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One Size Fits All? Examining Body Dissatisfaction and Eating Disorder Risk in Latina Women

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One Size Fits All? Examining Body Dissatisfaction and Eating Disorder Risk in Latina Women

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Report

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Arts

The University of Texas at Austin

December 2018

Abstract

One Size Fits All? Examining Body Dissatisfaction and Eating Disorder Risk in Latina Women

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The University of Texas at Austin, 2018

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Despite high reports of body-image related pathology in Latinas, how traditional cultural factors contribute to body dissatisfaction and eating disorder etiology is unknown. Current conceptualizations of eating disorder etiology, developed from studies on predominantly White women, reflect the Anglo-American experience. Examining the negotiation between Latino and American sociocultural ideals and influences is imperative to understanding culture's impact on body-image pathology. A hierarchical regression will be utilized where acculturation and cultural values will serve as predictors of body dissatisfaction and eating disorder risk in a sample of Latina college students. Failure to understand culturally-specific Latino influences perpetuates under-identification of EDs and comorbidities as well as inability to develop culturally-competent interventions.

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Introduction

Most research conducted in the areas of body image development and eating disorders (EDs) assumes such issues primarily affect White women from higher socio-economic status backgrounds (Bosson et al., 2008; Thompson et al., 1990). In ethnic minority women displaying body-related pathology, presenting symptomology is often conceptualized through a Westernized lens, which assumes that women of ethnic minority groups prioritize the same values and physical ideals as White women (Calogero et al., 2007; Gilbert et al., 2005). It has been widely hypothesized that if ethnically-based differences in aesthetic body ideals do exist, these differences mitigate cultural pressures contributing to body disparagement and disordered eating among White women, thus protecting ethnic minority women from developing severe body-related pathology. Despite such assumptions, research examining eating disorder etiology and body image development in ethnically diverse populations is limited or misunderstood (Dolan, B., 1991; Gluck & Geliebter, 2002; Striegel et al., 1986). In recent years, there has been a shift to include ethnic minority groups in eating disorder etiology and body dissatisfaction research to better understand the impact of culture on body image development and eating disorder manifestations, but much is still unknown (Grabe & Hyde, 2006; Hrabosky & Grilo, 2007; Lovejoy, 2001; Ricciardelli et al., 2007).

In the United States, 20 million women and 10 million men suffer from a clinically significant eating disorder at some time in their life (Wade et al., 2011; Diagnostic and Statistical Manual of Mental Disorders, DSM-5, 2013). Evidence suggests that Latinas are affected by eating disorders and poor body image. Although less

attention has been focused on this group, data is emerging exposing elevated eating disorder-related pathology documented in healthcare clinics and university mental health settings among Latina populations (Alegria et al., 2007). Comparable rates of disordered eating behaviors such as restricting (avoidance or restriction of food intake), purging (self-induced vomiting), and use of laxatives, diuretics, and diet pills are reported among Latinas and White college-aged women (Cachelin et al., 2000; Crago & Shisslak, 2003). Studies examining White, Latina, African-American, and Asian women indicate that Latina college-aged women have higher prevalence rates of disordered eating symptomology (Becker et al., 2003), rapidly increasing eating disorder diagnoses (Alegria et al., 2007), lower self-esteem surrounding appearance (Altabe, 1998; Granillo et al., 2005), and higher levels of body dissatisfaction than other ethnic minority groups (Altabe & O'Garo, 2002; Gordon et al., 2010; Perez & Joiner, 2003; Webb et al., 2013).

The proposed study intends to establish the extent to which body dissatisfaction and eating disorder risk in a sample of Latina college students are impacted by acculturation, sociocultural influences, objectification, and culture-specific values to elucidate how cultural components of identity contribute to the increase of body-image related psychopathology affecting Latina women in the U.S. The danger in failing to understand the culturally-specific, interconnected factors contributing to body image development and eating disorder risk in Latina women in the U.S. has resulted in vastly under-identifying eating disorders and comorbid dysfunction in this population, and failure in developing culturally-relevant interventions, thus coming far short of delivering culturally competent mental health care.

Literature Review

Body Dissatisfaction and Eating Disorder Risk

Body image is defined as the subjective image an individual has of their own body, specifically with respect to evaluative judgments about the perception of others and the ability to adjust or be impacted by such perceptions (Reber, 1995). Body image is a broad term, which includes behavioral, perceptual, cognitive, and affective phenomena (Thompson et al., 1999). Poor body image, also referred to as body dissatisfaction, is conceptualized as the discrepancy between the perceived self and the ideal self. Body dissatisfaction is consistently identified as the most powerful predictor for the development of eating disorder (ED) symptomology (Cash & Deagle, 1997; Hrabosky & Grilo, 2007; Polivy & Herman, 2002). Thompson et al. (1999) found that body image is central to adolescent female self-definition, and perceived appearance is the strongest single predictor of self-esteem ratings among female adolescents. Researchers have continuously found higher levels of body dissatisfaction among women with eating disorders (Williamson et al., 1993). Body dissatisfaction is so pervasive in conjunction with eating disorders that it is included as one of the two hallmark characteristics of clinical eating disorders recognized by the American Psychological Association (Striegel-Moore & Smolak, 2000). For the past 35 years, both the American Psychiatric Association in collaboration with the American Psychological Association and the World Health Organization include body image disturbances as diagnostic criteria for eating disorders.

Body dissatisfaction has been acknowledged by many researchers and practitioners as the "gateway" to eating disorder development (Perez & Joiner, 2003; Shroff & Thompson, 2006; Thompson et al., 1995). Multiple longitudinal studies conclude that poor body image, manifested in weight and shape concerns, predict the onset of eating disorders, with several studies also indicating that dieting practices to address such weight and shape concerns predict both the onset and exacerbation of eating disorder symptomology, severity, and onset of comorbid disorders (Wertheim, Paxton, & Blaney, 2009; Neumark-Sztainer et al., 2006; Stice et al., 1999). In addition to being a reliable predictor of disorder eating behavior, body dissatisfaction has been associated with decreased life satisfaction (Bromley, 1999), depression (Noles et al., 1985), low self-esteem (Powell and Hendricks, 1999), impaired sexual functioning, diminished quality of life, and lower evaluations of personal worth (Cash et al., 2004; Grogan, 1999; Smolak & Striegel-Moore, 2004).

Body dissatisfaction seems to be ubiquitous among females with few cultural exceptions. In general, eating disorder research posits that women perceive their current body figure to be heavier than a figure denoted as the "ideal". Such a perception has been found to be uniform across studies including adolescent and elderly White females, as well as minority adolescent females (Boroughs et al., 2010; Gluck & Geliebter, 2002; Thompson et al., 2004). Most of the research delineating body dissatisfaction as a risk factor for eating disorder development has been conducted on White college women due to convenience in sampling for many researchers, exposing a need to conduct more culturally-specific research to confirm the generalizability of body dissatisfaction as a

predictor to ED risk across ethnicities while also unmasking the specific etiology of body dissatisfaction and eating disorders in ethnic minority groups.

Literature on body image has debunked the myth that ethnic minority women are less concerned about weight and appearance and are at reduced risk for eating disorder development (Gilbert, 2003). Epidemiological evidence suggests that body dissatisfaction and eating disorders are not only prevalent in Latinas (George & Franko, 2010), they even surpass rates found among White women at times. Cashel et al. (2003) reported no significant differences in endorsement of body-related worries between Latina and White female undergraduates, while other studies note that within their samples, Latinas had higher rates of body-related concerns than their White counterparts (Alegria et al., 2007; Becker et al, 2003; George et al., 2007). Results in a study conducted by Robinson et al. (1996) found that young Latinas reported significantly greater body dissatisfaction than White and Asian girls, and suggested that Latina adolescent females were at greater risk of developing disordered eating than previously acknowledged.

There are also significant clinical issues related to the diagnosis and treatment of body-related disorders in Latinas, as studies have shown that across ethnic groups, Latinas are least likely to be referred for eating disorder evaluation despite endorsing the most severe cognitive and behavioral eating disorder symptoms compared to their White counterparts. Gordon et al. (2006) found that clinicians are less likely to recognize eating disorders in ethnic minority women than in White women, even after controlling for symptoms of severity, raising the question of whether the classification criteria for identifying body dissatisfaction and eating disorders is cross-culturally effective. The

under-recognition of body dissatisfaction and eating disorders in Latinas could be due to a number of factors, exposing the need for further research to delineate the process of body image development and eating disorder etiology specific to this population.

To address the growing prevalence of eating disorders and related symptomology in Latinas, researchers and clinicians have started to explore the role of ethnicity, culture, and ethnic identity in body image development and eating disorder etiology. Ethnic identity encapsulates the feeling of belonging to an ethnic or cultural group as well as how much an individual attributes ethnic cultural values, social practices, language, and attitudes as primary components of their self-identity (Phinney, 1996). In Latino culture, gender role themes are pervasive and represent central components of ethnic identity development for many Latinas. Since identity for Latinas is greatly influenced by gender-specific values, awareness of the unique cultural principles important to this population is integral to deciphering how culture impacts body-related pathology.

