Psychological correlates of adherence to femininity ideology in Hispanic and European-American college women

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PSYCHOLOGICAL CORRELATES OF ADHERENCE TO FEMININITY IDEOLOGY IN HISPANIC AND EUROPEAN-AMERICAN COLLEGE WOMEN

by

Carolina Villar-Mendez

Bachelor of Arts
University of Nevada, Las Vegas
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A thesis submitted in partial fulfillment
Of the requirements for the

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Department of Psychology
College of Liberal Arts

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ABSTRACT

Psychological Correlates of Adherence to Femininity Ideology in Hispanic and European-American College Women

by

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Submission to the desires of others and an objectified relationship to one’s body have been identified as two major components of femininity ideology. Research suggests that over-adherence to feminine ideals may result in reduced well-being, the extremes of which can be depression, anxiety, eating disordered behavior, low self-esteem and academic performance deficits. This study examined the 1) extent to which adherence to femininity ideology, as defined by the aforementioned two components, was related to well-being and academic performance and 2) ethnic differences in adherence to femininity ideology and its correlates in 162 college women, 80 of which self-identified as Hispanic American, and 82 as European American. Results indicated that adherence to both self-abnegation and objectification of one’s body was negatively related to well-being. Furthermore, Hispanic women scored higher than European American women on both aspects of femininity ideology and there were no group differences in the extent to
which adherence to either component of femininity ideology were associated with well-being deficits. Acculturation was not significantly related to either measure of femininity ideology or to measures of well-being, with the exception of a small negative association between acculturation and depression. Results are interpreted to indicated that Hispanic may be at higher risk for well-being difficulties as a consequence of their adherence to hyperfemininity.
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CHAPTER 1

INTRODUCTION

Gender roles have historically been an area of interest among researchers and mental health professionals (Berger, Levant, McMillian, & Kaye, 2005; Levant, Richmond, & Majors, 2003). Gender roles are defined as the rules and standards of femininity and masculinity that men and women learned at early stages of their development (Mahalik, Morray, Coonerty-Femiano, Ludlow, Slattery, & Smiler, 2005). Throughout history, researchers have developed several theories about the development of gender identity and how such concept influences our sense of self (Chodorow, 1978; Freud, 1905; Kohlberg, 1966; Bandura, 1977). Yet the definition of gender identity actually includes within it two different concepts: gender constancy and gender role identity (Fast, 1984). In essence, gender constancy is biologically determined, and gender role identity is culturally and socially constructed (Woodhill & Samuels, 2003). It is when there is tension between these two concepts, that gender role conflict arises within the self, which according to the research, it has an impact on the well-being of men and women.

Gender role conflict arises when culturally imposed gender role norms are experienced by individuals as restrictive or unattainable, resulting in some form of distress. Gender role identity and gender role conflict in men, as well as hypermasculinity
(a strict adherence to traditional masculinity ideology), have been researched extensively; however, the research on women’s problems with their gender roles has been surprisingly, relatively limited.

A consistent problem that women have faced throughout history lies in the constraints of traditional patriarchal ideologies, wherein men are considered more important than women, and wherein women are expected to accept the notion that men exert control and dominance over them. In some cases, women over-identify with traditional gender roles emanating from these ideologies and succumb to hyperfemininity, an extremely stereotypic conception of what it means to be a woman (Murnen & Byrne, 1991). This construct represents strict adherence to gender-specific traditional sex roles and this strict adherence appears to have consequences. Research suggests that gender role conflict has affected women’s well-being, causing depression, anxiety, somatic complaints, and eating disorders, to name a few associated problems (Silverstein, Perlick, Clauson, & McKoy, 1993). Some studies have linked gender role adherence and/or conflict to body image disturbances and preference for thinness in young girls (Cantelon, Leichner, and Harper, 1986). For example, in an attempt to adhere to the stereotypic ideal of female beauty, some young girls starve themselves to the point of experiencing uncontrollable hunger. They then binge eat to satisfy the hunger, but then feelings of guilt about their eating, fear of gaining weight, and low self-esteem lead them purge once again. It seems reasonable to assume that such gender role conflicts and attendant psychological problems may exist across various societies and cultures since the roles assigned to women are quite similar across the world. However, there is very
little cross-cultural research comparing levels of gender role conflict and psychological correlates in women belonging to different ethno-cultural groups.

In an attempt to add to our knowledge on these matters, this study focuses on the comparison of gender role adherence and its consequences among women belonging to two different ethnic groups in American society: European Americans and Hispanic-Americans. Research has shown that while European American women are significantly focused on their body image, Hispanic-American women appear to be more focused on the submission of their desires of those of others (marianismo). Concerns about physical attractiveness and an emphasis on relationship maintenance through self-abnegation are two central components of femininity ideology (the societally communicated expected gender role). Thus, it is possible that women with different cultural values adhere more closely to different aspects of femininity ideology because they align more closely with the values engendered by their culture of origin. Consequently, it might also be that women who adhere to aspects of femininity ideology that are not as promoted by their culture of origin as others might suffer more distress.

