population of Latinx women. To date, few studies have extended the objectification theory framework to Latinx women (e.g., Boie et al., 2013; Velez et al., 2015). Furthermore, few studies have also examined Latinx populations in the area of disordered eating (e.g., Crago et al., 1996; Grabe & Hyde, 2006), as the majority of research is conducted with White women. Thus, this study attends to the unique experiences of Latinx women. Several studies have demonstrated that clinicians are less likely to diagnose WOC with eating disorders compared to White women, even after controlling for symptom severity (e.g., Becker et al., 2003; Gordon et al., 2006). The information provided by this study may expand clinician's knowledge of eating disorders and aid clinicians in the diagnosis process. Due to the severity and mortality rates of eating disorders, overlooking possible diagnoses could be detrimental for those seeking therapeutic services.

An additional strength of the current study is that participants who spoke English or Spanish could participate in the study, as questionnaires were offered in both languages. This aided in reaching a wider range of individuals, who may have been left out otherwise. Also, due to body image concerns being salient across a women's lifespan (Tiggemann, 2004), and the majority of eating disorder related research being among college-age women (e.g., Eisenberg, Nicklett, Roeder, & Kirz, 2011; Mintz & Betz, 1998; Taylor et al., 2006;), this study was able to capture a larger age range. For example, the ages in the current study ranged from 18 to 64. This

broad range of ages may aid in further expanding the research to a wider demographic, and adding to the eating disorder body of research across the lifespan.

Additionally, the participants in the current study were from diverse ethnic and cultural backgrounds. For example, participants in the current study indicated that they were of various ethnic and cultural descent including, but not limited to the following geographic locations: Mexico, Puerto Rico, Cuba, the Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Peru, Uruguay, and Venezuela. The incorporation of Latinx women from these various cultural and ethnic backgrounds provides information about Latinx women's experiences on a wider scale, contributing to the generalizability of the results of this study.

Another strength of the current study was the integration of religious/spiritual coping within the objectification theory framework. Not only was this study the first to consider the role of religious/spiritual coping in the objectification theory framework, the current study also considered both the positive and negative impact that religious/spiritual coping may play in the various relationships. This helped shed light on the impact that negative religious/spiritual coping may have on Latinx women, when they are trying to cope with various potentially life-threatening stressors.

Furthermore, this study was one of the first of its kind to consider the role of enculturation within the objectification theory framework. Prior to the current study, only one other study incorporated enculturation as a possible protective factor for Latinx women (e.g., Bettendorf & Fischer, 2009), and no other studies have utilized enculturation in the objectification theory framework. This inclusion elucidates the importance of considering enculturation as a protective factor against internalization of sociocultural standards of beauty as well as disordered eating

behaviors. This may be an important area for clinicians to consider, particularly when working with women who identify as Latinx.

Aside from protective mechanisms, future research should also consider other negative outcomes that may be a result of sexual objectification for Latinx women. For instance, in Latinx individuals, experiences of discrimination have been linked to a variety of negative mental health outcomes, including depression, anxiety, and psychological distress (Lee & Ahn, 2012). Yet, in general, relatively less is understood about how discrimination plays a role in other behavioral health outcomes, such as alcohol abuse (Okamoto, Ritt-Olson, Soto, Baezconde-Garbanati, & Unger, 2009; Williams, Neighbors, & Jackson, 2003). As sexual objectification can be viewed as another form of discrimination, it is plausible that these experiences may also lead to other negative outcomes that are not currently contained in the objectification theory model. For example, the general prevalence rate of binge drinking (i.e., five or more drinks in one sitting during the past month) was 24.1% among Hispanics/Latinos aged 12 or older, and it was even higher (34.6%) for those aged 18–25 (Substance Abuse and Mental Health Services Administration, 2014).

Lastly, most of measures used in this study resulted in strong internal consistency estimate of reliability of test scores. For example, most of the alpha levels fell in the excellent (i.e., sexual objectification, disordered eating, positive religious coping) and good (i.e., internalization, enculturation, acculturative stress, negative religious coping) ranges, with only the acculturation measure falling within the acceptable alpha range ( $\alpha = .75$ ).

Alternatively, several limitations should be considered when interpreting the findings of the current study. For instance, one of the methodological limitations in the current study was obtaining the data through self-report measures, which may not accurately reflect the actual experiences of the participants (Szymanski, 2005). An example of this potential limitation could

be in the reporting of height and weight to obtain BMI scores. Though research has suggested that self-reports are highly correlated with actual heights and weights for Latinx individuals (Davis & Gergen, 1994), the potential still exists for inaccuracy in self-reports. Future studies may consider using an unbiased third party to more accurately measure the women's heights and weights, and thus provide more accurate BMI scores (i.e., using a scale to measure weight).

Another methodological issue refers to the utilization of correlational research. Though this method of analysis aids in assessing relationships among several variables, the results remain correlational in nature and does not establish causation. For this reason, Velez and colleagues (2015) suggested that future research may aim to integrate other sources of data and/or clinical assessment, such as experimental and/or longitudinal studies.

The last methodological issue to note is the overall statistical sequence in which the EFA's were conducted. In the current study, some of the factor loadings did not meet recommended guidelines within the current sample. Due to the researcher's error, the EFA's were conducted towards the end of the analyses processes, instead of during the initial stages, and items that may have been problematic were not removed from the scales. However, all instruments that were utilized in this study were pre-existing instruments, in which overall structural integrity had previously been evidenced through supporting literature (please see instrumentation section). Furthermore, all Spanish versions of the scales and subscales had previously been translated, validated, and utilized in other research studies prior to the current study. For these reasons, proceeding with analysis without the removal of particular impeding items appeared warranted.

In addition, though the women in this study identify as Latinx, we cannot assume that the experiences of each participant are the same. For example, most participants in the current study were of Mexican descent, in which their experiences may differ from other Latin and Hispanic ethnic groups. Furthermore, the current study did not collect data on the geographical locations in

which the participants resided, which may also impact acculturation, enculturation, acculturative stress, coping mechanism, and available resources. In future studies, it is important to examine the unique contextual factors specific Latinx groups experience, the geographical location they reside in, and how these factors may alter sexually objectifying experiences, internalization, disordered eating, and various coping mechanisms. This would be particularly important for clinicians to note, as the current study noted relationships among enculturation, internalization of the Westernized thin ideal, and disordered eating. Exploring the unique and specific factors that Latinx women are attending to within their own culture of origin may help strengthen their level of enculturation, thus leading to less internalization and disordered eating. In fact, Wood, Nikel, and Petrie (2010) suggested focusing on populations of Mexican American women, as there also remains limited data in this area.

Another related issue is that the results of this study can only be generalizable to nonclinical populations of women that identify as Latinx, residing in the United States. Thus, the utilization of clinical samples when conducting similar research may provide more information pertaining to the relevance of objectification theory among Latinx women who are receiving treatment for eating disorders. Future research may also extend the objectification theory framework with Latinx women residing in countries outside of the United States as eating disorders are not solely confined to American populations. For example, 22.5% of adolescent girls in Mexico City scored above the “at risk” cutoff on the Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkle, 1982), which approaches or exceeds the percentage of American female adolescents found to be “at risk” for an eating disorder by the same measure (Crago, Yates, Fleischer, Segerstrom, & Gray, 1996; Toro et al., 2006). Moreover, in a non-urban area of the state of Michoacán, Mexico, in a sample of 458 teenage girls, a quarter of the participants reported concerns about their weight and stated that they frequently used dangerous

dieting methods such as fasting (4.2%), diuretics (7.9%), or laxatives (3.5%; Bojorquez & Unikel, 2004).

Additionally, another potential demographic limitation may be that the majority of the participants in the current study reported higher levels of education than the overall reporting of American women in general. In the current study, over 50% ( $n = 201$ ) of the participants reported having a bachelor's degree or higher compared to the 33% reported by U.S. women (U.S. Census Bureau, 2016). This may be due to the sampling methodology used. For example, the study announcement was posted on professional listservs, in which professionals with higher educational levels could view, participate, and even refer their colleagues to take part in the study.

Lastly, due to the lack of spiritual coping scales available within psychological research, the current study did not use a separate measure for spirituality. Like the majority of other studies that assess spirituality (e.g., see Thune´-Boyle, Stygall, Keshtgar, & Newman [2006], for review), the current study modified the measure of positive and negative religious coping to include spirituality. Though the majority of participants in the current study identified with the dominant U.S. religion of Christianity ( $n = 270$ ), there remained a large portion of participants who identified as being “spiritual, but not religious” ( $n = 52$ ). Research suggests that spirituality may have a connection with religion, but it is not a requisite (Campesino & Schwartz, 2006). Furthermore, research also suggests that spirituality provides a unique route for coping in Latinx women (Jurkowski, Kurlanska, & Ramos, 2010). As many cultures utilize religious and spiritual practices, each culture's spiritual beliefs may differ.

For example, in Mexican cultural groups, *Mestizo spirituality* (Cervantes & Ramirez, 1992) highlights a spiritual base derived from a 500-year history of forced colonization, genocide, geographic relocations, and disease (Duran & Duran, 1995), leading to the disempowerment of

families, the denial of one's spiritual heritage other than Catholicism, and ultimately the loss of a more inclusive cultural identity (Duran, 2006). Mestizo spirituality can be defined as a philosophical model of healing and a tool for psychological intervention that highlights an introspective, spiritual understanding of one's journey through life (Comas-Diaz, 2006; Matovina & Riebe-Estrella, 2002). One important element of this perspective is its focus on a holistic model of healing that emphasizes the balance in one's relationship with self, family, and community that is overseen by a higher creative force or spirit (Comas-Diaz, 2006; Matovina & Riebe-Estrella, 2002).

Therefore, future researchers may wish to develop a sound spiritual coping measure that is normed with Latinx individuals from different cultural/ethnic backgrounds. This development could then aid in integrating the client's spiritual and religious beliefs and needs into clinical practice. These measures could help identify the importance of spiritual matters to the client, address any concerns regarding spirituality, and guide targeted interventions (Mueller, Plevak, & Rummans, 2001; Post & Wade 2009). Indeed, Cervantez (2010) outlined the need for cultural competence with Latinx clients as well as the integration of Mestizo spirituality, in particular, in clinical practice.

Furthermore, another area of future direction is to explore other culturally specific factors that may contribute to objectification of Latinx women. For example, Buchanan and colleagues (2008) noted the impact of skin tone on African American women's self-objectification and body image experiences. As suggested by Velez et al. (2015), exploring other aspects of Latinx women's body image, such as skin tone and hair texture, may help to create scales that more accurately measure the entire scope of body images concerns that these women are experiencing. Additionally, future research may also want to explore other culturally relevant predictors of disordered and eating behaviors. For example, in the current study alone, a large amount of

acculturation and enculturation related data was collected from the participants (e.g., generational status, language, etc.), which may have had some impact on disordered eating behaviors.

In itself, researchers find it particularly challenging to operationalize, assess, and analyze the processes associated with acculturation and enculturation in ways that echo and build upon current theory; often resulting in a broad array of measures and analytic approaches (Coatsworth, Maldonado-Molina, Pantin, & Szapocznik, 2005). In the current study, acculturative stress was measured by using a global score, as recommended (Rodriguez et al., 2002). Yet, the utilization of a global score may have provided a more generalized assumption of what may actually be taking place when experiencing acculturative stress. Due to the current study's findings pertaining to the relationships between acculturative stress, enculturation, and disordered eating, future research should explore acculturative stress in a more detailed manner. For example, the MASI (Rodriguez et al., 2002) has four stable and internally consistent factors: Spanish Competency Pressures, English Competency Pressures, Pressure to Acculturate, and Pressure Against Acculturation. Analyzing these subscales separately may help shed light on where exactly acculturative stress is creating the biggest impact in the lives of Latinx women, while also helping to clinically inform the therapeutic treatment interventions.