Latinas and Marianismo

The idea that ethnicity and culture play significant roles in the etiology of eating disorders has only recently been considered, with more current research suggesting a complex relationship between ethnicity, culture, body dissatisfaction, and EDs (Jacobi et al., 2004; Striegel-Moore & Smolak, 2000). Early accounts postulating that White women were at increased risk for eating disorders relative to members of ethnic-minority groups are now being contested after multiple studies examining racially diverse samples of women demonstrated that ethnic minority females were at similar, and sometimes

higher, levels of risk for developing psychopathological ED disturbance (Joiner & Kashubeck, 1996; Shroff & Thompson, 2004; Webb et al., 2013; Yanover & Thompson, 2010). Root (1990) suggested that Latinas experience an increasing vulnerability to EDs, potentially due to pressures from mainstream standards in the U.S. in addition to economic and sociopolitical factors.

Most empirical research on body dissatisfaction and eating disorders has not included Latinas. In the few instances where Latinas were included, cultural components pertinent to Latina identity were not examined explicitly despite the recognition that cultural variables and societally sanctioned standards of appearance in Western countries greatly impact body image and eating disturbance in Westernized White women (Heinberg, Thompson, & Stormer, 1995). Most effective evidence-based interventions for body image and eating disorders target Western cultural and societal influences (Thompson, 1992), demonstrating that body dissatisfaction and eating disorders are culturally and socially determined (Logue, 1991). Before incorporating cultural components into interventions and treatments to address the needs of Latinas with body image concerns, understanding Latino cultural values is imperative.

Latino communities comprise one of the fastest growing minority populations in the US, yet Latinas have largely been ignored in research on EDs (Keel & Klump, 1993; Reyes-Rodriguez et al., 2013). Some research has noted a subset of Latinas in their study samples reporting feeling pressure to conform to an unattainable White standard of beauty, but results were inconclusive due to issues surrounding subject samples (Davis & Yager, 1992), or acquiring the statistical significance necessary to assert that cultural

factors have a predictive effect on body dissatisfaction or ED risk (Joiner & Kashubeck, 1996).

Western standards of beauty have been widely disseminated among the non-Western world. As a result, some researchers assert that in Latino cultures, Western standards of beauty trump, or even erase, other culturally traditional standards of beauty (Thompson et al., 1999). In contrast to the belief that the native cultures of ethnic-minority populations boost self-esteem and protect members from developing EDs, some research suggests adolescents from ethnic-minority populations, specifically Latino immigrant populations, actually seek to be accepted and valued by the mainstream Western culture, ignoring or even rejecting traditional ethnic values and appearance ideals in the process (Chacis, 2007; Forbes, 2008).

Conflicting reports of the impact of Western standards of female beauty on Latino populations suggests Western influences alone do not fully account for the sociocultural influences impacting body image in Latinas (Marques et al., 2010). Values are a primary mechanism by which culture is transmitted (Roosa et al., 2002), and internalization of values is likely among the most important aspects contributing to ethnic identity development (Knight et al., 2009). Female gender roles for Latinas are particularly prominent and clearly defined in Latino culture. To capture the gender-specific and idealized beliefs, expectations, and norms placed on women in Latino culture, political scientist Evelyn Stevens (1973) developed the term *marianismo*. *Marianismo* describes an ideal Latina as virtuous, humble, self-sacrificing, pure, spiritual, and submissive to the demands of men and the family (Castillo & Cano, 2007). For Latinas, the process of

acculturation and identity development occurs within a heavily gender-specific context, which dictates how Latinas conceptualize and behaviorally display Latino cultural values (Stevens, 1973; Lavrin, 2004). Latino cultural values of *familismo, respeto,* and *simpatía* all have gender specific presentations within the context of *marianismo* and the culturally ideal Latina. *Familismo* is defined as an individual's strong identification with and attachment to the nuclear and extended family, stemming from a collectivistic worldview where interdependence and self-sacrifice for the group is the norm. Cultural norms for Latina adherence to *familismo* are expressed by providing physical and emotional support to the family, bearing and raising children, and maintaining the home (Raffaelli & Ontai, 2004; Triandis & Trafimox, 2001). *Respeto* is another gender specific value functioning to maintain the hierarchical family structure by providing a standard for how to respond to interpersonal discord (Santiago-Rivera et al., 2002). *Simpatía* is a cultural script outlining the expectation that Latinas display behavior promoting smooth and pleasant social relationships (Castillo & Cano, 2007). Since Latinas are expected to maintain the respect and honor of their family, *simpatía* dictates behaviors that maintain familial honor and relational harmony such as being patient and forgiving, avoiding controversial subjects, and not being critical of others (Castillo et al., 2010; Triandis et al., 1984).

Marianismo is comprised of both positive and negative behavioral expectations, both of which have been linked to mental health outcomes. The pressure from Latino family members to conform to traditional gender role norms can lead to internalized conflict for a Latina, especially if there is a discrepancy between a Latina's beliefs and her behaviors (Lester & Petrie, 1995). Due to the traditional gender-role qualities (self-

denial, submissiveness, objectification, chastity, and the patriarchal family structure) emphasized in *marianismo*, researchers hypothesize that Latina women who subscribe to *marianismo* are particularly vulnerable to psychological distress. Several studies exploring the impact of *marianismo* on mental health outcomes have found associations between endorsement of *marianismo* beliefs with intimate partner violence (Cianelly et al., 2008; Mouton, 2003), increased HIV risk (Jacobs & Thomlison, 2009), depression (Cuellar, Siles, & Bracamontes, 2004), and increased resistance to mental health interventions (Caplan & Whittemore, 2013).

It is difficult to decipher exactly how ascription to Latino cultural values impacts body dissatisfaction and ED risk in Latinas, although the data suggests that culture and ethnicity do matter. Due to adherence to traditional gender expectations described in *marianismo* coupled with increased body satisfaction, Latina women may be particularly vulnerable to psychological distress. Filling in the many gaps in understanding using multidisciplinary and mixed-methods research incorporating culturally-relevant intersectional considerations is critically important in better attuning treatment and prevention to body-related issues in Latinas. While *marianismo* is a necessary concept to integrate into conceptualizations of body image and eating pathology in Latinas, it is important to also examine how Westernized appearance standards and values impact Latina identity and body-related dysfunction.

Acculturation

Examining the impact of both Latino cultural values and Western influences on Latina identity is impossible to do without considering acculturation, or the process of shifting values to the host culture from the culture of origin (Graves, 1967). Immigrants tend to undergo a process of cultural transition in which their attitudes, beliefs, values, and behaviors change while adjusting to a new home country. The process of adjusting to mainstream American culture for Latino populations is complex, nuanced, and poorly understood. Although findings in research examining the effects of acculturation on Latino mental health are often inconsistent, evidence generally points towards acculturation having a negative effect on eating-related health behaviors in US Latino populations (Hester & Garner, 1992; Pumariega, 1986; Striegel-Moore et al., 1986). Higher levels of acculturation in Latinos have been associated with higher levels of alcohol use, increased substance abuse, obesity, and domestic violence (Boutelle et al., 2002; Striegel-Moore et al., 1986). In one study examining the link between acculturation and delinquent behavior in Latino adolescents, Vega et al. (1993) found significant associations between the acculturation process, low self-esteem, and internalizing problems, while the Center for Disease Control reported that nationally, nearly 20% of Latino high school students reported seriously considering suicide in the past twelve months (Kann et al., 2013). Researchers also report positive trends between acculturation and depression, social withdrawal, anxiety, and poor treatment compliance, although many of these studies were unable to achieve significant effects (Miranda et al, 2000; Berry, 1998; Harrell, 2000; Vega et al., 1993).

Research examining acculturative effects in Latina ED etiology is limited, but a few studies found evidence suggesting that increased level of acculturation was related to poor body image development in ethnic-minority populations (Chacis, 2007; Forbes, 2008). Studies have shown that Latinas categorized as more acculturated to the American culture are also more likely to endorse greater levels of body dissatisfaction and ED symptoms than less acculturated Latinas (Lopez et al., 1995; Chamorro & Flores-Ortiz, 2000; Pumariega, 1986). Researchers examining acculturative effects and ED pathology theorize that Latinas who acculturate to Western society are at an increased risk for developing body dissatisfaction and ED symptoms due to stress generated by arbitrating the conflicting cultural messages of excessive thinness projected by American media and Latino cultural messages of a full-figured ideal in their everyday lives (Torres et al., 2012). A study conducted by Perez et al. (2002) found acculturation to be a moderator of body dissatisfaction and bulimic symptoms in a sample of Latina, African-American, and Asian-American women, although the researchers grouped all three ethnic-minority groups together when conducting analyses. Failure to examine the distinct ethnic and acculturative experiences of Latinas has obscured the ability to uncover interactive effects between acculturation and ED-related factors. For Latinas who migrate to the United States or who live in environments that subscribe to Westernized appearance standards and pursue the White thin-ideal, degree of acculturation may account for increased body dissatisfaction, ED risk, and ED symptomology.