The following chapters will review the literature on gender roles, their psychological correlates, as well as cultural variations and challenges, after which the specific aims and hypotheses of the study will be presented. The general aim of the literature review and the study will be to elucidate the extent to which adherence to femininity ideology, as defined by striving for beauty and self-abnegation, is related to well-being. The more specific aim will be to investigate the extent to which these components of femininity ideology play out differently in two broadly defined cultural groups; European-Americans and Hispanic-Americans.
For the purpose of brevity and inclusiveness, the term Hispanic-American is meant to denote any individual that emanates from a Spanish speaking country, including all Latin American one. It is meant to encompass individuals who might better identify with the terms Chicano, or Latino.
CHAPTER 2

LITERATURE REVIEW

The Centrality of Gender Roles

Children begin to learn gender roles at a very early stage in their development (Sargent, 2005). The process is slow and involves, in part, becoming alert to the ways in which the social environment dictates the actions of men and women. It can be surprising to observe how quickly children during the ages of 3 to 6 years make conventional generalizations about how men and women are supposed to behave. It is during such early stages of development that one learns the rules and standards of femininity and masculinity as modeled by parents, teachers, peers, and the media (Mahalik, et. al., 2005). These gender role rules and standards provide guidance for young boys and girls about how they are supposed to behave, think, and feel, and they impose constraints on behavior that is non-conforming with these roles (Anderson & Hamilton, 2005).

Although arguments have been made that some aspects of these gender roles may be genetically determined (Woodhill & Samuels, 2003), gender roles are also thought to occur through the observation of the rewards and punishments that others receive for gender adherence and gender transgressions, as well as the simple modeling of oneself on one’s identified gender (Bussey & Bandura, 1999).

According to Bussey and Bandura (1999), gender role development is an important issue because it influences many aspects of our lives. Although gender roles...
provide us with a heuristic to facilitate complex social information processing (Hughes & Seta, 2003), they may also have detrimental effects in their implicit and explicit promotion of opportunities or constraints for one gender and not the other (Bussey & Bandura, 1999). Gender roles can deteriorate into gender stereotypes that propagate and sustain beliefs about the restricted actions and abilities of boys and girls (Fast, 1984). Defined by Lytton and Romney (1991) as “exaggerated beliefs associated with a category that justifies or rationalizes our conduct in relation to that category,” stereotypes have long been prominent in the area of gender, and children are exposed to these early in their development. One clear example is children’s literature. Children’s books tend to portray boys as active leaders exhibiting career skills, and girls as passive followers performing traditional tasks in the home (Anderson & Hamilton, 2005; Diekman & Murnen, 2004). There has been a substantial increase in children’s books that defy these stereotypes, but traditional gender themes still predominate. This type of instruction is concerning because it may result in adults who are insecure in the performance of tasks they have repeatedly been told are performed better by the opposite sex (Bem, 1976).

The educational environment is central in the development of gender roles and some researchers posit that it may be more formative than biological predispositions (Bandura, 1986, 1997). As the primary agent for the socialization of children, the family plays a central role in the development of gender roles. The family gives a child his or her principal identity, starting with his or her name. It goes on to teach social roles, moral standards, and society’s laws, and the family disciplines children who fail to comply with those norms and values (Bartollas, 1997). School is also instrumental. Fagot and Hagen (1991) reported that even in preschool, children are rewarded for behaving in a way
matching with their sex and may be punished for behaving in ways associated with the opposite sex. In a study conducted by Tatar and Emmanuel (2001) on the attitudes and perceptions of teacher behavior regarding students' gender roles, only 15% of teachers had attended courses on gender equality and over 50% of teachers did not respond to the questions concerning their school's gender policy. Such findings may reflect a relative lack of teacher awareness concerning the in-depth nature of gender stereotypes and their overall influences.

Even though Western society is now more flexible than it was in the past with regard to its expectations of males and females, old stereotypes persist. Lytton and Romney (1991) reviewed almost 200 studies on the socialization of boys and girls between 1952 and 1987. They concluded that most parents still try to influence their sons to take steps to be independent and confident, while encouraging their daughters differently. In this review, aggressive behavior was viewed as more appropriate for boys, and expressions of warmth were more tolerated in girls. Bronstein (1988) found clear differences in how fathers related to their sons and daughters. Their interactions with their daughters were more encouraging, loving, and accepting. In contrast, fathers' interactions with their sons were characterized by more regulating and supervising of their behavior; fathers also focused more on their sons' intellectual accomplishments than on their daughters' cognitive capacities.

It has indeed long been documented that, from the time their children are infants; parents treat sons and daughters differently, dressing them in gender-specific colors, giving gender-differentiated toys and expecting different behavior from boys and girls (Thorne, 1993). One study indicated that parents have differential expectations of sons
and daughters as early as 24 hours after birth (Bronstein, 1988). Parents generally encourage their sons and daughters to participate in sex-typed activities, including doll playing and housekeeping activities for girls and playing with trucks and sports activities for boys (Eccles, Jacobs, & Harold, 1990). Children's toy preferences have been found to be significantly related to parental sex-typing (Etaugh & Liss, 1992; Henshaw, Kelly & Gratton, 1992), with parents providing gender-differentiated toys and rewarding play behavior that is gender stereotyped (Bronstein, 1988).