Furthermore, as previously stated, biculturalism was not measured in the current study and deserves further exploration. Many individuals within the United States alone consider themselves to be bicultural. For example, approximately 13% of the U.S. population is foreign born, while 11% of this population has at least one foreign-born parent (US Census Bureau, 2012). Additionally, about 25% of the population in the United States identifies as being either first or second generation (US Census Bureau, 2012), and over 53% of foreign-born individuals are from Latin America (US Census Bureau, 2012). Those that identify as being bicultural may be experiencing such disturbances as sexual objectification and its effects in a different capacity.

For example, biculturalism was found to be one of the cultural aspects associated with fewer internalizing problems and higher self-esteem in 323 Latinx adolescents (Smokowski, & Bacallao, 2007). Also, perceived bicultural self-efficacy (i.e., perceived ability to function competently in two cultures) has been associated with bicultural college students' psychological well-being and mental health (David, Okazaki, & Saw, 2009).

Alternatively, Romero and Roberts (2003) argue that stress may result from cultural conflict for those within a bicultural context, creating intergenerational culture gaps, monolingual stressors, within-group discrimination, or peer pressure to conform to one's ethnic group cultural norms. Previous research also suggests that Latinx youths, in particular, may live in a dual cultural world, reflective of a family environment that may include individuals of different generations, different language preferences, and varying acculturation levels; creating internal family conflict associated with possible acculturation gaps that may result in intergenerational conflict (Arnett, 1999; Baptiste, 1993; Mead, 1996).

Thus, individuals that identify as bicultural may not be impervious to experiences related to sexual objectification and acculturative stress. Biculturalism may be an area of interest for future objectification theory related research, and appears particularly important to incorporate with Latinx populations. The Mexican American Biculturalism Scale (Basilio, Knight, O'Donnell, Roosa, Gonzales, Umaña-Taylor et al., 2014) may be an instrument that could be utilized in this area, as it is a three-factor model that assesses the respondent's degree of biculturalism rather than categories of acculturation types, lending credibility to the hypothesis that biculturalism is a multifactor construct (Basilio et al., 2014).

Moreover, considerations of current sociocultural issues, such as immigration reform, within the United States should be attended to, as the associated stressors may exacerbate adverse outcomes, including disordered eating. In addition, one area of much discussion in the

current sociocultural climate in the U.S. is health care reform. If policy change occurs, immigrants, in particular, may be discouraged from using healthcare, as it could potentially effect residency status (Jewett, Bailey, & Andalo, 2018). According to a draft of the plan, an immigrant holding a visa could be passed over for getting permanent residency if they use Medicaid, a subsidized Obamacare plan, food stamps, tax credits or a list of other non-cash government benefits (Jewett et al., 2018). Furthermore, even allowing a child who is a U.S. citizen to use such benefits could jeopardize a parent's chances of attaining lawful residency (Jewett et al., 2018).

Even more concerning, is the fear of possible deportation of immigrants residing in the United States. Currently, the arrest of thousands of immigrants with no criminal history is taking place in the U.S. (Yee, 2018). Furthermore, the residence of legal immigrants-many who have lived without papers for years are urgently seeking legal status by way of a parent, adult, child, or spouse who is already a citizen or permanent resident-is being compromised (Yee, 2018). It is plausible to consider that the current sociocultural climate in the United States may be an additional relevant stressor to many Latinx women. Thus, it is also plausible to consider that rates of disordered eating behaviors may be increasing within this population, as Latinx women may engage in more disordered eating as a way to cope with these concerns. This is just one of the many distressing scenarios that may be increasing stress in general for many people of color, and appears to be a relevant area to consider for future research with Latinx women.

Moreover, incorporating culturally informed gender role norms into the objectification theory framework may be useful. For example, gender plays a specific role in many cultures, including those of Latinx populations (Cauce & Domenech-Rodriguez, 2002). One example of an area that deserves attention is the emerging research on *Marianismo*, the gender schema that describes the various ways Latinx women are expected to conduct themselves (Castillo et al.,

2010). Traditional views of Marianismo depict Latinx women as submissive, virtuously pure, religiously superior to men, and selfless (Castillo & Cano, 2007), while self-sacrifice for the family is often expected (Piña-Watson et al., 2014). Thus, Marianismo is a multidimensional gender role construct, derived from a collectivistic worldview, in which interdependence and self-sacrifice is considered a cultural norm, and behaviors that sustain this worldview are greatly valued (Castillo et al., 2010). Future research with Latinx women should seek to incorporate this cultural construct to more accurately evaluate what it is like to be a Latinx woman, and how Marianismo contributes to everyday life, as gender roles and objectification theory strongly relate.

For instance, objectification theory (Fredrickson & Roberts, 1997) was initially created to help explain how sexually objectifying experiences may relate to psychological distress among girls and women. Objectification theory suggests that gender role socialization and women and girls' life experiences are regularly marked by experiences of sexual objectification, which can lead to other areas of distress such as internalization and disordered eating (Fredrickson & Roberts, 1997). Marianismo, and its description of gender schemas, may help Latinx women explain and better understand the culturally specific ways in which they may be experiencing objectification. Utilizing the Marianismo Beliefs Scale (Castillo et al., 2010) may be one avenue future researchers should consider.

Additionally, another highly important aspect of Latinx culture is interdependence with family, known as *familismo*. Familismo is an individual's strong identification with, and attachment to, nuclear and extended families (Castillo & Cano, 2007). For example, the role of *familismo* (a deeply ingrained sense of the individual being inextricably rooted in the family; Bacallao & Smokowski, 2007) may be another area to assess when utilizing objectification theory framework with Latinx women. Specifically, the importance of involving the family in the

treatment of eating disorders is often recommended and implemented, regardless of diversity factors. Since the role of the family in Latin cultures is so deeply important, it may be important to assess to what extent the interdependence is buffering or exacerbating symptoms related to objectification theory (i.e., sexual objectification, internalization, eating disorders).

The Academy for Eating Disorders (AED) acknowledges that family can play a role in the development and maintenance of eating disorders, though family is not the exclusive or primary instrument that underlie eating disorder pathology (le Grange, Lock, Loeb, & Nicholls, 2009). Unless involving the family is clearly ill advised on clinical grounds (i.e., family members are abusive, family members are actively in their own eating disorder, etc.), the AED recommends that families be included in the treatment eating disorders, particularly with younger patients (le Grange et al., 2009). Thus, due to a strong family involvement in Latinx cultures, family members of Latinx clients should be involved in the treatment of eating disorders (Trujillo, 2017).

### **Implications for Practice**

A variety of important clinical implications have resulted from this study. Clinicians may consider using psychoeducation to increase insight and awareness around sexually objectifying experiences, internalization of sociocultural standards of beauty, and disordered eating symptomology among Latinx women. Furthermore, clinicians working with Latinx women clients could also integrate the roles of religion/spirituality, acculturative stress, and enculturation into therapeutic interventions. For example, the results of the present study indicate that enculturation and acculturative stress may directly relate to internalization of sociocultural standards of beauty. Therefore, Latinx women dealing with various levels of acculturative stress may be at risk for developing disordered eating behaviors, while enculturation may act as a protective factor in the development of disordered eating behaviors. Clinicians should pay

attention to the array of stressors that Latinx clients are experiencing, as well as the impact these stressors may have on internalization and eating behaviors.

Additionally, utilizing a social justice standpoint may help the clinician and client develop ways to challenge the numerous sexually objectifying experiences when they may occur. For example, the core of feminist and multicultural practice, in which social justice is a key element, is a recognition that the difficulties experienced by so many people actually are rooted in oppressive social, political, and cultural forces (Atkinson, Thompson, & Grant, 1993; Morrow & Hawxhurst, 1998). Furthermore, these struggles cannot truthfully be resolved without changing the systems and structures from which they arise (Atkinson et al., 1993; Morrow & Hawxhurst, 1998). As Atkinson and colleagues (1993) explain, multicultural counseling theories adhere to this principle, and emphasize facilitating self-help and indigenous support systems. It is important for clinicians to understand the various support systems that are available in the indigenous culture, such as extended family, community elders, and religious support groups (Goodman et al., 2004). Goodman and colleagues (2004) suggest that by encouraging the ongoing development of support systems that evolved in the client's own culture, the clinician may ensure that the client can continue to be supported in a way that is sustainable after therapeutic services have rendered.

Because coping strategies are molded by cultural norms and values (Noh & Kaspar, 2003), this could also be an area to explore as sexually objectifying experiences occur. Helping clients develop various culturally relevant coping strategies (i.e., religious/spiritual coping), and exploring the impact of these coping mechanisms in the client's culture and well-being could more readily help the individual when these unwanted instances occur. Furthermore, clinicians should engage their Latinx women clients in dialogues pertaining to discrimination and the utilization of coping strategies (Villegas-Gold & Yoo, 2014). Clinicians should provide gender-

specific and culturally sensitive therapeutic services that include positive empowering aspects of gender roles (Nuñez et al., 2015). Incorporating culturally relevant aspects of social justice, empowerment, and feminism while also exploring Marianismo beliefs may be a way for clients to identify with the various aspects of one's identity, and thus protect against harmful outcomes such as body image disturbances and disordered eating.

Spirituality may also be one area for clinicians to attend to when working with Latinx women. The current body of literature on the utilization of spirituality with Latinxs in clinical practice remains scarce. One article looked at the integration of spirituality in clinical practice with Latinx clients (i.e., Comas-Diaz, 2006). In this area, several themes such as contextual interdependence, magical realism, and healing through spiritual entities were revealed (Comas-Diaz, 2006). Additionally, Cervantes (2010) also realized the importance in this area, and noted that spirituality formulates a core aspect of the Latinx psyche, and failure to incorporate this, is to overlook a relevant dimension of ethical practice with Latinx populations.

However, although the majority of the participants in the current study identified as being religious/spiritual, it is important that clinicians refrain from making the assumption that Latinx women may cope via that avenues of religiosity and spirituality solely due to their cultural and/or ethnic background. Instead, it may be helpful for clinicians to explore the areas of religious and spiritual coping with each individual. Furthermore, when working with Latinx clients who are not religious or spiritual, it may be important to explore other coping mechanisms that can be utilized, such as family.

As aforementioned, the importance of involving the family in the treatment of eating disorders is often recommended and implemented, regardless of diversity factors; and may be particularly recommended for Latinx clients in the treatment of eating disorders (Trujillo, 2017). Further exploring the role of *familismo* (a deeply ingrained sense of the individual being

inextricably rooted in the family; Bacallao & Smokowski, 2007) may be another area to assess when working with Latinx women. For example, friction with family members could potentially exacerbate symptoms of distress, and enhance negative religious/spiritual coping and disordered eating behaviors for clients. Attending to this area appears to be of great importance with working with Latinx women.