Distinguishing the impact of acculturation on identity development and mental health outcomes has resulted in convoluted findings, raising questions about the ability of

current measures to accurately capture the multifaceted components related to acculturation. Most acculturation measures are short, unidimensional instruments designed to target specific groups, but are often administered to sample populations where cross-cultural validity is unknown (Rudmin, 2011; Taras, 2007). Many validated measures are designed to assess behavioral acculturation outcomes without considering acculturation orientations (cultural adoption and cultural maintenance) or acculturation attitudes and preferences. There are two theoretical perspectives on acculturation directly implicated by acculturation orientation: dimensionality and domain-specificity (Arends-Toth & van de Vijver, 2003). Dimensionality, which captures the relationship of cultural adoption and maintenance, is commonly assessed in acculturation measures by organizing cultural maintenance and adoption as bipolar opposites, such that individual scores reflect the degree to which the culture of origin is maintained or the level of adaption to the culture of settlement. According to Berry (1997), conceptualizing acculturation orientations as anything but two distinct dimensions is highly problematic, as cultural maintenance and cultural adoption have been shown to be weakly associated. The Latina perception of ideal beauty could be a mixture of beauty characteristics from both Latino and American culture, which could very well be influenced by the bidimensional relationship of acculturation orientations yet overlooked during assessment of the acculturation process.

Latina perceptions of ideal beauty could stem from both Latino and American cultural values, further accentuating the fact that body-related dysfunction is a complex and multifaceted process influenced by many internal and external factors. Sociocultural

Theory (the theoretical perspective that body dissatisfaction is a consequence of multiple social and cultural factors) as well as Objectification Theory (a framework for understanding experiential consequences of sexual objectification of females) are two theoretical perspectives integrated into supported etiological models of body image development and eating disorders (Keel, 2005). Although there have recently been increased efforts to explore cultural factors related to body dissatisfaction and ED pathology, very few researchers have examined the applicability of etiological models of body dissatisfaction and disordered eating on Latina populations (Austin & Smith, 2008).

Sociocultural Theory and Objectified Body Consciousness

Although combinations of biological, psychological, familial, and sociological factors may precipitate EDs, many researchers view sociocultural influences as the major contributor to the rise of EDs in female populations. To understand the etiology and maintenance of EDs, one prominent etiological model that has received strong empirical support is the tripartite influence model (Thompson et al., 1999), which is based on sociocultural theories of body image disturbance and disordered eating (Tiggemann, 2011). This model theorizes that individuals are pressured by powerful social agents (i.e., peers, family, and the media) to adhere to culturally sanctioned appearance ideals, which emphasize unattainable thinness for women. These social pressures are proposed to lead individuals to internalize appearance ideals by setting the ideal as their own personal standard of attractiveness. Internalization of the unattainable ideal is thought to precipitate body dissatisfaction (Thompson, Schaefer, & Menzel, 2012).

The development of body dissatisfaction is heavily influenced by society's portrayal of beauty. Researchers posit body dissatisfaction may result not only from sociocultural pressures to be thin, but an inability to achieve the beauty ideal idolized in the dominant culture (Striegel-Moore et al., 1986; Silberstein et al., 1988). Some researchers have theorized that each culture has a unique view of what constitutes attractiveness in physical appearance, thus body types commonly associated with body dissatisfaction may differ across cultures (Hodes et al., 1996; Lopez et al., 1995). Since the Westernized White, ultra-thin, ideal female body portrayed by US media is unattainable for most women, attempts to reach this body type often result in body dissatisfaction and disordered eating behavior for American women (Agaliata & Tanteleff-Dunn, 2004; Moradi & Subich, 2002). Existing research suggests perceived pressure and internalization of American media ideals are highly associated with body image problems, however, there is little research exploring the role of acculturation and sociocultural ideals in body image development cross-culturally (Gordon et al., 2010; Pinhas et al., 1999).

Current research on EDs provides emphatic evidence of how cognitive components contribute to ED etiology, specifically components involving social cognition, social comparison, and objectification. Social cognition refers to the mental processes underlying human social behavior and interaction and has been described as "the ability to construct representations of the relation between oneself and others, and to use those representations flexibly to guide social behavior" (Adolphs, 2001). Social comparison theory suggests than an individual desires an accurate self-appraisal, which

motivates individuals to evaluate themselves based on their self-comparison to others (Festinger, 1954; Willis and Knobloch-Westerwick, 2014). In general, it has been shown that individuals will compare themselves to larger social groups (i.e. models or celebrities popularized by the media) or peers perceived to embody homogenous, positive attributes (Knobloch-Westerwick & Crane, 2012; Willis & Knoblock-Westerwick, 2014). An increasingly globalized, interconnected world exposes more people to the societal pressures common to many Western countries, which could explain the increased prevalence of EDs in ethnic minorities. Western media coverage promotes and bolsters an excessively thin ideal for women, which places pressure on the female demographic to conform to these perceived norms (Miller & Pumariega, 2001).

The process of acculturation involves social comparison when integrating into a host culture, as individuals use their social environments and the media during the comparative evaluation process. The process of acculturation may even increase the risk for body dissatisfaction and disordered eating in ethnic minority women, as the current ideal body image projected by Western society is much thinner and less achievable than the body image idealized in other cultures and societies (Cusumano & Thompson, 1997; Stice & Shaw, 1994). Thus, Western culture is deemed to be an influential platform for encouraging women to conform to an unrealistically thin ideal, hypothetically contributing to the manifestation of many maladaptive cognitive mechanisms underlying body dissatisfaction and ED pathology. It has been shown that media representations influence an individual's relationship to the dominant culture, cultivating ideas, norms,

and values to form a common worldview serving the dominant culture's needs (Stice & Shaw, 1994).

Images of unachievably thin, unrealistic women present in American media define women as successful or desirable if they achieve the ideal feminine state of thinness, or the "lean, fit, and toned" build (Bordo, 1993). For women in Western cultures, considerable value is placed on physical appearance as the central determinant of social standing, desirability, and personal worth. Researchers assert that women who attain excessive thinness, or the "lean, fit, and toned" build, gain social and economic rewards (Thompson et al., 1999). The reward of social and economic improvement reinforces a woman's desire to continue pursuing the American feminine ideal, even to the detriment of their health (Striegel-Moore et al., 1986; Thompson et al., 1999).

The social construction of female bodies within Westernized cultures, social comparison, and ED pathology can be bridged using the theoretical model of Objectification Theory, which suggests that a woman's body is often equated with who she is as a person (Fredrickson & Roberts, 1997; Moradi et al., 2005). Living in a culture where the female body is viewed as an object to be looked at, used, and sexualized by others teaches women to engage in self-objectification (to view their own bodies as outside observers), while simultaneously reinforcing a woman internalizing the idea that her true value is determined by societal opinions of her body's physical appeal. Using the conceptual foundation of Objectification Theory, the boundless objectification experienced by females is theorized to increase a woman's internalization of sociocultural standards of attractiveness, or the extent to which dominant societal beliefs

about appearance are adopted. Self-objectification is thought to result from exposure to objectified images of women in the media as well as women's perceptions that they are being physically scrutinized during interpersonal interactions (Frederickson and Roberts, 1997).

To capture the complex psychological manifestations and consequences described in Objectification Theory, McKinley & Hyde (1996) developed the psychological construct *Objectified Body Consciousness*, comprised of three dimensions: constant monitoring of how one's body looks *(body surveillance)*, internalization of cultural body standards *(internalization/body shame)*, and the belief that appearance can be controlled *(appearance control beliefs)*. Objectified body consciousness has been shown to implicate body esteem, psychological well-being, and the development of disordered eating behaviors among women (Fredrickson et al., 1998; Mckinley, 1999; Mckinley, 1995). Extensive research on objectified body consciousness, although primarily conducted on samples of White women in the US, provides evidence that having an objectified body perspective results in negative body experiences.

There are conflicting opinions on the role of objectified body consciousness in Latinas due to the assumption that Latino cultures and communities are more accepting of curvier female body types. Since the Latino culture and communities appear to classify a wider range of female body types as desirable, some researchers posit that Latinas are less concerned about achieving the excessively thin or "lean, fit, and toned" ideal salient for White women in Western cultures (Franko et al., 2012; Viladrich et al., 2009). Additionally, the link between acculturation and ED pathology in diverse samples has

yielded inconsistent results, although according to a review by Crago et al. (1996), one of the greatest risk factors among women of color for developing eating disorders is identifying with White cultural values. Of the limited research on objectification theory that included Latinas in their study samples, results indicated no significant difference in levels of objectified body consciousness between Latina and White women, suggesting that objectified body consciousness is salient cross-culturally (Boie et al., 2013; Montes de Oca, 2006). Frederick et al. (2007) examined self-surveillance in a sample of ethnically diverse women and reported significantly stronger body dissatisfaction sores in Latinas as compared to White women. The authors theorized that self-surveillance may have a larger impact on the body image of Latinas, because such behaviors highlight how a Latina deviates from the White beauty ideal.

Frederickson and Roberts (1997) proposed that self-objectification is experienced by all women due to their shared experiences of being objectified in society throughout their lives. For Latina populations, research suggests that objectification experiences are particularly frequent. Multiple studies report that substantial proportions of Latina women have indicated experiencing sexual discrimination or sexual harassment at significantly higher levels in comparison to other ethnic groups (Landrine et al., 1995; Shupe et al., 2002). The high rates of sexually objectified experiences in Latinas could be due to stereotypical gendered media portrayals marginalizing and sexualizing Latina characters and celebrities (Guzman & Valdivia, 2004). Latinas are more commonly portrayed in a sexualized manner in both U.S. and Latino media outlets than are White women (Lacroix, 2004). In an analysis of Latina representations in modern U.S. culture,

Guzman & Valdivia (2004) demonstrated that Latinas were habitually characterized as exotic, overly sexual, and foreign. Telenovelas are Spanish-language dramatic television serials popular with Latino audiences in Latin America and the U.S. (Lopez, 1995). Some researchers consider telenovelas a reflection of important values to Latino cultures, especially surrounding gender role attitudes. For example, a study by Rivadeneyra & Ward (2005) found a strong positive correlation between traditional gender role attitudes and amount of time watching telenovelas in a sample of Latino adolescents, with Latinas who watched more TV reporting higher levels of self-objectification. In addition to these sexual female portrayals, Latino characters are underrepresented in popular U.S. and Latino media, potentially making sexualized Latina portrayals even more influential in the development of self-objectification attitudes for Latina populations (Greenberg and Mastro, 2008).