Psychologists have long been concerned with gender roles because these develop concurrently with self-concept, perceived self, and conceptualizations of the ideal self, all of which are hypothesized to be linked to well-being. The sum of all our beliefs and feelings about ourselves is our self-concept (Byrne, 1996), and gender is a significant part of it. Because we have observed role models and become sensitive to how society expects us to act as males or females, our gender-related self-evaluations are important parts of self-concept (Tyler & Feldman, 2005). For example, our self-concept is, in some ways, based on a personal contrast between the person we are and the person we would like to become or have been told we should be. The perceived self, however, refers to the ways in which we recognize ourselves physically, intellectually, socially and, maybe, spiritually (Cheung, 2006). Additionally, most of us also have a secret idea of who we would like to be as we age, which is referred to as the ideal self (Hannover, Birkner, & Pohlmann, 2006). When we feel we are moving from the perceived self toward the ideal self, we usually experience a feeling of self-esteem or self-respect. Not living up to one's ideal self has been shown to correspond with decreased self-esteem (Hannover, Birkner, & Pohlmann, 2006). Negative self-image has also been theoretically and empirically
associated with a host of psychological disorders, most notably depression (Beck, 1987). Because of these important associations, gender roles have been the focus of research for over thirty years.

Theories of Gender Identity Development

Several theories have been developed to understand how gender roles influence our sense of self. Freud was perhaps the first to theorize about the issue, but more contemporary theories center on social learning and cognitive principles.

Classical psychoanalytic theory presented the hypothesis that, initially, both boys and girls identify with their mothers (Freud, 1905). However, between the ages of 3 and 5 years, identification shifts to the same-sex parent. Identification with the same-sex parent was presumed to resolve the conflict children supposedly experience as a result of erotic attachment to the opposite sex parent and jealousy toward the same sex parent. This attachment purportedly causes children much anxiety as they fear retaliation from the same-sex parent. The conflicted relationship with the same-sex parent is ultimately resolved through the development of identification with them (Freud, 1905).

A more recent adaptation of psychoanalytic ideas about gender development is found in Chodorow’s (1978) Theory of Gender Identity Development. Based on psychoanalytic object relations theory (Mahler, Pine, & Bergaman, 1978), Chodorow posited that all infants form a primary attachment to their mother, but the attachment is threatened by separation. Chodorow proposed that mothers experience boys as different (in that they are male) and tend to push them out. Similarly, when a boy realizes he is a different biological sex than his mother, he is forced to give up his attachment to her in an effort to establish a gender identity that is consistent with his biological sex. As a boy
proceeds through the separation process, his sense of self as masculine is threatened by his original identification with his mother. In contrast, girls do not experience themselves as different from their mothers, therefore they feel less threatened. This model is difficult to interpret in light of a voluminous empirical literature pointing to self-esteem deficits in women and a much higher prevalence of depression than that found in men. In any case, with little empirical evidence to support these psychoanalytical and neo-analytical ideas about the development of gender roles, psychologists turned to other theoretical constructs that were both more intuitive and more testable.

Cognitive-developmental theory was perhaps the first that attempted to account for gender role development using concepts more in line with current thinking about cognition and behavior. This theory of gender development posited that as children grow up and interact with other children, they receive confirmation of their roles as females or males. This confirmation helps create a mental "model" of masculinity and femininity, and the child then consciously behaves in a way that fits with her or his gender (Kohlberg, 1966). Children develop the stereotypic concepts of gender from what they see and hear around them. Once they achieve gender constancy (the belief that their own gender is fixed and irreversible), they positively value their gender identity and seek to behave only in ways that are consistent with that understanding (Kohlberg, 1966).

Bandura's (1977) social learning theory has been the most influential in our understanding of the development of gender roles. Drawing on some of Kohlberg's ideas about the observational component of the learning of gender roles, Bandura's Social Learning Theory emphasizes the social nature of learning and person-situation interactions through the mechanisms of self efficacy, observational learning, and
reciprocal determinism. Self-efficacy is based on Bandura’s (1999) contention that people are forward-directed planners who engage in self-organizing, proaction, self-reflection, and self-regulation rather than simply being reactive organisms shaped by external events. He believes that individuals vary in their efficacy expectations that these are key components of behavioral change (Bandura, 2001). Applied to gender roles, efficacy expectations can include decisions regarding the individual’s adherence to proscribed gender roles. In terms of observational learning, Bandura proposed that children learn how to behave in social situations by observing many different settings over long periods of time. As Kohlberg had already noted, gender roles are also learned, to some extent, observationally. The third and more significant innovation in Bandura’s social learning theory is the idea of reciprocal determinism, which is an examination of how people can shape their own environments (Bandura, 1978, 1989). According to this notion, the environment determines behavior but behavior also determines the environment; in other words, people can act to alter their environment. In relation to gender roles, this means that societal expectations about gender shape the individual’s gender-related behavior, but the individual’s gender related behavior can also have the effect of changing societal expectations. Bandura’s (1986, 1997) social cognitive theory of gender role development thus integrates psychological and sociocultural aspects within the same framework.

Focusing on the more cognitive aspects of social learning, Bem (1981) introduced another highly influential theory in the development of gender roles - gender-schema theory. According to Bem, the word “schema” refers to a set of beliefs about something that is generally accepted in a society. Gender schemas are common, sometimes
stereotypical, ways of thinking about the characteristics, abilities, and interests of men and women. A gender schema is developed from a set of observations and interpretations of how men and women behave and relate to each other. In this way, children examine their own actions and perhaps modify them in order to create more common and "normal" actions according to their observations.