Another important area to attend to therapeutically is the role of internalization of Westernized beauty standards. As the current study has previously noted, internalization was not only observed as a predictor of disordered eating, it also mediated the relationships from negative religious coping, acculturative stress, and enculturation to disordered eating. Within therapeutic settings, it appears highly important that the Westernized thin ideal is adequately critiqued with the individual. This may be particularly relevant in Latinx women, due to the average disordered eating related subscales and global scores being higher in current study than scores on undergraduate (i.e., Luce et al., 2008) and adult women (i.e., Mond et al., 2006; see Measures section). Past research has suggested that critiquing the thin ideal can result in a decrease in body dissatisfaction, negative affect, dieting behaviors, bulimic symptomology (Stice, Presnell, Gau, & Shaw, 2007), reduce eating disorder risk factors, eating disorder symptoms, and future eating disorder onset, (Stice, Rohde, Shaw, & Gau, 2011), as well as raise awareness about self-acceptance, emancipation from dieting, and more time and energy to pursue other interests (Donaghue, & Clemitshaw, 2012). Furthermore, evaluating the thin ideal has also been shown to be related to experiencing body acceptance and greater intuitive eating (Oh, Wiseman, Hendrickson, Phillips, & Hayden, 2012). Thus, the recommendation of thin ideal evaluation appears to be highly important and warranted with Latinx women.

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## Footnotes

<sup>1</sup>Per the DSM-5, EDNOS is now recognized as OSFED, other specified feeding or eating disorder.

Appendix A  
Participant Consent

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**Consent for Participation in a Research Study**  
*Social Experiences and Eating Patterns for Latina Women*

*Sara Aslan, MA; Laurel Watson, PhD*

**Request to Participate**

You are being asked to take part in a research study. This study is being conducted online through the University of Missouri-Kansas City.

The researcher in charge of this study is PhD student Sara Aslan, under the supervision of Dr. Laurel Watson. While the study will be run by her, other qualified persons who work with her may act for her.

Research studies only include people who choose to take part. This document is called a consent form. Please read this consent form carefully and take your time making your decision. This consent form explains what to expect: the risks, discomforts, and benefits, if any, if you consent to be in the study.

**Background**

The study team is asking you to take part in this research study because you are a Latina/Hispanic woman (i.e., women from Spanish-speaking cultures who live in the United States; U.S. Census Bureau, 2011) and are 18 years of age or older. We want to examine Latina women's social experiences and how they respond to these experiences. You will be one of about 350 subjects in the study.

**Purpose**

The purpose of this study is to better understand the types of social experiences that Latina women face in their lives. We also want to learn how these experiences affect Latina women. This study will help mental health professionals better understand the experiences that Latina women face.

**Procedures**

If you agree to participate in this study, you will be asked to complete a single online survey. This survey contains about eight short and medium-length questionnaires. It should take approximately 30 minutes for you to complete. You may complete this survey online on any computer at any

time, but you must complete it in one sitting. You cannot save your responses and return to it later. You will only be involved in the study for the time it takes you to complete the survey.

Participation in this study is entirely voluntary. Even if you do agree to participate, you have the option to not answer certain survey questions. If you wish to withdraw from this study while taking the online survey, please close the survey window.

### **Risks and Inconveniences**

The physical risks of taking part in this research study are not expected to be more than the risks in your daily life. However, you may experience some psychological discomfort when answering some of the survey questions. Please think carefully about whether you would like to take part in this study at this time. Please also think about where you might feel most comfortable answering these questions. For example, some people may feel more comfortable answering these questions at home. There are no other known risks to you if you choose to take part in this study.

### **Benefits**

You may gain insight into the experiences you deal with in life by answering the questions in the online survey. In addition, other people may benefit in the future from the information that comes from this study.

### **Fees and Expenses**

There are no fees or expenses to you for participating in this study.

### **Compensation**

If you meet the participation criteria and participate in the online survey, you will have the option to enter a raffle to win one of 15, \$25 Amazon gift cards.

### **Alternatives to Study Participation**

The alternative is not to participate in the study.

### **Confidentiality**

The only record linking you to the data will be a unique code. This code is assigned to you from the principle investigator. After the study is over, this code will be removed. The data will be reported in group format and you will not be personally identified. The “collect IP” feature for this survey has been disabled. While every effort will be made to keep confidential all of the information you provide, it cannot be absolutely guaranteed. Individuals from the University of Missouri-Kansas City Institutional Review Board (a committee that reviews and approves research studies), Research Protections Program, and Federal regulatory agencies may look at records related to this study in the event that they need to ensure quality improvement and regulatory functions. Although it is not the University’s policy to compensate or provide medical

treatment for persons who participate in studies, if you feel that you have been injured as a result of participating in this study, please call the IRB Administrator of UMKC's Social Sciences Institutional Review Board at (816) 235-5927.

### **In Case of Injury**

The University of Missouri-Kansas City appreciates people who help it gain knowledge by being in research studies. It is not the University's policy to pay for or provide medical treatment for persons who are in studies. If you think you have been harmed because you were in this study, please contact the researcher, Sara Aslan, at sara.m.aslan@mail.umkc.edu.

### **Contacts for Questions about the Study**

You should contact the Office of UMKC's Social Sciences Institutional Review Board at 816-235-5927 if you have any questions, concerns or complaints about your rights as a research subject. You may contact the researcher Sara Aslan at sara.m.aslan@mail.umkc.edu if you have any questions about this study. You may also contact her if any problems come up.

### **Voluntary Participation**

Taking part in this research study is voluntary. If you choose to be in the study, you are free to stop participating at any time and for any reason.

You have read this Consent Form. You have been told why this research is being done and what will happen if you take part in the study, including the risks and benefits. You have had the chance to ask questions, and you may ask questions at any time in the future by contacting Sara Aslan at sara.m.aslan@mail.umkc.edu. By selecting the "next" button below, you volunteer and consent to take part in this research study.

"Next"

## Appendix B

### List of Mental Health Services

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## NATIONAL SERVICES

### ARE YOU IN CRISIS?

Call 1-800-273-TALK (1-800-273-8255) to be connected to a trained counselor at a crisis center nearest you.

24/7 Treatment Referral Line: 1-800-662-Help (1-800-662-4357)

Disaster Distress Helpline (Red Cross): 1-800-985-5990; or text TalkWithUs to 66746

### NAMI-National Alliance on Mental Illness

Contact Us:

3803 N. Fairfax Dr., Suite 100

Arlington, VA 22203

Main: (703) 524-7600

Fax: (703) 524-9094

Member Services: (888) 999-6264

Helpline: (800) 950-6264

### Find your local NAMI

[http://www.nami.org/template.cfm?section=Your\\_Local\\_Nami](http://www.nami.org/template.cfm?section=Your_Local_Nami)

### Find your support program:

[http://www.nami.org/template.cfm?section=Find\\_Support](http://www.nami.org/template.cfm?section=Find_Support)

### Education, Training and Peer Support Center

[http://www.nami.org/template.cfm?section=Education\\_Training\\_and\\_Peer\\_Support\\_Center](http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center)

### Consumer Support

[http://www.nami.org/template.cfm?section=Consumer\\_support](http://www.nami.org/template.cfm?section=Consumer_support)

### Multicultural Action Center

[http://www.nami.org/Template.cfm?section=multicultural\\_support](http://www.nami.org/Template.cfm?section=multicultural_support)

### Child and Adolescent Action Center

[http://www.nami.org/template.cfm?section=child\\_and\\_teen\\_support](http://www.nami.org/template.cfm?section=child_and_teen_support)

### On Campus

[http://www.nami.org/template.cfm?section=NAMI\\_on\\_Campus1](http://www.nami.org/template.cfm?section=NAMI_on_Campus1)

### Legal Support

[http://www.nami.org/template.cfm?section=legal\\_support](http://www.nami.org/template.cfm?section=legal_support)

## NATIONAL INSTITUTE OF MENTAL HEALTH

If you or someone you know is in crisis and needs immediate assistance, visit our Crisis page:

<http://www.nimh.nih.gov/site-info/if-you-or-someone-you-know-is-in-crisis-and-needs-immediate-help.shtml>

<http://www.nimh.nih.gov/index.shtml>

email: [nimhinfo@nih.gov](mailto:nimhinfo@nih.gov)  
301-443-4513 (local)  
1-866-615-6464 (toll-free)  
301-443-8431 (TTY)  
1-866-415-8051 (TTY toll-free)  
National Institute of Mental Health (NIMH)  
6001 Executive Boulevard, Room 8184, MSC 9663  
Bethesda, MD 20892-9663

**The Substance Abuse and Mental Health Services Administration**

<http://www.samhsa.gov/>  
Email: [SAMHSAInfo@samhsa.hhs.gov](mailto:SAMHSAInfo@samhsa.hhs.gov)  
Phone: 1-877-SAMHSA-7 (1-877-726-4727)  
TTY: 1-800-487-4889  
Fax: 240-221-4292  
Mail: SAMHSA's Health Information Network  
P.O. Box 2345  
Rockville, MD 20847-2345  
Web Site: <http://store.samhsa.gov/>

**Mental Health America | formerly known as the National Mental Health Association**

<http://www.nmha.org/go/help>  
2000 N. Beauregard Street, 6th Floor Alexandria, VA 22311  
Phone (703) 684-7722  
Toll free (800) 969-6642  
Fax (703) 684-5968

**Center for Eating Disorders**

<http://www.centerforeatingdisorders.net/>

**National Association of Eating Disorders**

24 Hour Helpline: 1-800—931-2237  
<http://www.nationaleatingdisorders.org/>

## **Resources for Spanish Speakers**

**Mattie Rhodes Center**

1740 Jefferson  
Kansas City, MO 64108  
816-471-2536  
<http://www.mattierhodes.org/>

**Avenues to Recovery Olathe**

115 North Cooper Street  
Olathe, KS 66061

(913) 780-9600

**Linea de Crisis las 24 horas**  
206-461-3222 o 1-866-427-4747

### Hotline Numbers

<ul style="list-style-type: none"><li>• <b>Adolescent Suicide Hotline</b> <b>800-621-4000</b></li><li>• <b>Adolescent Crisis Intervention &amp; Counseling Nineline</b> <b>1-800-999-9999</b></li><li>• <b>AIDS National Hotline</b> <b>1-800-342-2437</b></li><li>• <b>CHADD-Children &amp; Adults with Attention Deficit/Hyperactivity Disorder</b> <b>1-800-233-4050</b></li><li>• <b>Child Abuse Hotline</b> <b>800-4-A-CHILD</b></li><li>• <b>Cocaine Help Line</b> <b>1-800-COCAINE (1-800-262-2463)</b></li><li>• <b>Domestic Violence Hotline</b> <b>800-799-7233</b></li><li>• <b>Domestic Violence Hotline/Child Abuse</b> <b>1-800-4-A-CHILD (800 422 4453)</b></li><li>• <b>Drug &amp; Alcohol Treatment Hotline</b> <b>800-662-HELP</b></li><li>• <b>Ecstasy Addiction</b> <b>1-800-468-6933</b></li><li>• <b>Eating Disorders Center</b> <b>1-888-236-1188</b></li></ul>	<ul style="list-style-type: none"><li>• <b>Missing &amp; Exploited Children Hotline</b> <b>1-800-843-5678</b></li><li>• <b>National Alliance on Mental Illness (NAMI)</b> <b>1-800-950-NAMI (6264)</b></li><li>• <b>Panic Disorder Information Hotline</b> <b>800- 64-PANIC</b></li><li>• <b>Post Abortion Trauma</b> <b>1-800-593-2273</b></li><li>• <b>Project Inform HIV/AIDS Treatment Hotline</b> <b>800-822-7422</b></li><li>• <b>Rape (People Against Rape)</b> <b>1-800-877-7252</b></li><li>• <b>Rape, Abuse, Incest, National Network (RAINN)</b> <b>1-800-656-HOPE (1-800-656-4673)</b></li><li>• <b>Runaway Hotline</b> <b>800-621-4000</b></li><li>• <b>Self-Injury (Information only)</b> <b>(NOT a crisis line. Info and referrals only)</b> <b>1-800-DONT CUT (1-800-366-8288)</b></li><li>• <b>Sexual Assault Hotline</b> <b>1-800-656-4673</b></li></ul>
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<ul style="list-style-type: none"> <li>• <b>Family Violence Prevention Center</b> <b>1-800-313-1310</b></li> <li>• <b>Gay &amp; Lesbian National Hotline</b> <b>1-888-THE-GLNH (1-888-843-4564)</b></li> <li>• <b>Gay &amp; Lesbian Trevor HelpLine</b> <b>Suicide Prevention</b> <b>1-800-850-8078</b></li> <li>• <b>Healing Woman Foundation (Abuse)</b> <b>1-800-477-4111</b></li> <li>• <b>Help Finding a Therapist</b> <b>1-800-THERAPIST (1-800-843-7274)</b></li> <li>• <b>Incest Awareness Foundation</b> <b>1-888 -547-3222</b></li> <li>• <b>Learning Disabilities - (National Center)</b> <b>1-888-575-7373</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Sexual Abuse - Stop It Now!</b> <b>1-888-PREVENT</b></li> <li>• <b>STD Hotline</b> <b>1-800-227-8922</b></li> <li>• <b>Suicide Prevention Lifeline</b> <b>1-800-273-TALK</b></li> <li>• <b>Suicide &amp; Crisis Hotline</b> <b>1-800-999-9999</b></li> <li>• <b>Suicide Prevention - The Trevor HelpLine</b> <b>(Specializing in gay and lesbian youth suicide prevention).</b> <b>1-800-850-8078</b></li> <li>• <b>Teen Helpline</b> <b>1-800-400-0900</b></li> <li>• <b>Victim Center</b> <b>1-800-FYI-CALL (1-800-394-2255)</b></li> <li>• <b>Youth Crisis Hotline</b> <b>800-HIT-HOME</b></li> </ul>
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## Appendix C