Illuminating the complex process of body image development in Latinas requires an understanding of American mainstream body ideals, Latino cultural values, influences, and archetypes, and the process by which Latina women negotiate between two potentially conflicting projected feminine ideals across two contrasting cultures (Torres et al. 2012). Hypothetically, the presence of dual beliefs in American cultural messages demanding excessive thinness and cultural messages imposing a different set of requirements to achieve the Latina feminine paragon exposes a need for Latina women to arbitrate between two contrasting and unattainable cultural ideals in their everyday lives (Goodman, 2002).

Proposed Study

The proposed study intends to establish the extent to which body dissatisfaction and eating disorder risk are impacted by U.S. sociocultural attitudes, objectified body consciousness, psychological acculturation, and endorsement of *marianismo* in a sample of Latina college students to illuminate the culturally-specific factors contributing to negative body image and ED development in Latina women. Few studies to date have explored the applicability of Westernized etiological models of body dissatisfaction and eating disorders to Latina women despite recognition in the field that individual, sociocultural, and environmental body-related influences do not present identically cross culturally. The danger in failing to understand the interconnected factors related to body dissatisfaction and ED risk in Latinas has resulted in vastly under-identifying EDs and comorbid dysfunction in this population as well as failing to tailor culturally relevant interventions, thus coming far short of delivering competent mental health care. Based on the review of the literature, the following research questions and hypotheses are posed:

Research Question 1

To what extent do generational status, length of time in the U.S., acculturation, sociocultural attitudes, objectified body consciousness, and endorsement of *marianismo* predict body dissatisfaction and eating disorder risk in Latinas? After controlling for BMI, how strong is the contribution of the following demographics (generational status and length of time in the U.S.) in predicting body dissatisfaction and eating disorder risk in Latinas? What do sociocultural attitudes towards appearance and objectified body

consciousness add to the prediction of body dissatisfaction and eating disorder risk in the presence of demographic categorization for Latinas after controlling for BMI? What do psychological acculturation and endorsement of *marianismo* add to the prediction of body dissatisfaction and eating disorder risk in the presence of demographic categorization (controlling for BMI), sociocultural attitudes towards appearance, objectified body consciousness, and acculturation in Latinas? What is the unique contribution of each variable in predicting body dissatisfaction and eating disorder risk in Latinas?

Hypothesis 1a. It is expected that after controlling for BMI, generational status and length of time in the U.S. will significantly predict body dissatisfaction and eating disorder risk in Latina women. Specifically, those of later generations and Latinas who spend more time in the U.S. will report higher levels of body dissatisfaction and will have higher eating disorder risk than those of earlier generations and individuals who have spent less time in the U.S. These variables are expected to account for some of the variability in levels of body dissatisfaction and eating disorder risk for Latinas.

Hypothesis 1b. It is expected that reliance on sociocultural influences to form attitudes towards appearance (Information, Pressures, Internalization-General, and Internalization-Athlete) and displaying objectified body consciousness (Body surveillance, Body shame, and Control beliefs) will significantly predict body dissatisfaction and eating disorder risk in Latina women. Specifically, Latina women who report stronger reliance on various media sources to obtain information about "being attractive" will report higher levels of body dissatisfaction and will have higher eating

disorder risk than Latinas who report lower levels of media reliance. Latina women who feel more pressured by various media sources to strive for Westernized cultural ideals of beauty will report higher levels of body dissatisfaction and be at higher risk for eating disorders than Latina women who feel less pressure to achieve Westernized cultural ideals. Latina women who report higher levels of acceptance and internalization of the unrealistically thin female beauty ideal will have higher levels of body dissatisfaction and higher eating disorder risk than Latina women who report lower endorsement of this ideal. Latina women who report higher levels of acceptance and internalization of the athletic and "toned" female body ideal will have higher levels of body dissatisfaction and higher eating disorder risk than Latina women who report lower endorsement of this ideal. Latina women who display higher levels of objectified body consciousness and thus report more body surveillance, body shame, and control beliefs, will have higher levels of body dissatisfaction and be at higher risk for developing an eating disorder than Latina women who display lower levels of objectified body consciousness.

Hypothesis 1c. It is expected that acculturation will significantly predict body dissatisfaction and eating disorder risk in Latina women. Latina women who identify more with Anglo-American culture will have higher levels of body dissatisfaction and be more at risk for developing an eating disorder than Latina women who identify more with Latino culture.

Hypothesis 1d. Although exploratory in nature, it is expected that the five cultural tenets comprising the construct *marianismo* (*familismo*, being virtuous and chaste, self-

subordination to others, self-silencing to maintain harmony, and religiosity/spirituality) will predict body dissatisfaction and eating disorder risk in Latina women.

Rationale. Literature provides strong evidence for the negative impact sociocultural attitudes and objectified body consciousness have on body image development in women. Researchers also continually reference the need to explore how such variables influence the body dissatisfaction Latino populations, as most studies on body image were conducted using samples of predominantly White women. Researchers have also reported cultural processes, such as acculturation, impacting body image development, although results are inconsistent and varied. Despite Latina populations being particularly vulnerable to body dissatisfaction and comorbid dysfunction, little is known about their unique body image development. Latino cultural beliefs and values have been linked to other psychopathological concerns, although such cultural beliefs and values in Latinas have not been examined in studies on body dissatisfaction. Examining culturally relevant variables in conjunction with psychological acculturation, sociocultural attitudes, and objectified body consciousness may help to illuminate the extent to which culture influences Latina body image.

Furthermore, research yields empirical support for demographic variables, sociocultural attitudes, objectified body consciousness, and acculturation having an impact on eating disorder risk in White women, although the factors affecting eating disorder risk in Latinas is relatively unknown. Body dissatisfaction is widely considered the single strongest predictor for eating disorder development in women, yet eating disorder etiology specific to Latinas is rarely examined. Rates of eating disorders are

rising in Latina populations, yet eating disorder risk presentations in Latinas are frequently overlooked by medical and mental health professionals. Eating disorder risk has been associated with increased gendered and self-objectified attitudes in Westernized female populations, and researchers have observed similar thinking patterns in women who identify with the Latino cultural value of *marianismo*. Although never explicitly studied in relation to eating disorder risk, *marianismo* has been linked to other mental health outcomes. Increasing the understanding of how cultural variables impact body dissatisfaction and eating disorder risk in Latinas will help identify the applicability of current etiological models for this population.

Research Question 2

To what extent does objectified body consciousness mediate the relationship between acculturation and eating disorder risk for Latinas?

Hypothesis 2. Objectified body consciousness will significantly mediate the relationship between psychological acculturation and eating disorder risk in that the relationship between acculturation and eating disorder risk will become nonsignificant once objectified body consciousness is added to the model. See Figure 1.

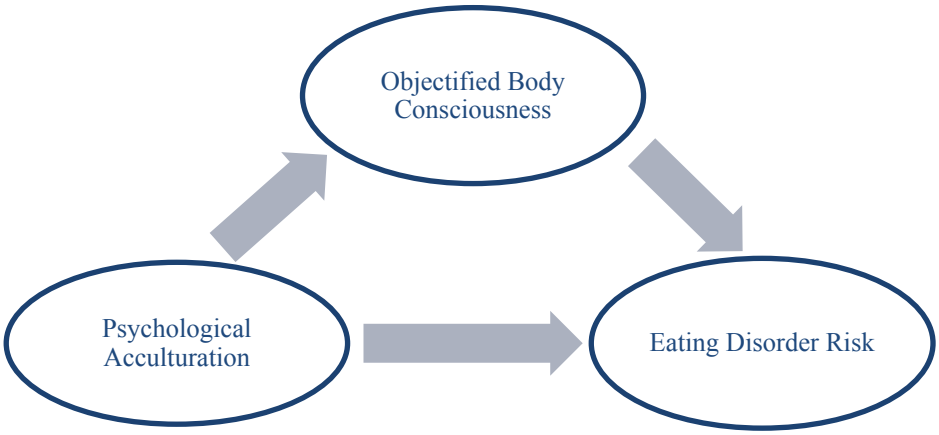

Figure 1. Hypothesized mediation model for the relationship among sociocultural attitudes towards appearance, objectified body consciousness, psychological acculturation, and ED risk.