Yet another conceptualization centers on gender role development as growing out of the simple realization of biologically determined restrictions. Fast (1984) proposed that, prior to the age of three, both boys and girls believe that all people are the same and that all possibilities are open to them. Somewhere between ages three and four, children discover sex differences and realize that their own experience is limited. Boys realize that they will not be able to have a baby, and girls realize that they will not be able to have a penis. This recognition of limits then triggers a sense of loss and deprivation in both boys and girls, but concurrently creates a lasting distinction with regards to their gender.

Gender Constancy, Gender Role Identity, and Gender Role Conflict

A consistent gender identity is defined as a prerequisite for the development of a consistent gender role identity (Levant & Pollack, 1995). Both are seen as necessary components of psychological well-being. Yet the definition of gender identity actually includes within it two different concepts: gender constancy and gender role identity. According to Kohlberg (1966), gender constancy refers to a cognitive understanding of biologically based limitations of behavior, namely that one is, and will always be, only one sex (with the exception of a subset of trans-gendered individuals who identify as having two genders). There is empirical evidence that children move through three stages of gender constancy understanding (Stangor & Ruble, 1987; Trautner, 1992): First,
learning to identify their own and others’ sex (gender identity or gender labeling), then learning that gender remains stable over time (gender stability), and finally learning that gender is a fixed and immutable characteristic that is not altered by superficial transformations in appearance or behavior (gender constancy). Gender role identity, in contrast, refers to the internalization of cultural expectations about what is appropriate or inappropriate behavior for members of each sex. As such, highly masculine men and highly feminine women perform their gender role identity based on traditional notions of what constitutes masculinity and femininity (Toller, Suter, & Trautman, 2004). In essence, gender constancy is biologically determined, and gender role identity is culturally and socially constructed (Woodhill & Samuels, 2003). When there is tension between these two concepts, gender role conflict arises within the self. This gender role conflict is important because research suggests that it has an impact on the well-being of men and women.

Gender role conflict (O’Neil, Helms, Gable, David, & Wrightman, 1986; Pleck, 1981) arises out of expected gender differences imposed on individuals by cultural pressures to conform to gender role norms. It refers to conflicting feelings about behaving in a way that does not conform to traditional gender stereotypes. According to O’Neil et al., (1986) gender roles are seen as operationally defined, internally inconsistent, constantly changing, and inevitably producing a degree of psychological distress in all individuals. From this theoretical perspective, many negative behaviors can be characterized as a consequence of the psychological damage men and women experience as they struggle to conform to a psychologically dysfunctional or distressing gender role. It is then that gender role conflict occurs. An important question in relation to gender
roles is thus the extent to which gender role adherence and gender role conflict impact on psychological well-being. The remainder of this literature review will center on how these issues play out in women, who will be the focus of our study.

**Femininity Ideology**

There has been extensive research on gender role identity and gender role conflict in men, as well as on the impact of hypermasculinity (a strict adherence to traditional masculinity ideology) (Berger, Levant, McMillian, & Kaye, 2005; Levant, Richmond, & Majors, 2003). Despite the women's movement of the 60's and 70's and the focus on equal rights for women in the past four decades, the research on women's problems with their gender roles has been relatively scarce. It was, however, during the women's movement of the 1970s that the idea that traditional, socialized gender roles may result in a number of negative consequences received some attention (Bolzendahl & Myers, 2004; Forisha, 1978). The women's movement prompted an increased awareness of the unreasonable oppression and restrictions placed on women through the traditional female role (Gilligan 1982, 1990; Rogers 1994). If it could be scientifically demonstrated that there were no significant differences between women and men, then it would be inappropriate to limit opportunities for women based on stereotyped beliefs about their abilities. Many feminists didn't want to find or acknowledge any significant gender differences for this very reason. Gilligan (1982), however, argued that moral reasoning develops differently in boys and girls, with girls more likely to develop a nurturing perspective and boys a more rational, rule-oriented perspective. Gilligan (1982) also pointed out that gender role scripts communicated that for girls to stand out as high performing or "special," they had to do so at the expense of being nurturing. Whether
notions of femininity were biologically determined or socially constructed or both, they seemed to result in a double-bind for women, one in which achievement involved turning one's back on the welfare of others.

Notions of femininity and masculinity are generally considered gender-role ideologies and they represent specific expectations that define how men and women must act within society and with each other. One way to classify gender-role ideologies is along a scale ranging from contemporary to traditional beliefs (Best & Williams, 1993). Contemporary ideologies tend to be democratic, view men and women as equals, and reject the domination of one gender over the other. Traditional ideologies, in contrast, tend to be non-egalitarian, view men as more important than women, and accept as given that men exert control and dominance over women. For example, Griffin (1971) and others (Malamuth, Sockloskie, & Koss, 1991; Muehlenhard, Harney, and Jones, 1992) contend that men are generally considered more dominant and aggressive and view themselves as sexual initiators, while women are generally considered more passive and submissive and view themselves as sexual objects.