### Demographic Questionnaire

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1. Please indicate your age in years:
2. Please list your current weight in pounds:
3. Please list your height in inches (e.g., each foot equals 12 inches. So, if you were five feet, five inches, this would equal 5 feet x 12 inches = 60 inches + 5 inches = 65 inches total):
4. Please indicate your gender:
  - 1 = Woman
  - 2 = Man
  - 3 = Transgender
5. Please indicate your sexual orientation:
  - 1 = Gay/Lesbian
  - 2 = Bisexual
  - 3 = Queer
  - 4 = Questioning
  - 5 = Pan/Omnisexual
  - 6 = Heterosexual/Straight
  - 7 = Other
6. Please indicate how YOU would describe your ethnicity/race? (If multiracial, mark all that apply.):
  - 1 = Latina/Hispanic
  - 2 = Latina/Hispanic White
  - 3 = Latina/Hispanic Black
  - 4 = Bi/Multiracial
  - 5 = American Indian or Alaskan Native
  - 6 = Other (please specify)
7. What is your estimated average household income? (Refer to your parents' income level if you live with them or are a dependent):
  - \$25,000 or below
  - \$25,001 - \$35,000
  - \$35,001 - \$45,000
  - \$45,001 - \$55,000

\$55,001 - \$65,000  
\$65,001 - \$75,000  
\$75,001 - \$85,000  
\$85,001 - \$95,000  
\$95,001 - \$105,000  
\$105,001 and above

8. Please select the item that most accurately depicts your highest level of education:

- 1 = Some High School/No Diploma
- 2 = High School Diploma
- 3 = GED
- 4 = Vocational or Trade School
- 5 = Some College/No Degree
- 6 = Associates Degree
- 7 = Bachelor's Degree (Ex: BA, BS, AB, BSW)
- 8 = Master's Degree (Ex: MA, MS, MSW, MPH, MEd)
- 9 = Doctorate Degree (Ex: Ph.D., Ed.D., Sc.D., DA, DB, DSW)

9. Please select where you were born:

- 1 = United States (not including Puerto Rico)
- 2 = México
- 3 = Puerto Rico
- 4 = Cuba
- 5 = Central America (Please Specify Country)
- 6 = South America (Please Specify Country)
- 7 = Other (Please Specify Country)

10. Please indicate where your parents were born:

- 1 = United States (not including Puerto Rico)
- 2 = México
- 3 = Puerto Rico
- 4 = Cuba
- 5 = Central America (Please Specify Country)
- 6 = South America (Please Specify Country)
- 7 = Other (Please Specify Country)

11. Please indicate whether you are:

- 1 = 1st generation (born in the U.S.)
- 2 = 2nd generation American (U.S.-born children of at least one foreign-born parent)
- 3 = 3rd generation American (U.S.-born children of at least one U.S.-born parent, where at least one grandparent is foreign-born)
- 4 = Other (family has been in the US for more than 3 generations)

12. If you were born outside of the U.S., how many years have you lived in the U.S.?  
\_\_\_\_\_

13. How many years have you lived in the United States? \_\_\_\_\_

14. Please indicate your spiritual/religious affiliation (if applicable):

1 = Agnostic

2 = Atheist

3 = Buddhist/Taoist

4 = Christian/Catholic

5 = Christian/Protestant

6 = Christian/Other

7 = Hindu

8 = Jewish

9 = Muslim/Islam

10 = Spiritual, but not religious

11 = Other, please specify \_\_\_\_\_

## Appendix D

### Interpersonal Sexual Objectification Scale

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Please think carefully about your experiences in **the past year** as you answer the questions below.

**1. How often have you been whistled at while walking down a street?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**2. How often have you noticed someone staring at your breasts when you are talking to them?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**3. How often have you felt like or known that someone was evaluating your physical appearance?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**4. How often have you felt that someone was staring at your body?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**5. How often have you noticed someone leering at your body?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**6. How often have you heard a rude, sexual remark made about your body?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**7. How often have you been touched or fondled against your will?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**8. How often have you experienced sexual harassment (on the job, in school, etc.)?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**9. How often have you been honked at when you were walking down the street?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**10. How often have you seen someone stare at one or more of your body parts?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**11. How often have you overheard inappropriate sexual comments made about your body?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**12. How often have you noticed that someone was not listening to what you were saying, but instead gazing at your body or a body part?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**13. How often have you heard someone make sexual comments or innuendos when noticing your body?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**14. How often has someone grabbed or pinched one of your private body areas against your will?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

**15. How often has someone made a degrading sexual gesture towards you?**

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Almost Always

## Appendix E

### Sociocultural Attitudes Towards Appearance Questionnaire-Internalization Subscale

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

1	2	3	4	5
Completely Disagree		Neither agree Nor Disagree		Completely Agree
1. Women who appear in TV shows and movies project the type of appearance that I see as my goal.				
1	2	3	4	5
2. I believe that clothes look better on thin models.				
1	2	3	4	5
3. Music videos that show thin women make me wish that I were thin.				
1	2	3	4	5
4. I do not wish to look like the models in the magazines. *				
1	2	3	4	5
5. I tend to compare my body to people in magazines and on TV.				
1	2	3	4	5
6. Photographs of thin women make me wish that I were thin.				
1	2	3	4	5
7. I wish I looked like a swimsuit model.				
1	2	3	4	5
8. I often read magazines like <i>Cosmopolitan</i> , <i>Vogue</i> and <i>Glamour</i> and compare my appearance to the models.				
1	2	3	4	5

\*Note: Reverse scored item.

Appendix F

The Eating Disorder Examination Questionnaire

Please check a response for each of the statements below. Remember that the questions only refer to the past four weeks (28 days) only:

On how many of the past 28 days...	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1. Have you been deliberately <u>trying</u> to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2. Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3. Have you <u>tried</u> to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4. Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or	0	1	2	3	4	5	6

weight (whether or not you have succeeded)?							
5. Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6. Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7. Has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8. Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9. Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10. Have you <u>had a definite fear that you might gain weight?</u>	0	1	2	3	4	5	6
11. Have you felt fat?							

	0	1	2	3	4	5	6
12. Have you had a strong desire to lose weight?	0	1	2	3	4	5	6
13. Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?							
14. On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?							
15. Over the past 28 days, on how many <b>DAYS</b> have such episodes of overeating occurred (i.e., you have eaten an unusually large amount of food and have had a sense of loss of control at the time)?							
16. Over the past 28 days, how many times have you made yourself sick (vomit) as a means of controlling your shape or weight?							
17. Over the past 28 days, how many times have you taken laxatives as a means of controlling your shape or weight?							
18. Over the past 28 days, how many times have you exercised in a “driven” or “compulsive” way as a means of controlling your weight, shape, or amount of fat, or to burn off calories?							
Questions 19-21: Please mark the appropriate number. Please note that for these questions the term “binge eating” means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.							
19. Over the past 28 days, on how many days have you eaten in secret (i.e., furtively)? <u>Do not count episodes of binge eating</u>	No days 0	1-5 days 1	6-12 days 2	13-15 days 3	16-22 days 4	23-27 days 5	Every day 6
20. On what proportion of the times that you have eaten have you felt guilty (felt that you’ve done wrong) because of its effect on your shape	None of the times 0	A few of the times 1	Less than half 2	Half of the times 3	More than half 4	Most of the time 5	Every time 6

or weight? Do not count episodes of binge eating							
21. Over the past 28 days, how concerned have you been about other people seeing you eat? Do not count episodes of binge eating	Not at all 0	1	Slightly 2	3	Moderately 4	5	Markedly 6
Over the past 28 days...	Not at all	Slightly			Moderately		Markedly
22. Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23. Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24. How much would it had upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25. How dissatisfied have you been with your weight?	0	1	2	3	4	5	6
26. How dissatisfied have you been with your shape?	0	1	2	3	4	5	6
27. How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop	0	1	2	3	4	5	6

<p>window reflection, while undressing or taking a shower)?</p>							
<p>28. How uncomfortable have you felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?</p>	0	1	2	3	4	5	6

Appendix G

Acculturation Rating Scale for Mexican Americans-II

Please select the number next to each item that best applies to you:

1	Not at all
2	Very little or not very often
3	Moderately
4	Much or very often
5	Extremely often or almost always

**1. I speak Spanish.**

1                      2                      3                      4                      5

**2. I speak English.**

1                      2                      3                      4                      5

**3. I enjoy speaking Spanish.**

1                      2                      3                      4                      5

**4. I associate with Anglos.**

1                      2                      3                      4                      5

**5. I associate with Latino/as and/or Latino/a Americans.**

1                      2                      3                      4                      5

**6. I enjoy listening to Spanish language music.**

1                      2                      3                      4                      5

**7. I enjoy listening to English language music.**

1                      2                      3                      4                      5

**8. I Enjoy Spanish language TV.**

1                      2                      3                      4                      5

**9. I enjoy English language TV.**

1                      2                      3                      4                      5

**10. I enjoy English language movies.**

1                      2                      3                      4                      5

**11. I enjoy Spanish language movies.**

1                      2                      3                      4                      5

**12. I enjoy reading (e.g., books in Spanish).**

1                      2                      3                      4                      5

**13. I enjoy reading (e.g., books in English).**

1                      2                      3                      4                      5

**14. I write (e.g., letters in Spanish).**

1                      2                      3                      4                      5

**15. I write (e.g., letters in English).**

1                      2                      3                      4                      5

**16. My thinking is done in the English language.**

1                      2                      3                      4                      5

**17. My thinking is done in the Spanish language.**

1                      2                      3                      4                      5

**18. My contact with Latin countries has been**

1                      2                      3                      4                      5

**19. My contact with the USA has been**

1                      2                      3                      4                      5

**20. My father identifies or identified himself as a 'Latino'.**

1                      2                      3                      4                      5