Rationale. The literature suggests that there are several factors that can add substantively to current etiological models of EDs to capture the body-related experiences of Latina women. The research suggests that acculturation may be associated with eating disorder risk in Latinas, although due to the multidimensional nature of acculturation, the relationship between acculturation and eating disorder risk appears to be more complex than previously assumed (Keel, 2005; Striegel-Moore, Silberstein, & Rodin, 1986). Researchers examining acculturation and eating disorder pathology have successfully linked acculturation and body dissatisfaction (Cordero, 2011), which suggests that acculturation should function similarly when predicting eating disorder risk, as body dissatisfaction is recognized as the single strongest predictor of future eating disorder development in female populations (Altabe, 1998; George & Franko, 2010; Warren et al., 2005). In literature examining eating disorder etiology, gender-specific sociocultural contexts perpetuating the sexual objectification of women are major risk

factors for future eating disorder development (Greenleaf, 2005; Miner-Rubino et al., 2002; Tiggeman & Lynch, 2001). Furthermore, self-objectification, body shame, and sexual objectification experiences are central to the construct of objectified body consciousness, an established predictor of eating disorder risk in the literature and a variable shown to influence Latina body dissatisfaction (Moradi et al., 2005; Morry & Staska, 2001). A potential explanation for inconsistencies in the relationship between acculturation and eating disorder risk in Latinas could be the mediating effect of objectified body consciousness. Objectified body consciousness is more proximal to eating disorder risk, and since Latinas who are more acculturated to Westernized values and sociocultural norms also display higher levels of objectified body consciousness, acculturation is theorized to indirectly predict eating disorder risk through the intervening effect of objectified body consciousness.

Methods

Participants

Convenience sampling will be utilized to recruit college-aged Latina women from the Educational Psychology Department (EDP) subject pools at the University of Texas at Austin (UT). Female students who indicate being at least 18 years of age and identify as Latina will be eligible to participate in the proposed study. All measures included are published scales that reported adequate levels of validity and reliability.

Power analysis using the G*Power 3.1 program recommends a sample size of 107 to detect a medium effect of f^2=0.15 with an alpha of 0.05 and power at 0.8 (Cohen,

1988). This recommendation is made for a linear multiple regression (fixed model, R^2 increase) with two tested predictor blocks and three total predictor blocks. To ensure the suggested sample size is attained in anticipation of participant attrition, and to increase the likelihood of sampling a wide range of body-related data specific to Latinas, 200 participants will be requested from the subject pool.

Study Design and Procedure

UT students will be recruited from the EDP subject pool. The University of Texas-Austin subject pool is a population consisting of students enrolled in a set of EDP undergraduate courses taught in the College of Education. The survey will be housed in Qualtrics, an independently affiliated commercial online survey service that provides a password-secure survey program. Participants will access the survey through a URL located in the University of Texas EDP subject pool management systems.

To qualify for the proposed study, participants will answer three prescreen questions inquiring about gender, ethnicity, and age. Only females who indicate they are at least 18 years of age and identify as Latina will be eligible to participate.

After qualifying to participate, subjects will be able to access the survey link. Participants will first view the informed consent page outlining study procedures. The informed consent page states participants have the right to skip any questions they do not feel comfortable answering and may withdraw participation any time during the survey. Upon providing informed consent, participants will be asked to complete a web-based survey containing a demographic questionnaire and six measures of interest. Completing

the study will take approximately 30-45 minutes. No deception will be used, eliminating the need to debrief participants upon completion of the survey. Subject pool participants will receive a full participation credit for completing this study through the EDP or PSY course research requirement.

Measures

Demographic Questions: Participants will be asked to disclose their generational status, length of time spent in the United States, current weight, and current height.

Eating Disorder Inventory-3 Risk Composite (EDI-3RC; Garner, 2004): The EDI-3RC is one of six composites of the Eating Disorder Inventory 3 (EDI-3; Garner, 2004), and is the most widely used brief self-report measure for examining ED pathology (Garner, 2004). The aim of the EDI-3RC is to assess the presence and intensity of three primary psychological traits specific to ED development: 1) Drive for thinness, 2) Bulimia, and 3) Body dissatisfaction. The EDI-3RC yields standardized, objective scores and profiles that are useful in case conceptualization, treatment planning, and psychopathological research for individuals with a confirmed or suspected ED. The EDI-3RC consists of 25 items organized on a 6-point Likert scale, with 1 indicating "Never" and 6 indicating "Always". Higher total scores on the composite correspond to higher risk for developing an eating disorder. The "Drive for thinness" subscale consists of 7 items examining extreme desire to be thinner, concern with dieting, preoccupation with weight, and an intense fear of weight gain (e.g., "If I gain a pound, I worry that I will keep gaining."). The Bulimia subscale assesses the tendency to think about and engage in

bouts of uncontrollable overeating in response to being upset through 8 items (e.g., "When I am upset, I worry that I will start eating."). The Body Dissatisfaction subscale consists of 9 items designed to assess beliefs that specific parts of the body typically associated with fat increases during puberty are too large (e.g., "I think that my thighs are too large"; "I like the shape of my buttocks"). The Eating Disorder Risk Composite score is calculated by converting an individual's scores on the three subscales into standard scores and combining these into a single index to reflect overall eating pathology. Internal consistency reliability of the EDI-3RC subscales range from .83-.94. Test-retest reliability for the measure range from .86-.98, which is considered excellent (Garner, 2004).

Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS; Cash et al., 2004). The MBSRQ-AS is a 34-item measure that evaluates the appearance-related components of body image. Items are rated on a 5-point scale ranging from 1 "Definitely Disagree" to 5 "Definitely Agree". The proposed study will assess body dissatisfaction using the 7-item Appearance Evaluation subscale of the MBSRQ-AS, which measures feelings of physical attractiveness and overall satisfaction/dissatisfaction with one's looks. Items in the appearance evaluation subscale measure the extent to which a person feels attractive and satisfied with their appearance (e.g., "I like my looks just the way they are."). The Appearance Evaluation subscale of the MBSRQ-AS has been found to have good psychometric properties among both genders and various cultural groups with a reported reliability coefficient of .9 for females (Cash, 1994).

Marianismo Beliefs Scale (MBS; Castillo et al., 2010): The MBS is a 24 item measure designed for Latina women to assess a multidimensional gender role construct present in Latina culture on traditional cultural tenets emphasized for females: *familismo*, *respeto*, and *simpatía*. The MBS is intended to measure the extent to which a Latina believes she should practice the cultural values that comprise the construct of *marianismo*. The MBS is comprised of five subsales, each of which were validated on a large sample of Latina women: The Family Pillar factor, which captures the idea that Latinas should maintain family harmony and prioritize child rearing (e.g. "A Latina must be a source of strength for her family."), The Virtuous and Chaste factor (e.g. "A Latina should remain a virgin until marriage."), The Subordinate to Others factor reflecting the belief that Latinas should show obedience and respect for the Latina/o hierarchical family structure (e.g. "A Latina must do anything a male in the family asks her to do."), Self Silencing to Maintain Harmony, describing the belief that Latinas should keep confrontation and discomfort to a minimum within interpersonal relationships (e.g. "A Latina should not express her needs to her partner."), and The Spiritual Leader and Educator Pillar (e.g. "A Latina is the spiritual leader of the family."). Participants select item responses based on the extent to which they agree or disagree with each statement on a 4-point Likert scale with 1 indicating "strongly disagree" and 4 indicating "strongly agree". Higher total scores of the MBS indicate higher endorsement of *marianismo* values. Internal consistency reliability for each subscale upon initial development ranged from Cronbach's α=.77-.85.

Psychological Acculturation Scale (PAS; Tropp et al., 1999): The PAS is a 10-item scale that assesses an individual's sense of attachment to, and understanding of, Anglo-American and Latina/Hispanic cultures. The PAS was developed to measure acculturation as it is psychologically experienced by an individual by examining an ethnic individual's sense of emotional attachment and understanding of the cultures in which he or she exists. Instead of prioritizing behavioral or attitudinal manifestations of acculturation such as language use and migration history, the PAS focuses on an individual's psychological negotiation of two cultural entities. Items were created to reflect one of Berry's (1984) acculturation modes (i.e., Assimilation, Separation, Integration, and Marginalization) and were developed from literature reviews which identified cultural loyalty, solidarity identification, and comprehension as components of responses to exposure to other cultures. Example items include, "I usually find myself avoiding contact with Americans" and "I prefer speaking my native language whenever I have a choice between that and English." Items are organized on a 9-point Likert scale ranging from *only Hispanic/Latina* (1) to *only Anglo/American* (9). Higher scores suggest a greater Anglo-American identification. Overall, the scale demonstrates excellent internal consistency reliability (Cronbach's α=.85, $p<.001$; Tropp et al., 1999).

Sociocultural Attitudes towards Appearance Questionnaire-3 (SATAQ-3; Thompson et al. 2004): The SATAQ-3 is a 30-item measure of one's endorsement of Western societal appearance ideals. The measure is comprised of four subscales: Information, Pressures, Internalization-General, and Internalization-Athlete. The Information subscale captures the acknowledgement that information regarding

appearance standards is available from media sources (e.g., "Movies are an important source of information about fashion and "being attractive"). The Pressures subscale contains items that index a subjective sense of feeling pressure from exposure to media images and messages to modify one's appearance (e.g., "I've felt pressure from TV or magazines to be thin"). The internalization scales assess an incorporation of appearance standards and attitudes surrounding "thinness" (e.g., "I would like my body to look like the models who appear in magazines") and the "lean, fit, and toned" athletic body ideal (e.g., "I try to look like sports athletes") projected by Western media into one's self-identity to the point that an individual desires or strives to meet the ideals. Cronbach's α for each subscale are as follows: Information (.96), Pressures (.94), Internalization General (.96). and Internalization-Athlete (.95). Convergent validity was established for all subscales as well as construct validity (Cronbach's α= .96, p<.001; Thompson et al., 2004).