Feminist theory claims that femininity ideology is a type of oppression of women and a fundamental component of patriarchy (Griffin, 1971). Although there are multiple femininity ideologies circulating through American society (Collins & Gunnar, 1990; Espin, 1997), the femininity ideology linked specifically with the patriarchal system of the dominant White, middle-class culture of the United States is the form that public institutions (Brown, 1998) support and perpetuate, wherein males adopt dominant and aggressive behaviors, while women are required to adopt adaptive and nurturing behavior (Levant, 1996). According to Tolman and Porche (2000), femininity ideology is not a
neutral or natural set of beliefs, attitudes, or ideas but rather an oppressive mechanism by which to dominate women. Institutionalized, oppressive and dominant ideologies are persistent largely because they are considered to represent reality or the way things are, and they work through internalization (Tolman & Porche, 2000). These ideologies share in common (a) norms for regulating inferior group members’ relationships and appropriate conduct that support and increase the power of the dominant group and (b) an association of inferior groups with a dehumanized and objectified physical body (Duckitt, Sidanius & Pratto, 1999; Tolman & Porche, 2000). The inferior group members’ self-knowledge, effectiveness, and personal rational power are often threatened by such ideologies, which may cause psychological and material disadvantage through internalized oppression (Tolman & Porche, 2000). However, inferior and dominant group members have access to alternatives to resist these oppressive ideologies, therefore, decreasing or avoiding their effects (Brown, 1998; Mosher & Sirkin, 1984). The extent to which an individual relates to an ideology created to diminish one’s self is a variable and important topic of both psychological and sociological interest.

One way to relate to such gender ideologies is to over-identity with them. Research on individual differences in people’s acceptance of extremely stereotypic gender beliefs have yielded two “personality” dimensions, hypermasculinity in men (Mosher & Sirkin, 1984) and hyperfemininity in women (Murnen & Byrne, 1991). These constructs represent strict adherence to gender-specific traditional sex roles and this strict adherence appears to have consequences.

With regard to hyperfemininity, Griffin (1971) argued that socialization into traditional gender stereotypes increases a woman’s risk of victimization. Some female
victims of sexual aggression may have personality dispositions, or have experiences of

 certain life events that may enhance their risk of experiencing sexual coercion (Dawson,
 1989; Murnen & Byrne, 1991). Women are taught not to engage in sex freely or directly
display interest in sex, even if they desire it (Muehlenhard, Harney, & Jones, 1992).

 Murnen and Byrne (1991) describe a personality dimension, hyperfemininity, which
represents a woman’s adherence to extremely stereotypic feminine gender roles. They
contend that hyperfemininity consists of three interrelated components. First,

 hyperfeminine women think that their ability to succeed is based on the ability to foster
and achieve relationships with men. Relationships with men are therefore fundamental to
hyperfeminine women. Hyperfeminine women view their attractiveness and their
sexuality as advantages within a romantic relationship; therefore, by using sexuality as a
tool, hyperfeminine women attempt to manipulate relationship partners. (Hamburger,
Hogben, McGowan, & Dawson, 1996). In a study conducted by Matschiner and Murnen,
1999) it was hypothesized that a woman’s expression of hyperfeminine attitudes would
lead male college student participants to agree with her in response to a persuasive speech
because it would indicate her compliance with women’s subordinate status. It was found
that men (but not women) who listened to a very hyperfeminine speaker agreed with her
more than did men who heard a mildly hyperfeminine speaker, despite the fact that the
high hyperfeminine speaker was judged less competent and knowledgeable. Implications
of the results included the idea that the sexual objectification of women perpetuates
women’s subordinate status. The persistent sexual subordination of women in U.S.
culture has meant that some women learn to define themselves as sexual objects, to agree
with attitudes indicative of “hyperfemininity.” Murnen and Byrne (1991) developed a
scale to measure hyperfemininity, which was defined as exaggerated adherence to a feminine gender role as it related to heterosexual relationships. Examples of some hyperfeminine attitudes on the Hyperfemininity Scale (Murnen & Byrne, 1991) are the statements, “Sometimes women have to compete with one another for men”; “Sometimes I care more about my boyfriend’s feelings than my own”; “Men need sex more than women do”; “Sometimes women need to make men feel jealous so they will be more appreciative”; and “I feel a little flattered when men whistle at me.”

Strong agreement with hyperfeminine attitudes has been found to be related to agreement with ideas that reflect support for a traditional and sometimes subordinate societal position for women. For example, hyperfeminine women reported negative attitudes toward women, were more likely to endorse a traditional family ideology, were more likely to express that marriage is more important than a career, and to report the belief that it is important for a spouse to have an economically successful, prestigious job (Murnen & Byrne, 1991). Hyperfeminine women advocated less harsh reactions to sexual-aggression scenarios and more self-blame if they were themselves the victims of sexual aggression (Murnen, Perot, & Byrne, 1989). In another study it was found that agreement with hyperfeminine attitudes was correlated with justifying male sexual coercion (McKelvie & Gold, 1994). Although many correlates of hyperfeminine attitudes have been examined, there has been little research that attempts to explain why women might adopt such attitudes. Women might learn that being an object of male sexual desire is part of their expected role. Further, according to Matschiner and Murnen (1999) one of the reasons why hyperfeminine attitudes exist is because they can represent an influential way for women to interact with men, since men are more powerful than women in North
American society as they have easier access to sources of influence, such as money and
higher status roles (Berger, Rosenholtz, & Zelditch, 1980), and generally exercise more
direct influence over others (Gruber & White, 1986).