**21. My mother identifies or identified herself as 'Latina'.**

1                      2                      3                      4                      5

**22. My friends, while I was growing up, were of Latino/a origin.**

1                      2                      3                      4                      5

**23. My friends, while I was growing up, were of Anglo origin.**

1                      2                      3                      4                      5

**24. My family cooks Latino/a foods.**

1                      2                      3                      4                      5

**25. My friends now are of Anglo origin.**

1                      2                      3                      4                      5

**26. My friends now are of Latino/a origin.**

1                      2                      3                      4                      5

**27. I like to identify myself as Anglo American.**

1                      2                      3                      4                      5

**28. I like to identify myself as Latino American.**

1                      2                      3                      4                      5

**29. I like to identify myself as a Latino/a.**

1                      2                      3                      4                      5

**30. I like to identify myself as an American.**

1                      2                      3                      4                      5

Appendix H

Multidimensional Acculturative Stress Inventory

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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, select YES. Then select 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, select 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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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 #3.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

8. I don't speak English 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 #9.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
----------	----------	----------	----------	----------

<i>Not At All Stressful</i>	<i>A Little Stressful</i>	<i>Somewhat Stressful</i>	<i>Very Stressful</i>	<i>Extremely Stressful</i>
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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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
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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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
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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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

18. It bothers me when people don't respect my Mexican/Latino values (e.g., family). **YES**  
**NO**

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

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b><i>Not At All</i></b>	<b><i>A Little</i></b>	<b><i>Somewhat</i></b>	<b><i>Very</i></b>	<b><i>Extremely</i></b>
<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>

19. It bothers me when people don't respect my American values (e.g., independence). **YES**  
**NO**

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

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b><i>Not At All</i></b>	<b><i>A Little</i></b>	<b><i>Somewhat</i></b>	<b><i>Very</i></b>	<b><i>Extremely</i></b>
<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>

20. I am self-conscious about my Latino background. **YES**  
**NO**

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

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b><i>Not At All</i></b>	<b><i>A Little</i></b>	<b><i>Somewhat</i></b>	<b><i>Very</i></b>	<b><i>Extremely</i></b>
<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>

21. I am self-conscious about my American background. **YES**  
**NO**

If you answered YES, how stressful has this situation been during the past 3 months?  
If you answered NO, go to #22.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b><i>Not At All</i></b>	<b><i>A Little</i></b>	<b><i>Somewhat</i></b>	<b><i>Very</i></b>	<b><i>Extremely</i></b>
<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b><i>Not At All</i></b>	<b><i>A Little</i></b>	<b><i>Somewhat</i></b>	<b><i>Very</i></b>	<b><i>Extremely</i></b>
<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>	<b><i>Stressful</i></b>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

24. I don't feel accepted by 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 #25.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

26. I have had conflicts with others because I prefer American customs (e.g., celebrating Halloween, Thanksgiving) over Mexican/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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

27. I have had conflicts with others because I prefer Mexican/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.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
----------	----------	----------	----------	----------

<i>Not At All Stressful</i>	<i>A Little Stressful</i>	<i>Somewhat Stressful</i>	<i>Very Stressful</i>	<i>Extremely Stressful</i>
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28. People look down upon me if I practice Mexican/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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

30. I feel uncomfortable when I have to choose between Mexican/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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

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.

<i>1 Not At All Stressful</i>	<i>2 A Little Stressful</i>	<i>3 Somewhat Stressful</i>	<i>4 Very Stressful</i>	<i>5 Extremely Stressful</i>
---------------------------------------	-------------------------------------	-------------------------------------	---------------------------------	--------------------------------------

32. I feel uncomfortable because my family does not know Mexican/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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

34. I feel uncomfortable when others expect me to know Mexican/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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

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.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

36. At times, I wish that I were more Mexican/Latino. **YES**  
**NO**

If you answered YES, how stressful has this situation been during the past 3 months?

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Not At All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>	<i>Stressful</i>

Appendix I

Brief Measure of Religious Coping Styles

For each item, please select the value that best applies to you:

1	2	3	4
Not at all			A great deal

*Positive Religious Coping Subscale Items*

1. Looked for a stronger connection with God.	1	2	3	4
2. Sought God's love and care.	1	2	3	4
3. Sought help from God in letting go of my anger.	1	2	3	4
4. Tried to put my plans into action together with God.	1	2	3	4
5. Tried to see how God might be trying to strengthen me in this situation.	1	2	3	4
6. Asked forgiveness for my sins.	1	2	3	4
7. Focused on religion to stop worrying about my problems.	1	2	3	4

*Negative Religious Coping Subscale Items*

8. Wondered whether God had abandoned me.	1	2	3	4
9. Felt punished by God for my lack of devotion.	1	2	3	4
10. Wondered what I did for God to punish me.	1	2	3	4
11. Questioned God's love for me.	1	2	3	4
12. Wondered whether my church had abandoned me.	1	2	3	4
13. Decided the devil made this happen.	1	2	3	4
14. Questioned the power of God.	1	2	3	4

Consentimiento del participante

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**Consentimiento para la participación en un estudio de investigación**

*Experiencias sociales y los patrones de comer para las mujeres latinas*

*Sara Aslan, MA; Laurel Watson, PhD*

**Solicitar su Participación**

Se les pide participar en un estudio de investigación. Este estudio está siendo llevado a cabo por internet a través de la Universidad de Missouri-Kansas City. El investigador responsable de este estudio es estudiante de doctorado Sara Aslan, bajo la supervisión del la Dr. Laurel Watson. El estudio de investigación sólo incluye a personas que deciden participar.

**Antecedentes**

El equipo de estudio le pide su participación en este estudio de investigación porque usted es una mujer Latina/Hispana (es decir, las mujeres de las culturas de habla hispana que viven en los Estados Unidos; U.S. Census Bureau, 2011) y tiene 18 años de edad o más. Queremos examinar las experiencias sociales de las mujeres latinas y cómo responden a estas experiencias. Usted será uno de los cerca de 350 sujetos en el estudio.

**Objeto**

El propósito de este estudio es entender mejor a los tipos de experiencias sociales que mujeres Latina enfrentan en sus vidas. También queremos aprender cómo estas experiencias afectan a las mujeres latinas. Este estudio ayudará a profesionales de la salud mental a entender mejor las experiencias que las mujeres latinas enfrentan.

**Procedimiento**

Si está de acuerdo en participar en este estudio, se le pedirá que comple una encuesta por internet. Debe tomar aproximadamente 30 minutos para completar. Usted puede completar esta encuesta por internet en cualquier computadora y en cualquier momento, pero al comenzar usted debe de completar la encuesta en total. No puede guardar sus respuestas y regresar a la encuesta.

La participación en este estudio es totalmente voluntaria. Incluso si usted acepta participar, tiene la opción de no contestar ciertas preguntas de la encuesta. Si desea retirarse de este estudio durante la encuesta por internet, por favor, cierre la ventana de la encuesta.

**Riesgos y Inconveniencia**

Los riesgos de participar en este estudio de investigación no se espera que sean más que los riesgos en su vida diaria. Sin embargo, usted puede tener alguna incomodidad psicológica al responder algunas de las preguntas de la encuesta. No hay otros conocidos riesgos para usted si usted decide tomar parte en este estudio.

### **Beneficios**

Usted puede ganar una perspectiva en las experiencias de su vida contestando las preguntas en la encuesta. Además, en el futuro, otras personas pueden beneficiarse de la información que proviene de este estudio.

### **Costos y Gastos**

No hay costos o gastos por participar en este estudio

### **Compensación**

Si usted cumple con los criterios de participación y participa en la encuesta por internet, usted tendrá la opción de entrar en una rifa para ganar una de las 15 Amazon tarjetas de regalo de 25 dólares.

### **Alternativas para participar en el estudio**

La alternativa es no participar en el estudio

### **Confidencialidad**

Un código único es lo que sólo enlaza los datos. Los datos serán reportados en un grupo y usted no será identificado personalmente. Mientras cada esfuerzo se hará para mantener toda la información que usted proporcione confidencial, no se puede garantizar absolutamente. Individuos de la Junta de revisión institucional Universidad de Missouri-Kansas City (un Comité que revisa y aprueba los estudios de investigación), programa de investigación de protecciones y las agencias reguladoras federales pueden ver registros relacionados con este estudio en caso de que necesiten asegurar la calidad y funciones reguladoras. Aunque no es política de la Universidad de compensar o proporcionar tratamiento médico para las personas que participan en los estudios, si usted siente que usted ha sido herido como resultado de participar en este estudio, por favor llame al administrador de la IRB de ciencias sociales de Junta de UMKC de revisión institucional en (816) 235-5927.

### **En Caso de Daño**

La Universidad de Missouri-Kansas City agradece a quienes le ayudan a ganar conocimiento por su participación en investigación. No es política de la Universidad pagar o proporcionar tratamiento médico para las personas que participan en estudios. Si usted piensa que han sido

heridos por ser parte de este estudio, póngase en contacto con la investigadora, Sara Aslan, [sara.m.aslan@mail.umkc.edu](mailto:sara.m.aslan@mail.umkc.edu) .

### **Contactos para preguntas sobre el estudio**

Debe comunicarse con la oficina de revisión institucional de las ciencias sociales de UMKC al 816-235-5927 si usted tiene preguntas, preocupaciones o quejas acerca de sus derechos como un sujeto de investigación. Puede contactar a la investigadora Sara Aslan [sara.m.aslan@mail.umkc.edu](mailto:sara.m.aslan@mail.umkc.edu) si tienes alguna pregunta sobre este estudio. Usted puede también contactarse con ella si surgen problemas.

### **Participacion Voluntaria**

Tomar parte en esta investigación es voluntaria. Si usted decide participar en el estudio, usted es libre de dejar de participar en cualquier momento y por cualquier motivo.

Seleccionando el botón "siguiente", usted se ofrece voluntariamente y da su consentimiento a participar en este estudio de investigación.

**“Siguiente”**

## Appendix K

### Lista de Servicios de Salud Mental

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## NATIONAL SERVICES

### ARE YOU IN CRISIS?

Call 1-800-273-TALK (1-800-273-8255) to be connected to a trained counselor at a crisis center nearest you.