Objectified Body Consciousness Scales (OBCS; McKinley & Hyde, 1996): The OBCS is a 24 item measure developed to assess objectified body consciousness, or the act of experiencing one's body as an object, as well as the corresponding beliefs associated with such objectification. Higher levels of objectified body consciousness are postulated by feminist theorists and researchers to react with social constructions of the feminine body to propagate a negative body experience and poor body esteem in women (Bartky, 1988; Spitzack, 1990). The OBCS consists of three scales, each measuring one of the three constructs theorized to comprise objectified body consciousness: 1) Body surveillance, 2) Body shame, and 3) Control beliefs. Each scale contains eight items rated

on a 7-point Likert scale ranging from "strongly disagree" to "strongly agree". The Body surveillance subscale assesses a woman's level of self-objectification in order to comply with cultural body standards and avoid negative judgments from others. Items measure the internalization of an outside observer perspective toward one's own body (e.g., "During the day, I think about how I look many times"). The Body shame subscale provides an index of the extent to which a woman feels shame about herself and her body if she does not meet cultural standards of beauty (e.g., "I feel ashamed of myself when I haven't made the effort to look my best."). The Control beliefs subscale contains items examining how responsible a woman feels for her appearance as well as beliefs that appearance can be controlled (e.g., "I can weigh what I'm supposed to when I try hard enough."). Each scale achieved internal consistency reliability (Cronbach's α=0.79 (Body surveillance), 0.84 (Body shame), and 0.76 (Control beliefs), $p<.001$; McKinley & Hyde, 1996).

Analyses

Two hierarchical linear regressions will be used to examine how much variability in Body Dissatisfaction and Eating Disorder Risk can be accounted for by the degree of 1) sociocultural attitudes and objectified body consciousness, and 2) psychological acculturation and endorsement of *marianismo* after controlling for the following demographic variables: 1) generational status, 2) length of time in the USA, and 3) BMI calculated from self-reports of weight and height. Although the outcome variables of interest are different for each regression (Outcome variables of interest are Body

Dissatisfaction and Eating Disorder Risk), both outcome variables are continuous, with higher scores indicating increasing Body Dissatisfaction and Eating Disorder Risk. Prior to analysis, body mass index will be calculated and controlled, and other demographic items of interest will be dummy coded due to their categorical nature. The following figure specifies the order in which the predictor variables will be blocked and entered into the two regression models (Regression model 1=Body dissatisfaction, Regression model 2=Eating disorder risk).

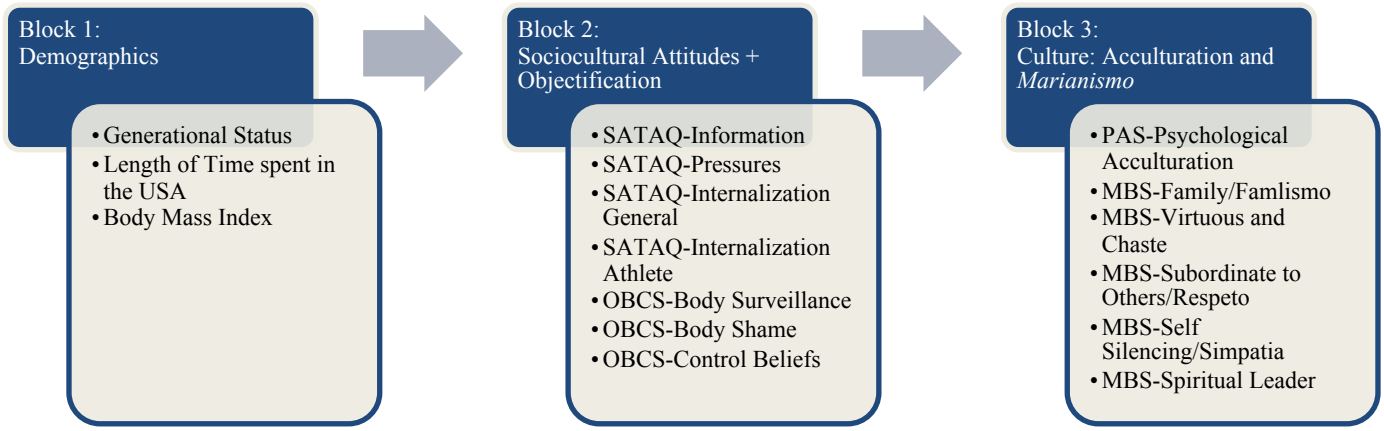

Figure 2. Organization of predictor variables for the proposed hierarchical regression models.

Each block of predictor variables will be regressed on participants' level of body dissatisfaction for the first regression and level of eating disorder risk for the second regression. The adjusted R^2 value will be analyzed for the first block to determine what percentage of variability in either body dissatisfaction or eating disorder risk is accounted for by demographics, followed by sociocultural attitudes and objectified body consciousness, and finally acculturation and *marianismo.* Each block's R^2 value

establishes how much additional variability in predicting body dissatisfaction or eating disorder risk is provided by the block's constructs. Squared semi-partial correlations will be calculated to assess the unique percentage of variance accounted for by each individual dimension or component comprising the construct of interest.

To test if objectified body consciousness acts as a mediator between acculturation and ED risk in Latinas, Baron and Kenny's method will be used (1986). First, using multiple regression, ED risk scores will be regressed onto acculturation scores to determine the presence or absence of mediation effects. Next, objectification scores will be regressed onto acculturation scores to show that the predictor variable (acculturation) is related to the mediator (objectified body consciousness). ED risk scores will then be regressed simultaneously on objectified body consciousness scores and acculturation scores to test whether objectified body consciousness is related to ED risk while also calculating an estimate of the relation between acculturation and ED risk controlling for objectified body consciousness. Partial, full, or absent mediation of objectified body consciousness will be determined after examining the z-score of the mediated effect for significance (z>1.96; Baron & Kenny, 1986; Kenny et al., 1998).

Discussion and Limitations

The proposed study seeks to explore culturally-specific factors contributing to body dissatisfaction and eating disorder risk in a sample of Latina women to elucidate understanding of eating disorder pathology unique to this underserved population. There is need for relevant research investigating factors that may mediate, moderate, or simply

contribute to body dissatisfaction and eating disorder pathology among ethnic minority women. Previous research, although limited, has found certain factors, such as internalization of the Western thin-ideal body type, experiences of objectification, and body dissatisfaction to be significant predictors of disordered eating symptomology among Latinas, but there is very little research examining the cultural nuances experienced by Latinas in regard to body image development and eating disorder etiology (Kroon Van Diest et al., 2014; Warren et al., 2010). Furthermore, there is no study to date exploring how identification with Latino-specific cultural values influences eating disorder pathology in Latinas (Harrison et al., 2010; Warren et al., 2010) though there is research linking cultural values to other mental health outcomes (Castillo et al., 2010).

Although the proposed study would contribute to a more nuanced understanding of body image development and eating disorder etiology in Latinas, it is important to discuss possible limitations to this investigation. The proposed study would consist of a sample containing entirely undergraduate women, limiting the generalizability of any potential findings. Non-collegiate women may have different ethnic, sociocultural, affective, and acculturative experiences, among other unexplored differences, which may impact the ability to accurately identify moderators of body dissatisfaction and eating disorder risk. Furthermore, study participants will be recruited from a large southern university, which would impact the generalizability of results to women who may have a lower level of education or socioeconomic status. Some of the recent research on body satisfaction has started to recognize the importance of the large cultural variety encompassed within the term “Latino”. Another potential limitation may be that findings

reported in either the literature review or gathered during data collection are not applicable for each subgroup within the broad range of ethnicities comprising the term 'Latino'. The proposed study is non-experimental in nature, which eliminates the ability to fully imply causality, or establish temporal sequence among body dissatisfaction, eating disorder risk, and culturally-related variables of interest.

Currently, the frameworks of Objectification Theory and Sociocultural Theory for body dissatisfaction and eating disorder development do not explicitly account for issues surrounding diversity (Boie et al., 2013). The broadening of both frameworks to more accurately address multiple dimensions of identity would greatly benefit efforts to accurately conceptualize body dissatisfaction and eating disorder etiology in Latinas. Furthermore, instruments designed to incorporate intersectional conceptualization would greatly enhance abilities to accurately capture cultural and body-related experiences salient for Latina populations (Gordon et al., 2010; Cole, 2009).

There may be an overarching conceptual limitation apparent in much of the current research surrounding eating disorder etiology. Current eating disorder etiological theory has been heavily influenced by the assumption that eating disorder risk and pathology is a byproduct of a flawed Western societal structure that places inordinate pressure on women to conform to media and peer standards of beauty and thinness (Dolan, 1991; Katzman & Lee, 1997; Miller & Pumariega, 2001). Some researchers in the field argue that although the DSM definition and criteria for eating disorders do not implicate specific groups of people as being at higher risk, society usually considers eating disorders and related body dissatisfaction to be issues primarily affecting

Westernized females (Altabe, 1998; Bardone-Cone & Boyd, 2007; Gilbert, 2003). This conceptualization of eating disorder etiology and body image development reflects a belief in cultural determinism, which posits that ideas about beauty are culturally determined (Furnham & Baguma, 1994). The traditional hypothesis surrounding eating disorder etiology reflected in diagnostic assessment, clinical application, and treatment procedures implicates Western culture with its competing pressures to conform and to succeed as both a necessary and sufficient cause for the maladaptive cognitive and behavioral mechanisms underlying body dissatisfaction and eating disorder pathology (Silber, 1986; Miller & Pumariega, 2001).