Psychological Distress and Female Gender Role Adherence

Gender role conflict has been theorized and shown to have serious consequences
for individuals as well as for organizations of all types (Chusmir & Koberg, 1988).
Numerous studies have investigated the link between gender roles and psychological
well-being in the past twenty years (Bassoff & Glass, 1982; Marsh & Myers, 1986; Pyke
& Johnson, 2003). American women have also consistently shown higher levels of
gender role conflict than men, regardless of the type of measurement, or instrument used
(Pyke & Johnson, 2003). The question is whether or not such conflict affects women’s
well-being.

Grimmell and Stern (1992) advanced the social conflict model to account for
gender related phenomena. In this model, gender roles may affect well-being by any or
all of three mechanisms: suppressing otherwise healthy coping behavior that is
considered gender-inappropriate, causing an intrinsically harmful hypertrophy of other
behaviors, and most generally, by setting up negative self-evaluations based upon the
difference between one’s own perceived behavior and one’s idea of the ideal person of
one’s gender. In support of the third aspect of this model, Grimmell (1998) reported
finding that gender-role self-discrepancy — the degree of perceived difference between
one self and the ideal person on gender-typed attributes — was a stronger predictor of
psychological well-being than was personal gender role alone.

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Negative affect and somatic complaints.

In a study conducted by Zamarripa, Wampold and Gregory (2003), male gender role conflict, depression, and anxiety were studied in order to clarify and perhaps generalize to women. Results showed that conflict between work and family was related to depression and anxiety in both men and women. Clearly, the increase in women in the workforce has changed the role of women from supporting men’s career progress to having to balance work and family roles (Rogers & Amato, 2000). There is some evidence, however, that women’s experience of the conflict is even more problematic because they feel more responsible for the family commitments and home tasks than do men (Peake & Harris, 2002). The Zamapirra and colleagues (2003) study also showed that restricted emotionality and depression were related for both men and women. Of course we do not know from this study if restricted emotionality led to depression or vice versa.

It is consistently found that women exhibit a higher prevalence of major depressive disorder than do men (Cairney & Wade, 2002; Stordal & Kruger, 2001). Starting in early adolescence, more girls than boys become depressed, and this gender difference in depression persists throughout adulthood. The female preponderance in depression is present across many different countries and cultures (Weissman, Bland, & Canino, 1996). Recent studies suggest the possibility that this gender difference may result from women being subjected to gender role-related limitations. Female high school students who reported that they believed that their fathers wished they were male or that their fathers believed that a woman’s place is in the home were found to be particularly likely to report depression combined with somatic symptomatology, eating

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disorders, and preference for thinness (Silverstein, Perlick, Clauson & McKoy, 1993). In high school and college samples, young women who filled out a scale comprised of items such as “More people would pay attention to my ideas if I was male” and “Being female has never held me back” provided additional data regarding the link between traditional gender role influence and mental health (Silverstein, Caceres, Perdue, & Cimarolli, 1995). Respondents who scored high on gender role interference exhibited higher prevalence of somatic depression, but not higher prevalence of pure depression. Some girls and women who experience biases or limitations placed on them due to their gender may develop a sense of personal limitations or restricted opportunities that later surface as symptoms of anxiety, somatic complaints, and depression (Silverstein & Blumenthal, 1997).

Silverstein and Blumenthal (1997) suggest that gender related limitations are communicated to young women in different ways, including modeling. Girls who see their mothers enacting roles that afford them relatively little prestige, power, or financial security may come to associate femaleness with lesser status or limitations. Girls may be particularly likely to be troubled if their mothers appear to feel limited by their roles or distressed by their inability to achieve outside of the home. According to Silverstein and Blumenthal (1997), girls who reported that they felt limited by the external world’s responses to their gender, or who viewed their mothers as having been limited in this way, exhibited higher prevalence of depression accompanied by anxiety, somatic symptoms such as headaches, and poor body image/preference for thinness compared to other girls or to boys.
Broderick and Korteland (2002) reported on three separate studies designed to investigate the interrelationships among coping styles, gender roles, and level of depression for early adolescents. Results suggested that girls displayed more depression than boys, and girls who identified with the feminine gender role showed increases in depression with age.

**Body dysmorphia and eating disorders.**

As found in some of the aforementioned studies, gender role adherence and conflict have been linked to body image disturbances and preference for thinness in young girls. The fact that eating disorders generally surface during those life stages highlighted by the development of social and professional identity (adolescence and young womanhood), a link has been posited between the process of identity formation and the onset of eating disorders. If that is in fact the case, it would seem reasonable to hypothesize that that gender-specific issues in the identity formation process might be involved (Catina, Boyadijieva, & Bergner, 1996).