24/7 Treatment Referral Line: 1-800-662-Help (1-800-662-4357)

Disaster Distress Helpline (Red Cross): 1-800-985-5990; or text TalkWithUs to 66746

### NAMI-National Alliance on Mental Illness

Contact Us:

3803 N. Fairfax Dr., Suite 100

Arlington, VA 22203

Main: (703) 524-7600

Fax: (703) 524-9094

Member Services: (888) 999-6264

Helpline: (800) 950-6264

### Find your local NAMI

[http://www.nami.org/template.cfm?section=Your\\_Local\\_Nami](http://www.nami.org/template.cfm?section=Your_Local_Nami)

### Find your support program:

[http://www.nami.org/template.cfm?section=Find\\_Support](http://www.nami.org/template.cfm?section=Find_Support)

#### Education, Training and Peer Support Center

[http://www.nami.org/template.cfm?section=Education\\_Training\\_and\\_Peer\\_Support\\_Center](http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center)

#### Consumer Support

[http://www.nami.org/template.cfm?section=Consumer\\_support](http://www.nami.org/template.cfm?section=Consumer_support)

#### Multicultural Action Center

[http://www.nami.org/Template.cfm?section=multicultural\\_support](http://www.nami.org/Template.cfm?section=multicultural_support)

#### Child and Adolescent Action Center

[http://www.nami.org/template.cfm?section=child\\_and\\_teen\\_support](http://www.nami.org/template.cfm?section=child_and_teen_support)

#### On Campus

[http://www.nami.org/template.cfm?section=NAMI\\_on\\_Campus1](http://www.nami.org/template.cfm?section=NAMI_on_Campus1)

#### Legal Support

[http://www.nami.org/template.cfm?section=legal\\_support](http://www.nami.org/template.cfm?section=legal_support)

## NATIONAL INSTITUTE OF MENTAL HEALTH

If you or someone you know is in crisis and needs immediate assistance, visit our Crisis page:

<http://www.nimh.nih.gov/site-info/if-you-or-someone-you-know-is-in-crisis-and-needs-immediate-help.shtml>

<http://www.nimh.nih.gov/index.shtml>

email: [nimhinfo@nih.gov](mailto:nimhinfo@nih.gov)  
301-443-4513 (local)  
1-866-615-6464 (toll-free)  
301-443-8431 (TTY)  
1-866-415-8051 (TTY toll-free)  
National Institute of Mental Health (NIMH)  
6001 Executive Boulevard, Room 8184, MSC 9663  
Bethesda, MD 20892-9663

### **The Substance Abuse and Mental Health Services Administration**

<http://www.samhsa.gov/>  
Email: [SAMHSAInfo@samhsa.hhs.gov](mailto:SAMHSAInfo@samhsa.hhs.gov)  
Phone: 1-877-SAMHSA-7 (1-877-726-4727)  
TTY: 1-800-487-4889  
Fax: 240-221-4292  
Mail: SAMHSA's Health Information Network  
P.O. Box 2345  
Rockville, MD 20847-2345  
Web Site: <http://store.samhsa.gov/>

### **Mental Health America | formerly known as the National Mental Health Association**

<http://www.nmha.org/go/help>  
2000 N. Beauregard Street, 6th Floor Alexandria, VA 22311  
Phone (703) 684-7722  
Toll free (800) 969-6642  
Fax (703) 684-5968

### **Center for Eating Disorders**

<http://www.centerforeatingdisorders.net/>

### **National Association of Eating Disorders**

24 Hour Helpline: 1-800—931-2237  
<http://www.nationaleatingdisorders.org/>

## **Resources for Spanish Speakers**

### **Mattie Rhodes Center**

1740 Jefferson  
Kansas City, MO 64108  
816-471-2536  
<http://www.mattierhodes.org/>

### **Avenues to Recovery Olathe**

115 North Cooper Street  
Olathe, KS 66061

(913) 780-9600

**Linea de Crisis las 24 horas**  
206-461-3222 o 1-866-427-4747

### Hotline Numbers

<ul style="list-style-type: none"><li>• <b>Adolescent Suicide Hotline</b> <b>800-621-4000</b></li><li>• <b>Adolescent Crisis Intervention &amp; Counseling Nineline</b> <b>1-800-999-9999</b></li><li>• <b>AIDS National Hotline</b> <b>1-800-342-2437</b></li><li>• <b>CHADD-Children &amp; Adults with Attention Deficit/Hyperactivity Disorder</b> <b>1-800-233-4050</b></li><li>• <b>Child Abuse Hotline</b> <b>800-4-A-CHILD</b></li><li>• <b>Cocaine Help Line</b> <b>1-800-COCAINE (1-800-262-2463)</b></li><li>• <b>Domestic Violence Hotline</b> <b>800-799-7233</b></li><li>• <b>Domestic Violence Hotline/Child Abuse</b> <b>1-800-4-A-CHILD (800 422 4453)</b></li><li>• <b>Drug &amp; Alcohol Treatment Hotline</b> <b>800-662-HELP</b></li><li>• <b>Ecstasy Addiction</b> <b>1-800-468-6933</b></li><li>• <b>Eating Disorders Center</b> <b>1-888-236-1188</b></li></ul>	<ul style="list-style-type: none"><li>• <b>Missing &amp; Exploited Children Hotline</b> <b>1-800-843-5678</b></li><li>• <b>National Alliance on Mental Illness (NAMI)</b> <b>1-800-950-NAMI (6264)</b></li><li>• <b>Panic Disorder Information Hotline</b> <b>800- 64-PANIC</b></li><li>• <b>Post Abortion Trauma</b> <b>1-800-593-2273</b></li><li>• <b>Project Inform HIV/AIDS Treatment Hotline</b> <b>800-822-7422</b></li><li>• <b>Rape (People Against Rape)</b> <b>1-800-877-7252</b></li><li>• <b>Rape, Abuse, Incest, National Network (RAINN)</b> <b>1-800-656-HOPE (1-800-656-4673)</b></li><li>• <b>Runaway Hotline</b> <b>800-621-4000</b></li><li>• <b>Self-Injury (Information only)</b> <b>(NOT a crisis line. Info and referrals only)</b> <b>1-800-DONT CUT (1-800-366-8288)</b></li><li>• <b>Sexual Assault Hotline</b> <b>1-800-656-4673</b></li></ul>
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<ul style="list-style-type: none"> <li>• <b>Family Violence Prevention Center</b> <b>1-800-313-1310</b></li> <li>• <b>Gay &amp; Lesbian National Hotline</b> <b>1-888-THE-GLNH (1-888-843-4564)</b></li> <li>• <b>Gay &amp; Lesbian Trevor HelpLine</b> <b>Suicide Prevention</b> <b>1-800-850-8078</b></li> <li>• <b>Healing Woman Foundation (Abuse)</b> <b>1-800-477-4111</b></li> <li>• <b>Help Finding a Therapist</b> <b>1-800-THERAPIST (1-800-843-7274)</b></li> <li>• <b>Incest Awareness Foundation</b> <b>1-888 -547-3222</b></li> <li>• <b>Learning Disabilities - (National Center)</b> <b>1-888-575-7373</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Sexual Abuse - Stop It Now!</b> <b>1-888-PREVENT</b></li> <li>• <b>STD Hotline</b> <b>1-800-227-8922</b></li> <li>• <b>Suicide Prevention Lifeline</b> <b>1-800-273-TALK</b></li> <li>• <b>Suicide &amp; Crisis Hotline</b> <b>1-800-999-9999</b></li> <li>• <b>Suicide Prevention - The Trevor HelpLine</b> <b>(Specializing in gay and lesbian youth suicide prevention).</b> <b>1-800-850-8078</b></li> <li>• <b>Teen Helpline</b> <b>1-800-400-0900</b></li> <li>• <b>Victim Center</b> <b>1-800-FYI-CALL (1-800-394-2255)</b></li> <li>• <b>Youth Crisis Hotline</b> <b>800-HIT-HOME</b></li> </ul>
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Appendix L  
Cuestionario Demografico

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1. Porfavor indique su edad en anos:
2. Porfavor anuncie su peso actual en libras:
3. Por favor anuncie su altura en pulgadas (por ejemplo, cada pie es igual a 12 pulgadas. Si usted es cinco pies y cinco pulgadas, esto equivaldría 5 pies x 12 pulgadas= 60 pulgadas + 5 pulgadas = 65 pulgadas total):
4. Por favor indique su género:
  - 1 = Mujer
  - 2 = Hombre
  - 3 = Transgénico
5. Porfavor indique su orientación sexual:
  - 1 = Gay/ Lesbiana
  - 2 = Bisexual
  - 3 = Queer
  - 4 = Questioning
  - 5 = Pan/Omnisexual
  - 6 = Heterosexuals
  - 7 = Otro
6. Por favor indique como USTED describiría su origen étnico/raza? (Si multirracial marque todos los que apliquen):
  - 1 = Latina/Hispana
  - 2 = Latina/Hispana Caucásico
  - 3 = Latina/Hispana Africano
  - 4 = Bi/Multirracial
  - 5 = Indio Americano o Nativo de Alaska
  - 6 = Otro (Por Favor Especifica)
7. ¿Cuál es su ingreso familiar promedio estimado? (Consulte el nivel de ingresos de sus padres si vive con ellos o si es un dependiente)
  - \$25,000 o abajo
  - \$25,001 - \$35,000

\$35,001 - \$45,000  
\$45,001 - \$55,000  
\$55,001 - \$65,000  
\$65,001 - \$75,000  
\$75,001 - \$85,000  
\$85,001 - \$95,000  
\$95,001 - \$105,000  
\$105,001 o mas

8. Por favor, seleccione el elemento que representa con mayor precisión su nivel más alto de educación:

1 = Algún Escuela Secundaria/ No Diploma  
2 = Escuela Secundaria con Diploma  
3 = GED  
4 = Escuela vocacional o comercial  
5 = Algun colegio/ No Licenciatura  
6 = Associates Degree  
7 = Bachelor's Degree (Ex: BA, BS, AB, BSW)  
8 = Master's Degree (Ex: MA, MS, MSW, MPH, MEd)  
9 = Doctorate Degree (Ex: Ph.D., Ed.D., Sc.D., DA, DB, DSW)

9. Por Favor, seleccione donde nacio:

1 = Estados Unidos (no incluye Puerto Rico)  
2 = México  
3 = Puerto Rico  
4 = Cuba  
5 = Centroamérica (especifique el país)  
6 = Sudamérica (especifique el país)  
7 = Otro (especifique el país)

10. Indique donde nacieron sus padres:

1 = Estados Unidos (no incluye Puerto Rico)  
2 = México  
3 = Puerto Rico  
4 = Cuba  
5 = Centroamérica (especifique el país)  
6 = Sudamérica (especifique el país)  
7 = Otro (especifique el país)

11. Responda esta pregunta solamente si usted nació en los EE.UU. Por favor indique si usted es:

1 = Primera Generación (Nacido en los Estados Unidos)

- 2 = Segunda Generacion Americano (Hijos nacidos en Estados Unidos de al menos un padre nacido en el extranjero)
- 3 = Tercera Generacion Americano (Hijos nacidos en los Estados Unidos de al menos un padre nacido en Estados Unidos, en el que por lo menos un abuelo es nacido en el extranjero)
- 4 = Otro (Familia ha estado en los EE.UU. por más de 3 generaciones)

12. Si nació fuera de los Estados Unidos, ¿cuántos años ha vivido en los Estados Unidos?

\_\_\_\_\_

13. Cuántos años ha vivido en los estados unidos \_\_\_\_\_

14. Indique su afiliación espiritual / religiosa (si corresponde):

- 1 = Agnostico
- 2 = Ateo
- 3 = Budista/Taoista
- 4 = Cristiano/Catolico
- 5 = Cristiano/Protestante
- 6 = Cristiano/Otro
- 7 = Hindu
- 8 = Judio
- 9 = Musulman/Islam
- 10 = Espiritual pero no religioso
- 11 = Otro, Por Favor especifica

## Appendix M

### Spanish Version of the Interpersonal Sexual Objectification Scale

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Por favor, piense detenidamente acerca de sus experiencias en el ÚLTIMO AÑO y responda a las preguntas de acuerdo con la siguiente escala:

**1. ¿Con qué frecuencia te han silbado mientras caminas por la calle?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**2. ¿Con qué frecuencia has notado que alguien te mira los pechos cuando está hablando contigo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**3. ¿Con qué frecuencia has sentido que alguien estaba evaluando tu apariencia física?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**4. ¿Con qué frecuencia has sentido que alguien estaba mirando fijamente tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**5. ¿Con qué frecuencia has notado que alguien mira lascivamente tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**6. ¿Con qué frecuencia has escuchado comentarios sexuales groseros sobre tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**7. ¿Con qué frecuencia te han manoseado contra tu voluntad?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**8. ¿Con qué frecuencia te has sentido acosada sexualmente (en el trabajo, en la escuela, etc.)?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**9. ¿Con qué frecuencia te han pitado mientras estabas caminando por la calle?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**10. ¿Con qué frecuencia has visto que alguien se fija en algunas partes de tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**11. ¿Con qué frecuencia has escuchado sin querer, a otros, hacer comentarios sexuales sobre tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**12. ¿Con qué frecuencia has notado que alguien no estaba escuchando lo que dices, sino mirando fijamente algunas partes de tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**13. ¿Con qué frecuencia has escuchado que alguien hace un comentario sexual o se insinúa mientras está mirando tu cuerpo?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**14. ¿Con qué frecuencia te han agarrado o pellizcado alguna parte íntima de tu cuerpo contra tu voluntad?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

**15. ¿Con qué frecuencia alguien ha hecho gestos sexuales degradantes sobre ti?**

1	2	3	4	5
Nunca	Rara vez	Ocasionalmente	Frecuentemente	Siempre

Appendix N

Spanish Version of the Sociocultural Attitudes Towards Appearance Questionnaire-  
Internalization Subscale

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Por favor lee las siguientes preguntas cuidadosamente y elije la respuesta de 1  
(Totalmente de acuerdo) a 5 (Totalmente en desacuerdo) que mejor se adecue a tí.