There are a few problems with the current Western etiological model of eating disorders. Ambiguity exists surrounding whether EDs develop from the pressure to conform to certain body image standards, from certain general and stereotyped expectations for female behavior that make women feel out of control, or elements of both (Miller & Pumariega, 2001). Although the DSM-5 can be said to reflect a Western description of eating disorders and their subtypes, its model lacks explanatory power for cases that deviate from the narrow diagnostic criteria, and it fails to attribute blame to specific components outside of Western culture. It could be argued that a social cause of eating disorders and elevated eating disorder risk stems from women's roles within a larger cultural framework, which suggests more variability in eating disorders than if Westernized culture itself was the primary determinant (Bemporad, 1997). The DSM-5 has taken steps toward correcting some of the diagnostic issues surrounding the higher incidence and variation of eating disorder pathology in Western society (American

Psychiatric Association & American Psychiatric Association Task Force on DSM-5, 2013), but these corrections do not fully account for corresponding increases in incidence and variation in other societies and minority populations across the world. The criterion of weight phobia, as well as the overall emphasis on appearance, may mask even greater increases in ED pathology and body dissatisfaction in non-Western populations than are currently recognized (Miller & Pumariega, 2001).

The conceptualization of eating disorder etiology is crucial for proper identification, diagnosis, and treatment in underserved, ethnic-minority populations. It may be helpful to re-evaluate definitions and categorizations of current eating disorder understanding in order to produce more accurate assessments of eating disorder etiology and body dissatisfaction development. The way eating disorder etiology is conceptualized has broad implications for the identification of at-risk ethnic minorities, efficacy of medical and psychological interventions, and the applicability of diagnostic criteria.

A nuanced and comprehensive understanding of eating disorder etiology and body dissatisfaction development in Latina women is imperative, as evidenced by recent statistics revealing alarmingly high increases in eating disorder diagnoses and reports of body dissatisfaction in this population (Hrabosky & Grilo, 2007; Joiner & Kashubeck, 1996; Lopez et al., 1995). Understanding and incorporating the multifaceted components and cultural factors contributing to body dissatisfaction and eating disorder etiology in Latinas could help clinicians better identify, conceptualize, and treat body dissatisfaction and eating disorder etiology with cultural competency.

Appendices

Appendix A

Demographic Questions

1. Which of the following best describes your race/ethnicity?
    a. African-American/Black
    b. Hispanic-American/Latina/Chicana
    c. Native-American/American Indian
    d. Asian-American
    e. Middle Eastern/North African American
    f. Caucasian/European-American/White
    g. Multiracial (Please specify)
    h. Other (Please specify)
2. What is your sex?
    a. Male
    b. Female
    c. Transgendered
3. Are you at least 18 years of age?
    a. Yes
    b. No
4. How many years have you lived in the USA?
    a. Less than 1 year
    b. 1-5 years
    c. 5-10 years
    d. More than 10 years
5. Were you born in another country?
    a. Yes (please specify country)
    b. No
6. Was your mother born in another country?
    a. Yes (please specify country)
    b. No
7. Was your father born in another country?
    a. Yes (please specify country)
    b. No
8. What is your current weight?
9. What is your current height?

Appendix B

Sociocultural Attitudes Towards Appearance Questionnaire-3 (Thompson et al., 2004)

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

Definitely Disagree = 1
Mostly Disagree = 2
Neither Agree Nor Disagree = 3
Mostly Agree = 4
Definitely Agree = 5

1. TV programs are an important source of information about fashion and "being attractive."
   1 _____ 2_____ 3 _____ 4 _____ 5
2. I've felt pressure from TV or magazines to lose weight.
   1 _____ 2_____ 3 _____ 4 _____ 5
3. I do not care if my body looks like the body of people who are on TV.
   1 _____ 2_____ 3 _____ 4 _____ 5
4. I compare my body to the bodies of people who are on TV.
   1 _____ 2_____ 3 _____ 4 _____ 5
5. TV commercials are an important source of information about fashion and "being attractive."
   1 _____ 2_____ 3 _____ 4 _____ 5
6. I do not feel pressure from TV or magazines to look pretty.
   1 _____ 2_____ 3 _____ 4 _____ 5
7. I would like my body to look like the models who appear in magazines.
   1 _____ 2_____ 3 _____ 4 _____ 5
8. I compare my appearance to the appearance of TV and movie stars.
   1 _____ 2_____ 3 _____ 4 _____ 5
9. Music videos on TV are not an important source of information about fashion and "being attractive."
   1 _____ 2_____ 3 _____ 4 _____ 5
10. I've felt pressure from TV and magazines to be thin.
    1 _____ 2_____ 3 _____ 4 _____ 5
11. I would like my body to look like the people who are in movies.
    1 _____ 2_____ 3 _____ 4 _____ 5
12. I do not compare my body to the bodies of people who appear in magazines.
    1 _____ 2_____ 3 _____ 4 _____ 5
13. Magazine articles are not an important source of information about fashion and "being attractive."
    1 _____ 2_____ 3 _____ 4 _____ 5
14. I've felt pressure from TV or magazines to have a perfect body.

1 _____ 2_____ 3 _____ 4 _____ 5

15. I wish I looked like the models in music videos.
    1 _____ 2_____ 3 _____ 4 _____ 5
16. I compare my appearance to the appearance of people in magazines.
    1 _____ 2_____ 3 _____ 4 _____ 5
17. Magazine advertisements are an important source of information about fashion and "being attractive."
    1 _____ 2_____ 3 _____ 4 _____ 5
18. I've felt pressure from TV or magazines to diet.
    1 _____ 2_____ 3 _____ 4 _____ 5
19. I <u>do not</u> wish to look as athletic as the people in magazines.
    1 _____ 2_____ 3 _____ 4 _____ 5
20. I compare my body to that of people in "good shape."
    1 _____ 2_____ 3 _____ 4 _____ 5
21. Pictures in magazines are an important source of information about fashion and "being attractive."
    1 _____ 2_____ 3 _____ 4 _____ 5
22. I've felt pressure from TV or magazines to exercise.
    1 _____ 2_____ 3 _____ 4 _____ 5
23. I wish I looked as athletic as sports stars.
    1 _____ 2_____ 3 _____ 4 _____ 5
24. I compare my body to that of people who are athletic.
    1 _____ 2_____ 3 _____ 4 _____ 5
25. Movies are an important source of information about fashion and "being attractive."
    1 _____ 2_____ 3 _____ 4 _____ 5
26. I've felt pressure from TV or magazines to change my appearance.
    1 _____ 2_____ 3 _____ 4 _____ 5
27. I <u>do not</u> try to look like the people on TV.
    1 _____ 2_____ 3 _____ 4 _____ 5
28. Movie starts are <u>not</u> an important source of information about fashion and "being attractive."
    1 _____ 2_____ 3 _____ 4 _____ 5
29. Famous people are an important source of information about fashion and "being attractive."
    1____ 2_____ 3 _____ 4 _____ 5
30. I try to look like sports athletes.
    1 _____ 2_____ 3 _____ 4 _____ 5

Appendix C

Objectified Body Consciousness Scales (McKinley & Hyde, 1996)

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

1 Strongly disagree
2
3
4
5
6 Strongly agree

1. I rarely think about how I look

2. I think it is more important that my clothes are comfortable than whether they look good on me.

3. I think more about how my body feels than how my body looks.

4. I rarely compare how I look with how other people look.

5. During the day, I think about how I look many times.

6. I often worry whether the clothes I am wearing make me look good.

7. I rarely worry how I look to other people.

8. I am more concerned with what my body can do than how it looks.

9. When can't control my weight, I feel like something must be wrong with me.

10. I feel ashamed of myself when I haven't made the effort to look my best.

11. I feel like I must be a bad person when I don't look as good as I could.

12. I would be ashamed for people to know what I really weigh.

13. I never worry that something is wrong with me when I am not exercising as much as I should.

14. When I'm not exercising enough, I question whether I am a good enough person.

15. Even when I can't control my weight, I think I'm an okay person.

16. When I'm not the size I think I should be, I feel ashamed.

17. I think a person is pretty much stuck with the looks they are born with.

18. A large part of being in shape is having that kind of body in the first place.

19. I think a person can look pretty much how they want to if they are willing to work at it.

20. I really don't think I have much control over how my body looks.

21. I think a person's weight is more determined by the genes they are born with.

22. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same.