Bulimia nervosa can be seen as an attempt by young women to conform to feminine gender role expectations which are impossible to meet. The feminine gender role for women encourages contradictory behaviors. Young girls are taught that womanly success entails the preparation and consumption of rich foods at the same time as the cooks are supposed to maintain their bodies prepubescent in appearance (Devor, 1996). Women are supposed to be feminine and motherly nurturers, as well as consumers of the riches of life, while remaining thin, voluptuous only in terms of certain body parts, and alternately androgynous to the extent that femaleness is only selectively desirable (Broderick & Korteland, 2002). When young women’s maturing bodies exhibit an
unacceptable level of fleshiness, according to the prevailing standard of beauty, they may attempt to remove that flesh. In accordance with current stereotypical standards of femininity, they may diet, exercise excessively, or otherwise purge themselves of the food which they need to consume in order to maintain an optimal body weight. In the process of trying to be beautiful, they starve themselves to the point of experiencing uncontrollable hunger. They then binge eat to satisfy the hunger. Guilty about their eating, fearful of weight gain, suffering from low self-esteem regarding both, they purge once again. Thus, the cycle of bulimia nervosa is established. Women who suffer from bulimia tend to be more feminine and less feminist or less androgynous women (Brown, Cross, & Nelson, 1990).

Young women who suffer from anorexia nervosa come of age in societies which increasingly value and encourage unhealthy thinness in women. A majority of young women in Western societies have negative body images (Tolman & Debold, 1994) and most of them overestimate their body size (Tiggerman & Rothblum, 1988). They learn that their social worth is largely based on their ability to live in accordance with feminine ideals of beauty and thinness and they pursue those ideals constantly. Additionally, young women who suffer from anorexia nervosa have been described as “compliant, perfectionistic” individuals who display a great need to seek approval and a tendency to conform (Garner, Garfinkel & Bermis, 1982). Furthermore, they have also been observed to be somewhat obsessional, socially insecure, and given to overcompliance (Strober, 1986)

Cantelon, Leichner, and Harper (1986) hypothesized that sex-role conflict could actually lead to eating disorders in women and that it could influence the etiology and
course of anorexia nervosa and bulimia in women. Their hypothesis was not confirmed in their study, but the bulimic group experienced significantly more dissatisfaction with the qualities they possessed as women than the other two groups (anorexic and control group). Martz, Handley and Eisler (1995) found that eating disorders and concerns about body image were particularly common among women who scored high on a scale measuring the extent of perceptions of "the negative aspects of the feminine role."

Cantrell and Ellis (1991) conducted a study investigating the relationship of gender roles and eating disordered behavior in 103 male and 134 female undergraduate student volunteers, ranging in ages from 17 to 33 years. They found that androgynous women had the greatest risk of manifesting eating dysfunction versus any other gender role group. The authors suggested that the preponderance of women diagnosed with eating disorders may not be a function of their being female but may be significantly affected by the complex transitions of the female role in our culture. According to Perlick and Silverstein (1994) women who have striven to achieve intellectually, professionally, or politically have, throughout history, confronted massive barriers as a result of being female. This suggests that many such women have experienced ambivalent feelings regarding their gender and that, for centuries, women experiencing what Perlick and Silverstein (1994) called "gender ambivalence" have developed a syndrome comprised of disordered eating, and other related symptoms. According to Vemaleken (1997), women's socialization promotes supportive, socioemotional, and passive roles in American society. Supportive caretaking roles in the society limit women's freedom of expression and place women in vulnerable positions, both economically and
psychologically. Eating disorders may be one of the manifestations of these vulnerabilities.

Disturbances in eating have been well-documented in female undergraduate populations (Mintz & Betz, 1988): changing gender roles and sociocultural environments emphasizing thinness have been strongly implicated as etiological factors (Garner, Garfinkel, Olmstead, & Polivy 1983). Although there appears to be some link between disturbances in eating and gender role, further clarification of this relationship is necessary to better understand its specifics and to hopefully intervene efficiently (Johnson & Petrie, 1996).

Achievement and Self-esteem

There are some data that also support a link between occupational success and gender roles. The most consistent finding has been that, among the female populations studied, possession of masculine traits (gender role non-adherence) is correlated with lower levels of anxiety, less depressed mood, and lower levels of hostility (Antill & Cunningham, 1979; Markstrom-Adams, 1989). Some studies cast doubt upon the generalization of the “masculinity effect” (Forshaw & Shmukler, 1993). For example, Steenbarger and Greenberg (1990) reported that feminine attributes can become more important to well-being than masculine attributes when job settings require the expression of typically feminine traits for successful performance. Similarly, Luhaorg and Zivian (1995) found that being in an occupation that did not match the person’s gender role led to higher levels of gender role conflict, regardless of whether the person was male or female. These and other findings suggest that the influence of gender roles on psychological well-being within the workplace may be situational rather than general,
and may also interact with other social roles a person might adopt or with their culture of origin.

Feelings of competence, self-esteem, and agency have been related to nontraditional gender roles among women (Ossana, Helms & Leonard, 1992). Ahrens and O’Brien, (1996) examined gender-role attitudes in relation to interpersonal and vocational success in women. Results showed that gender-role attitudes were correlated with GPA, career self-efficacy, and instrumentality, suggesting that young women with feminist attitudes exhibited ability and confidence in themselves and their ability to pursue career-related tasks. These findings were consistent with recent research which indicated that females embracing more liberal gender-role attitudes were academically more capable and efficacious in a wide range of areas (Luhaorg & Zivian, 1995).