1. Las mujeres que aparecen en shows o espectáculos televisivos y películas tienen el tipo de apariencia que veo como mi meta:

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

2. Creo que la vestimenta se ve mejor en modelos delgadas:

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

3. Los videos musicales que muestran mujeres delgadas me hacen desear ser delgada:

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

4. Me gustaría verme o ser como las modelos en las revistas: (not reverse scored)

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

5. Tiendo a comparar mi cuerpo con gente de revistas y TV:

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

6. Las fotografías de mujeres delgadas me hacen desear ser delgada: (6)

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

7. Me gustaría verme como una modelo de traje de baño: (7)

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

8. Leo regularmente revistas como Cosmo, Vogue y Vanidades y comparo mi apariencia con la de las modelos: (8)

1	2	3	4	5
Totalmente de acuerdo				Totalmente en desacuerdo

## Appendix O

### Spanish Version of the Eating Disorder Examination Questionnaire

Instrucciones: Este cuestionario evalúa los hábitos y estilos de alimentación. Las siguientes preguntas se refieren al **ÚLTIMO MES O A LOS ÚLTIMOS TRES MESES**. Lee cada pregunta con atención y rodea con un círculo el número que corresponda. Es importante que contestes a todas las preguntas. No hay respuestas buenas ni malas, sino que es tu propia respuesta la que cuenta.

Cuántos días en los pasados 28 días...	Ningún día	1-5 días	6-12 días	13-15 días	16-22 días	23-27 días	Todos los días
1. ¿Has intentado limitar deliberadamente la cantidad de comida que comes para que influya en tu silueta o peso?	0	1	2	3	4	5	6
2. ¿Has pasado por períodos de 8 o más horas de vigilia sin comer nada para que influya en tu silueta o peso?	0	1	2	3	4	5	6
3. ¿Has intentado evitar comer algunos alimentos que te gustan para que influya en tu silueta o peso?	0	1	2	3	4	5	6
4. ¿Has intentado seguir reglas determinadas en tu alimentación destinadas a influir en tu silueta o peso; por ejemplo,	0	1	2	3	4	5	6

limitar calorías, la cantidad total de ingesta, o normas como cuánto o cuándo comer?							
5. ¿Has deseado que tu estómago esté vacío?	0	1	2	3	4	5	6
6. ¿Pensar en alimentos o su contenido calórico ha interferido con tu capacidad de concentrarte en cosas en las que estás interesado como, por ejemplo, leer, ver la TV o seguir una conversación?	0	1	2	3	4	5	6
7. ¿Has tenido miedo de perder el control sobre la comida?	0	1	2	3	4	5	6
8. ¿Has tenido episodios de atracones?	0	1	2	3	4	5	6
9. ¿Has comido en secreto (exceptuando atracones)?	0	1	2	3	4	5	6
10. ¿Has tenido un claro deseo de tener el vientre plano?	0	1	2	3	4	5	6

11. ¿Pensar en la silueta o el peso ha interferido con tu capacidad de concentrarte en cosas en las que estás interesado, como, por ejemplo, leer, ver la TV o seguir una conversación?	0	1	2	3	4	5	6
12. ¿Has sentido un claro temor de engordar o de convertirte en obeso/a?	0	1	2	3	4	5	6
13. ¿Te has sentido gordo/a?	0	1	2	3	4	5	6
14. ¿Has sentido un fuerte deseo de perder peso?	0	1	2	3	4	5	6

### EN LOS ÚLTIMOS TRES MESES:

15 ¿Cuántas veces te has sentido culpable después de comer por el efecto que pueda tener en tu silueta y peso (exceptuando atracones)

- 0 - Ninguna vez
- 1 - Alguna vez
- 2 - Menos de la mitad de las veces
- 3 - La mitad de las veces
- 4 - Más de la mitad de las veces
- 5 - La mayoría de las veces
- 6 - Siempre

16 ¿Ha habido veces en las que has sentido que has comido lo que para otras personas es una cantidad anormalmente grande de comida en esas circunstancias? 0 – No 1 - Sí

En caso afirmativo:

17 ¿Cuántas veces a la semana han tenido lugar como promedio estos episodios de sobreingesta? \_\_\_\_\_

18 ¿Durante cuántos de estos episodios de sobreingesta has tenido la sensación de perder el control sobre lo que comías? \_\_\_\_\_

19 ¿Ha habido otros episodios en los que has tenido la sensación de perder el control y comer demasiado, sin que haya sido una cantidad anormalmente grande en esas circunstancias?

0 – No 1 - Sí

En caso afirmativo:

20 ¿Cuántas veces han tenido lugar estos episodios? \_\_\_\_\_

21 ¿Te has provocado el vómito para controlar tu figura o tu peso? 0 – No 1 - Sí

En caso afirmativo:

22 ¿Cuántas veces a la semana lo has hecho como promedio? \_\_\_\_\_

23 ¿Has tomado laxantes para controlar tu figura o tu peso? 0 – No 1 – Sí

En caso afirmativo:

24 ¿Cuántas veces a la semana lo has hecho como promedio? \_\_\_\_\_

25 ¿Has tomado diuréticos para controlar tu figura o tu peso? 0 – No 1 – Sí

En caso afirmativo:

26 ¿Cuántas veces a la semana lo has hecho como promedio? \_\_\_\_\_

27 ¿Has realizado ejercicio enérgico para controlar tu figura o tu peso? 0 – No 1 – Sí

En caso afirmativo:

28 ¿Cuántas veces a la semana lo has hecho como promedio? \_\_\_\_\_

En los últimos 3 meses...	Nada en absoluto		Levemente		Moderadamente		Marcadamente	
	0	1	2	3	4	5	6	
29. ¿Ha influido tu peso en cómo te has juzgado a ti mismo/a como persona?	0	1	2	3	4	5	6	
30. ¿Ha influido tu figura en cómo te has juzgado a ti mismo/a como persona?	0	1	2	3	4	5	6	
31. ¿En qué medida te molestaría si tuvieras que pesarte una vez por semana durante los próximos tres meses?	0	1	2	3	4	5	6	
32. ¿En qué grado has sentido insatisfacción por tu peso?	0	1	2	3	4	5	6	
33. ¿En qué grado has sentido insatisfacción por tu figura?	0	1	2	3	4	5	6	
34. ¿En qué grado te ha								

preocupado que otra gente te vea comer?	0	1	2	3	4	5	6
35. ¿En qué grado te has sentido incómodo/a al ver tu cuerpo, por ejemplo, en el espejo, reflejado de un escaparate, cuando te desvistes o te duchas?	0	1	2	3	4	5	6
36. ¿En qué grado te has sentido incómodo/a cuando otros ven tu cuerpo, por ejemplo, en los vestuarios, nadando o llevando ropas ajustadas?	0	1	2	3	4	5	6

Appendix P

Spanish Version of the Acculturation Rating Scale for Mexican Americans-II

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Para cada articulo, por favor, seleccione el valor que mejor se aplique a usted:

- (5) Muchísimo o casi todo el tiempo
- (4) Mucho o muy frecuente
- (3) Moderado
- (2) Un poquito o a veces
- (1) Nada

- 1. Yo hablo Español..... (1) (2) (3) (4) (5)
- 2. Yo hablo Inglés..... (1) (2) (3) (4) (5)
- 3. Me gusta hablar en Español..... (1) (2) (3) (4) (5)
- 4. Me asocio con Mexicanos con Anglos..... (1) (2) (3) (4) (5)
- 5. Me asocio con Mexicanos o con Norte Americanos..... (1) (2) (3) (4) (5)
- 6. Me gusta la musica Mexicana (musica en idioma Español ..... (1) (2) (3) (4) (5)
- 7. Me gusta la musica de idioma Ingles..... (1) (2) (3) (4) (5)
- 8. Me gusta ver programas en la televisión que sean en Español..... (1) (2) (3) (4) (5)
- 9. Me gusta ver programas en la televisión que sean en Inglés ..... (1) (2) (3) (4) (5)
- 10. Me gusta ver películas en Español..... (1) (2) (3) (4) (5)
- 11. Me gusta ver películas en Inglés. .... (1) (2) (3) (4) (5)
- 12. Me gusta leer en Español..... (1) (2) (3) (4) (5)
- 13. Me gusta leer en Inglés..... (1) (2) (3) (4) (5)
- 14. Escribo (como cartas) en Español..... (1) (2) (3) (4) (5)
- 15. Escribo (como cartas) en Inglés..... (1) (2) (3) (4) (5)
- 16. Mis pensamientos ocurren en el idioma Inglés..... (1) (2) (3) (4) (5)
- 17. Mis pensamientos ocurren en el idioma Español ..... (1) (2) (3) (4) (5)
- 18. Mi contacto con países latinos ha sido..... (1) (2) (3) (4) (5)
- 19. Mi contacto con Estados Unidos ha sido..... (1) (2) (3) (4) (5)
- 20. Mi padre se identifica (o se identificaba) como Latino..... (1) (2) (3) (4) (5)
- 21. Mi madre se identifica (o se identificaba) como Latina..... (1) (2) (3) (4) (5)
- 22. Mis amigos(as) de mi niñez eran de origen Latino/a..... (1) (2) (3) (4) (5)
- 23. Mis amigos(as) de mi niñez eran de origen Anglo Americano..... (1) (2) (3) (4) (5)
- 24. Mi familia cocina comidas Latino/as..... (1) (2) (3) (4) (5)
- 25. Mis amigos(as) recientes son Anglo Americanos..... (1) (2) (3) (4) (5)
- 26. Mis amigos(as) recientes son Latinos/as..... (1) (2) (3) (4) (5)
- 27. Me gusta identificar me como Anglo Americano..... (1) (2) (3) (4) (5)
- 28. Me gusta identificar me como Latino/a Americano o Norte Americano... (1) (2) (3) (4) (5)
- 29. Me gusta identificar me com Latino/a..... (1) (2) (3) (4) (5)
- 30. Me gusta identificar me como un(a) Americano(a)..... (1) (2) (3) (4) (5)

Appendix Q

Spanish Version of the Multidimensional Acculturative Stress Inventory

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Lea cada frase cuidadosamente y primero decide si ha experimentado la situación en los últimos 3 meses. Si ha experimentado la situación en los últimos 3 meses, circule SÍ. Entonces circule el numero que mejor representa CUÁNTO ESTRÉS ha tenido en esa situación. Si no ha experimentado la situación en los últimos 3 meses, circule NO y sigue al proximo frase.