23. I can weigh what I'm supposed to when I try hard enough.

24. The shape you are in depends mostly on your genes.

Appendix D

Psychological Acculturation Scale (Tropp et al., 1999)

PSYCHOLOGICAL ACCULTURATION SCALE (PAS)

(Tropp, Erkut, Coll, Alarcon, & Vazquez-Garcia, 1999)

1. With which group of people do you feel you share most of your beliefs and values?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

2. With which group of people do you feel you have the most in common?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

3. With which group of people do you feel most comfortable?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

4. In your opinion, which group of people best understands your ideas (your way of thinking)?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

5. Which culture do you feel proud to be a part of?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

6. In what culture do you know how things are done and feel that you can do them easily?

Only with Hispanics/Latinos				Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)
o	o	o	o	o	o	o	o	o

7. In what culture do you feel confident you know how to act?

o	o	o	o	o	o	o	o	o
Only with Hispanics/Latinos			Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)	

8. In your opinion, which group of people do you understand best?

o	o	o	o	o	o	o	o	o
Only with Hispanics/Latinos			Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)	

9. In what culture do you know what is expected of a person in various situations?

o	o	o	o	o	o	o	o	o
Only with Hispanics/Latinos			Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)	

10. Which culture do you know the most about (for example: its history, traditions, and customs)?

o	o	o	o	o	o	o	o	o
Only with Hispanics/Latinos			Equally with Hispanics/Latinos and Anglos (Americans)				Only with Anglos (Americans)	

Appendix E

Marianismo Beliefs Scale (Castillo et al., 2010)

INSTRUCTIONS: Please indicate the extent to which you agree or disagree to each statement using the following scale.

1= strongly disagree 2=disagree 3=agree 4=strongly agree

1. A Latina must be a source of strength for her family. []
2. A Latina is considered the main source of strength of her family. []
3. A Latina keeps the family unified. []
4. A Latina teaches her children to be loyal to the family. []
5. A Latina does things that make her family happy. []
6. A Latina should remain a virgin until marriage. []
7. A Latina should wait until after marriage to have children. []
8. A Latina should be pure. []
9. A Latina should adopt the values taught by her religion. []
10. A Latina should be faithful to her partner. []
11. A Latina must satisfy her partner's sexual needs without argument. []
12. A Latina must not speak out against men. []
13. A Latina must respect men's opinions even when she does not agree. []
14. A Latina must avoid saying no to people. []
15. A Latina must do anything a male in the family asks her to do. []
16. A Latina should not discuss birth control. []
17. A Latina should not express her needs to her partner. []
18. A Latina should feel guilty about telling people what she needs. []
19. A Latina should not talk about sex. []
20. A Latina should be forgiving in all aspects. []
21. A Latina should always be agreeable to men's decisions. []
22. A Latina is the spiritual leader of the family. []
23. A Latina is responsible for taking family to religious services. []
24. A Latina is responsible for the spiritual growth of the family. []

Appendix F

Multidimensional Body-Self Relations Questionnaire-Appearance Scales (Cash et al., 2004)

INSTRUCTIONS—PLEASE READ CAREFULLY

The following pages contain a series of statements about how people might think, feel, or behave. You are asked to indicate the extent to which each statement pertains to you personally.

Your answers to the items in the questionnaire are anonymous. In order to complete the questionnaire, read each statement carefully and decide how much it pertains to you personally. Using a scale like the one below, indicate your answers.

EXAMPLE:

I am usually in a good mood.

On questionnaire, enter:

1 if you **definitely disagree** with the statement;
2 if you **mostly disagree**;
3 if you **neither agree nor disagree**;
4 if you **mostly agree**;
5 if you **definitely agree** with the statement.

There are no right or wrong answers. Just give the answer that is most accurate for you. Remember, your responses are confidential, so please be completely honest and answer all items.

1	**2**	**3**	**4**	**5**
Definitely Disagree	**Mostly Disagree**	**Neither Agree Nor Disagree**	**Mostly Agree**	**Definitely Agree**

1. Before going out in public, I always notice how I look.

2. I am careful to buy clothes that will make me look my best.

3. My body is sexually appealing.

4. I constantly worry about being or becoming fat.

5. I like my looks just the way they are.

6. I check my appearance in a mirror whenever I can.

7. Before going out, I usually spend a lot of time getting ready.

8. I am very conscious of even small changes in my weight.

9. Most people would consider me good-looking.

10. It is important that I always look good.

11. I use very few grooming proucts.

12. I like the way I look without my clothes on.

1	**2**	**3**	**4**	**5**
Definitely Disagree	**Mostly Disagree**	**Neither Agree Nor Disagree**	**Mostly Agree**	**Definitely Agree**

13. I am self-conscious if my grooming isn't right.

14. I usually wear whatever is hand without caring how it looks.

15. I like the way my clothes fit me.

16. I don't care what people think about my appearance.

17. I take special care with my hair grooming.

18. I dislike my physique.

19. I am physically unattractive.

20. I never think about my appearance.

21. I am always trying to improve my physical appearance.

22. I am on a weight-loss diet.

For the following items use the response scale given with the items.

23. I have tried to lose weight by fasting or going on crash diets.
    1. Never
    2. Rarely
    3. Sometimes
    4. Often
    5. Very Often

24. I think I am:
    1. Very Underweight
    2. Somewhat Underweight

3. Normal Weight
4. Somewhat Overweight
5. Very Overweight

25. From looking at me, most other people would think I am:
1. Very Underweight
2. Somewhat Underweight
3. Normal Weight
4. Somewhat Overweight
5. Very Overweight

26-34. Use this 1 to 5 scale to indicate how dissatisfied or satisfied you are with each of the following areas or aspects of your body:

1	**2**	**3**	**4**	**5**
Very Dissatisfied	**Mostly Dissatisfied**	**Neither Satisfied Nor Dissatisfied**	**Mostly Satisfied**	**Very Satisfied**

26. Face (facial features, complexion)

27. Hair (color, thickness, texture)

28. Lower torso (buttocks, hips, thighs, legs)

29. Mid torso (waist, stomach)

30. Upper torso (chest or breasts, shoulders, arms)

31. Muscle tone

32. Weight

33. Height

34. Overall appearance

Appendix G

Eating Disorder Inventory-3 (Garner, 2004)

INSTRUCTIONS

First, write your name and the date on the EDI-3 Answer Sheet. Your ratings on the items below should be circled on the Answer Sheet. The items ask about your attitudes, feelings, and behaviors. Some of the items relate to food or eating; other items ask about your feelings about yourself.

For each item, decide if the item is true about you **ALWAYS** (**A**), **USUALLY** (**U**), **OFTEN** (**O**), **SOMETIMES** (**S**), **RARELY** (**R**), or **NEVER** (**N**). Circle the letter that corresponds to your rating on the Answer Sheet. For example, if your rating for an item is **OFTEN**, you would circle the "**O**" for that item on the Answer Sheet.

Respond to *all* of the items, making sure that you circle the letter for the rating that is true about you. **DO NOT ERASE!** If you need to change an answer, mark an "X" through the incorrect letter, and then circle the correct one.

---

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.

(continued)

27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.

61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.
85. I experience marked mood shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

EDI-3

Answer Sheet

David M. Garner, PhD

Fill in your name and the date. Follow the instructions in the EDI-3 Item Booklet and enter your ratings on this sheet.

Name _____ Date ____/____/____

A = ALWAYS U = USUALLY O = OFTEN S = SOMETIMES R = RARELY N = NEVER

1.	A U O S R N	19.	A U O S R N	37.	A U O S R N	55.	A U O S R N	73.	A U O S R N
2.	A U O S R N	20.	A U O S R N	38.	A U O S R N	56.	A U O S R N	74.	A U O S R N
3.	A U O S R N	21.	A U O S R N	39.	A U O S R N	57.	A U O S R N	75.	A U O S R N
4.	A U O S R N	22.	A U O S R N	40.	A U O S R N	58.	A U O S R N	76.	A U O S R N
5.	A U O S R N	23.	A U O S R N	41.	A U O S R N	59.	A U O S R N	77.	A U O S R N
6.	A U O S R N	24.	A U O S R N	42.	A U O S R N	60.	A U O S R N	78.	A U O S R N
7.	A U O S R N	25.	A U O S R N	43.	A U O S R N	61.	A U O S R N	79.	A U O S R N
8.	A U O S R N	26.	A U O S R N	44.	A U O S R N	62.	A U O S R N	80.	A U O S R N
9.	A U O S R N	27.	A U O S R N	45.	A U O S R N	63.	A U O S R N	81.	A U O S R N
10.	A U O S R N	28.	A U O S R N	46.	A U O S R N	64.	A U O S R N	82.	A U O S R N
11.	A U O S R N	29.	A U O S R N	47.	A U O S R N	65.	A U O S R N	83.	A U O S R N
12.	A U O S R N	30.	A U O S R N	48.	A U O S R N	66.	A U O S R N	84.	A U O S R N
13.	A U O S R N	31.	A U O S R N	49.	A U O S R N	67.	A U O S R N	85.	A U O S R N
14.	A U O S R N	32.	A U O S R N	50.	A U O S R N	68.	A U O S R N	86.	A U O S R N
15.	A U O S R N	33.	A U O S R N	51.	A U O S R N	69.	A U O S R N	87.	A U O S R N
16.	A U O S R N	34.	A U O S R N	52.	A U O S R N	70.	A U O S R N	88.	A U O S R N
17.	A U O S R N	35.	A U O S R N	53.	A U O S R N	71.	A U O S R N	89.	A U O S R N
18.	A U O S R N	36.	A U O S R N	54.	A U O S R N	72.	A U O S R N	90.	A U O S R N
								91.	A U O S R N

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