1. Tengo dificultad entendiendo a la gente cuando hablan en inglés.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto stres ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #2.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Nada</i>	<i>Un Poco</i>	<i>Algo</i>	<i>Mucho</i>	<i>Muchísimo</i>
<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>Estrés</i>

2. Tengo dificultad entendiendo a la gente cuando hablan en español.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto stres ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #3.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Nada</i>	<i>Un Poco</i>	<i>Algo</i>	<i>Mucho</i>	<i>Muchísimo</i>
<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>Estrés</i>

3. Me siento presionado/a al aprender español.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto stres ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #4.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Nada</i>	<i>Un Poco</i>	<i>Algo</i>	<i>Mucho</i>	<i>Muchísimo</i>
<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>de Estrés</i>	<i>Estrés</i>

4. Me molesta que hablo ingles con un acento.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto stres ha tenido en esta situación en los últimos 3 meses?

Si contestó NO, sigue a #5.

<b>1</b> <i>Nada de Estrés</i>	<b>2</b> <i>Un Poco de Estrés</i>	<b>3</b> <i>Algo de Estrés</i>	<b>4</b> <i>Mucho de Estrés</i>	<b>5</b> <i>Muchísimo Estrés</i>
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5. Me molesta que hablo español con un acento.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #6.

<b>1</b> <i>Nada de Estrés</i>	<b>2</b> <i>Un Poco de Estrés</i>	<b>3</b> <i>Algo de Estrés</i>	<b>4</b> <i>Mucho de Estrés</i>	<b>5</b> <i>Muchísimo Estrés</i>
---------------------------------------	--	---------------------------------------	--	---

6. Como no hablo bien el inglés, la gente me ha tratado rudamente o injustamente.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #7.

<b>1</b> <i>Nada de Estrés</i>	<b>2</b> <i>Un Poco de Estrés</i>	<b>3</b> <i>Algo de Estrés</i>	<b>4</b> <i>Mucho de Estrés</i>	<b>5</b> <i>Muchísimo Estrés</i>
---------------------------------------	--	---------------------------------------	--	---

7. He sido discriminado porque tengo dificultad hablando inglés.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #8.

<b>1</b> <i>Nada de Estrés</i>	<b>2</b> <i>Un Poco de Estrés</i>	<b>3</b> <i>Algo de Estrés</i>	<b>4</b> <i>Mucho de Estrés</i>	<b>5</b> <i>Muchísimo Estrés</i>
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8. No hablo inglés o no lo hablo bien.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #9.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Nada de Estrés</i>	<i>Un Poco de Estrés</i>	<i>Algo de Estrés</i>	<i>Mucho de Estrés</i>	<i>Muchísimo Estrés</i>

9. No hablo español o no lo hablo bien.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #10.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Nada de Estrés</i>	<i>Un Poco de Estrés</i>	<i>Algo de Estrés</i>	<i>Mucho de Estrés</i>	<i>Muchísimo Estrés</i>

10. Me siento presionado/a al aprender inglés.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #11.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Nada de Estrés</i>	<i>Un Poco de Estrés</i>	<i>Algo de Estrés</i>	<i>Mucho de Estrés</i>	<i>Muchísimo Estrés</i>

11. Me siento incómodo/a alrededor de gente que sólo habla inglés.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #12.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<i>Nada de Estrés</i>	<i>Un Poco de Estrés</i>	<i>Algo de Estrés</i>	<i>Mucho de Estrés</i>	<i>Muchísimo Estrés</i>

12. Me siento incómodo/a alrededor de gente que sólo habla español.

**SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #13.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
----------	----------	----------	----------	----------

*Nada  
de Estrés*

*Un Poco  
de Estrés*

*Algo  
de Estrés*

*Mucho  
de Estrés*

*Muchísimo  
Estrés*

13. Me molesta cuando la gente asume que hablo inglés.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #14.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

14. Me molesta cuando la gente asume que hablo español.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #15.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

15. Como no hablo bien el español, la gente me ha tratado rudamente o injustamente.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #16.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

16. He sido discriminado porque tengo dificultad hablando español.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #17.

*1*

*2*

*3*

*4*

*5*

*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

17. Me molesta cuando la gente me presiona a asimilar al modo Americano de hacer las cosas.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #18.

*1 Nada de Estrés*                      *2 Un Poco de Estrés*                      *3 Algo de Estrés*                      *4 Mucho de Estrés*                      *5 Muchísimo Estrés*

18. Me molesta cuando la gente no respeta mis valores Mexicanos/Latinos (por ejemplo, familia).

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #19.

*1 Nada de Estrés*                      *2 Un Poco de Estrés*                      *3 Algo de Estrés*                      *4 Mucho de Estrés*                      *5 Muchísimo Estrés*

19. Me molesta cuando la gente no respeta mis valores Americanos (por ejemplo, independecia).

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #20.

*1 Nada de Estrés*                      *2 Un Poco de Estrés*                      *3 Algo de Estrés*                      *4 Mucho de Estrés*                      *5 Muchísimo Estrés*

20. Estoy consciente de mi mismo/a por mi fondo Mexicano/Latino.

*SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #21.

*1*                      *2*                      *3*                      *4*                      *5*

*Nada  
de Estrés*

*Un Poco  
de Estrés*

*Algo  
de Estrés*

*Mucho  
de Estrés*

*Muchísimo  
Estrés*

21. Estoy consciente de mi mismo/a por mi fondo Americano.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #22.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

22. Por mi origen cultural, tengo dificultad relacionando con Americanos.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #23.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

23. Por mi origen cultural, tengo dificultad relacionando con Mexicanos/Latinos.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #24.

*1  
Nada  
de Estrés*

*2  
Un Poco  
de Estrés*

*3  
Algo  
de Estrés*

*4  
Mucho  
de Estrés*

*5  
Muchísimo  
Estrés*

24. No me siento aceptado/a por Mexicanos/Latinos.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #25.

*1*

*2*

*3*

*4*

*5*

*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

25. No me siento aceptado/a por Americanos. *SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #26.

*1*                      *2*                      *3*                      *4*                      *5*  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

26. He tenido conflictos con otros porque prefiero las costumbres Americanas (por ejemplo, celebrando Halloween, Thanksgiving), sobre las costumbres Mexicanas/Latinas (por ejemplo, celebrando Dia de los Muertos, Quinceañeras). *SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #27.

*1*                      *2*                      *3*                      *4*                      *5*  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

27. He tenido conflictos con otros porque prefiero las costumbres Mexicanas/Latinas, (por ejemplo, celebrando Dia de los Muertos, Quinceañeras), sobre las costumbres Americanas (por ejemplo, celebrando Halloween, Thanksgiving). *SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #28.

*1*                      *2*                      *3*                      *4*                      *5*  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

28. La gente me mira mal si practico costumbres Mexicanas/Latinas. *SÍ*  
*NO*

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #29.

*1*                      *2*                      *3*                      *4*                      *5*

*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

29. La gente me mira mal si practico costumbres Americanas. **SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #30.

**1**                      **2**                      **3**                      **4**                      **5**  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

30. Me siento incómodo/a cuando tengo que escoger entre los modos Mexicanos/Latinos y los modos Americanos de hacer las cosas. **SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #31.

**1**                      **2**                      **3**                      **4**                      **5**  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

31. Me siento incómodo/a porque mi familia no sabe los modos Americanas de hacer las cosas. **SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #32.

**1**                      **2**                      **3**                      **4**                      **5**  
*Nada de Estrés*                      *Un Poco de Estrés*                      *Algo de Estrés*                      *Mucho de Estrés*                      *Muchísimo Estrés*

32. Me siento incómodo/a porque mi familia no sabe los modos Mexicanos/Latinos de hacer cosas. **SÍ**  
**NO**

Si contestó SÍ, ¿cuánto estres ha tenido en esta situación en los ultimos 3 meses?  
Si contestó NO, sigue a #33.

**1**                      **2**                      **3**                      **4**                      **5**

<i>Nada de Estrés</i>	<i>Un Poco de Estrés</i>	<i>Algo de Estrés</i>	<i>Mucho de Estrés</i>	<i>Muchísimo Estrés</i>
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33. Me siento incómodo/a cuando otros esperan que yo sepa el modo Americano de hacer las cosas.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #34.

<i>1 Nada de Estrés</i>	<i>2 Un Poco de Estrés</i>	<i>3 Algo de Estrés</i>	<i>4 Mucho de Estrés</i>	<i>5 Muchísimo Estrés</i>
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34. Me siento incómodo/a cuando otros esperan que yo sepa el modo Mexicano/Latino de hacer las cosas.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #35.

<i>1 Nada de Estrés</i>	<i>2 Un Poco de Estrés</i>	<i>3 Algo de Estrés</i>	<i>4 Mucho de Estrés</i>	<i>5 Muchísimo Estrés</i>
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35. A veces, quisiera ser mas Americano/a.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?  
Si contestó NO, sigue a #36.

<i>1 Nada de Estrés</i>	<i>2 Un Poco de Estrés</i>	<i>3 Algo de Estrés</i>	<i>4 Mucho de Estrés</i>	<i>5 Muchísimo Estrés</i>
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36. A veces, quisiera ser mas Mexicano/Latino.

*SÍ  
NO*

Si contestó SÍ, ¿cuánto estrés ha tenido en esta situación en los últimos 3 meses?

<i>1 Nada de Estrés</i>	<i>2 Un Poco de Estrés</i>	<i>3 Algo de Estrés</i>	<i>4 Mucho de Estrés</i>	<i>5 Muchísimo Estrés</i>
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## Appendix R

### Spanish Version of the Brief Measure of Religious Coping Styles

Para cada artículo, por favor, seleccione el valor que mejor se aplique a usted:

1	2	3	4
Nada			Mucho

#### *Religioso Positivo*

1. Busqué una conexión más fuerte con Dios.	1	2	3	4
2. Busqué el amor y el cuidado de Dios.	1	2	3	4
3. Busqué la ayuda de Dios para renunciar a mi coraje.	1	2	3	4
4. Traté de llevar a cabo mis planes junto con Dios.	1	2	3	4
5. Traté de ver cómo podría Dios estar tratando de fortalecerme en esta situación.	1	2	3	4

#### *Religiosos Negativos*

6. Me pregunté si Dios me había abandonado.	1	2	3	4
7. Sentí que Dios me estaba castigando por mi falta de devoción.	1	2	3	4
8. Me pregunté que es lo que hice para que Dios me castigara.	1	2	3	4
9. Cuestioné el amor de Dios por mí.	1	2	3	4
10. Me pregunté si mi iglesia me había abandonado.	1	2	3	4
11. Cuestioné el poder de Dios.	1	2	3	4

## VITA

Sara Aslan was born on April 5, 1983 in Indio, California. She was educated in local public schools, graduating from La Quinta High School in 2001. Sara also graduated from The University of California, San Bernardino with a bachelor's degree in psychology, and The University of San Francisco with a master's degree in counseling psychology, with an emphasis on marriage and family therapy. Sara became involved in research, and was involved in international research at both the undergraduate and graduate levels.

Upon completion of her master's degree, Sara worked in the field of eating disorder treatment; in nonprofit, private practice, and IOP/PHP levels of treatment. Wanting to gain more knowledge in assessment and trauma, Sara pursued her Ph.D. in counseling psychology at The University of Missouri – Kansas City. Clinical and research interest areas focused primarily of diversity-based topics, with a particular focus on objectification theory, eating disorders, trauma, and culturally specific coping mechanism among Women of Color.