Thus, gender role adherence and gender role conflict in women has been linked to negative affect, somatic complaints, body dysmorphia, eating disturbances, self-esteem deficits and lower levels of achievement in mainstream culture. But how does the relationship of gender roles and well-being play out in minority cultural groups? After all, gendered social arrangements vary substantially by race, ethnicity, and class in the United States. Little attention has been focused on racial and ethnic variations in gender-role attitudes and the impact of gender-role adherence and gender role conflict on psychological well-being within these groups (Kane, 2000). For example, many studies have found lower rates of eating disorders and body image disturbances among African Americans, Asian Americans and Hispanic-Americans than in American Caucasians (Crago, Shisslak, & Estes, 1996; Fitzgibbon, Spring, Avellone, & Blackman, 1998; Zhang & Snowden, 1999). This suggests that femininity ideology may be playing out
differently within these populations. Harris and Kuba (1997) contend that a complex relationship exists between ethnocultural identity, eating practices, and cultural convergence. This interaction crosses boundaries of nationality, ethnicity, culture, and immigration status and can result in the development of aberrant eating patterns among those who are attempting to adjust to the world around them. The extent to which the mainstream femininity ideology and the culture of origin ideology interact to produce eating disordered behavior or not is an empirical question yet to be answered. It could be that femininity ideologies with an increased emphasis on nurturance and self abnegation produce one type of mental health problem (depression) while those with an increased emphasis on physical attractiveness produce another (eating disturbances). In any case, culture cannot be ignored in the investigation of gender roles and their impact.

Culture and Gender Roles

The division of societal responsibilities and privileges according to gender is universal in human cultures. Over much of the 20th century, a discrepancy has existed in the United States between beliefs about appropriate roles for men and women and the social, lived reality. Survey data indicated that until the late 1960's and early 1970's, most men and women expressed approval of a model of the family in which income-producing work was separated from the household, with the husband assuming the role of "breadwinner" and the wife assuming the full-time domestic role of maintaining the household and caring for children (Mason, Czajka, & Arber, 1976). Congruent with this conception, it was believed that working women would harm their children by depriving them of the care of their mother. Furthermore, there appeared to be a consensus that in
jobs and in education, men deserved preference over women, both for reasons of
purported natural talent as well as in consideration of the provider role that men fulfilled.

Despite these sex-role attitudes, the proportion of women who work has
progressively increased to include many more women than the poor or single women
without alternative sources of support. Most remarkable has been the upsurge in the
proportion of married, middle-class women with young children who report paid
employment. By the late 1990s, more than 70% of women with children joined the
workforce (U.S. Bureau of the Census, 1999). Women have also made steady educational
progress. Studies of gender role attitudes have chronicled a progressive shift toward
egalitarianism, a greater proportion of both men and women endorsing the concept of
equal educational and vocational opportunities for men and women and equal pay for
equal work (Helmreich, Spence & Gibson, 1982; Kane, 2000; Mason, Czajka & Arber,
1976). Attitudes also became liberalized about the appropriateness of women with
children working outside the home, a considerably greater number of both men and
women expressing doubt that the effects on children would necessarily be deleterious.
The majority of young middle-class women also began to express aspirations for a career
which they expected to combine with the role of wife and mother.

Although women in the United States have made marked strides forward over the
past decades, they continue to face barriers. At every educational level, working women
do not achieve vocationally to the same degree as men and at every occupational level,
their salaries are lower than are men's (Babladelis, Deaux, Helmreich & Spence, 1983;
Kane, 2000). Furthermore, variations in femininity ideologies across cultures seem to
play an important role in the advancement of women.
Variations in gendered social arrangements by race/ethnicity compose the context in which racial differences in gender-related attitudes must be understood (Kane, 2000). Employment and family situations are two of the most important social arrangements that need mention. Gendered patterns of labor force experience vary tremendously by class, but overall differences are evident by race/ethnicity as well. Caucasian women have a history of lower levels of labor force participation and higher levels of economic dependence on men compared to African American women (Farley & Allen 1987). But along with high rates of labor force participation relative to Caucasian women, African-American women also “suffer from higher unemployment rates (twice that of white women), experience greater difficulty finding full-time work, and are much more likely to support families alone” (Kane, 2000). For Hispanic Americans, on the other hand, women’s labor force participation rates have been somewhat lower than those for Caucasians, although they have been converging in recent years (U.S. Census Bureau, 1999). Hispanic-American women are more likely than African-American women to be economically dependent on men, with a much higher proportion of Hispanic-American households headed by a married couple rather than by a woman (Garcia-Preto, 1996).

In terms of family, patterns of variation in family experiences by ethnicity have been documented and debated in the literature. African Americans are less likely than Caucasians or Hispanic-Americans to live in households headed by a married couple (Garcia-Preto, 1996), and as noted previously, African-American women are less likely than Caucasians or Hispanic-Americans to be economically dependent on men. In addition, while Caucasian families in the United States have a long tradition of male dominance, scholars of the history of the African-American family have argued that the
legacy of slavery has been one of greater equality in family decision making and division of household labor among African Americans (Gittell, 1971). Wade (1993) argues that African American gender roles are more egalitarian than those found among whites. Along with the greater role equality noted in African American households relative to Caucasian households, there has been a long tradition of assuming that male dominance is particularly marked among Hispanic Americans. Several critical literature reviews on the topic have noted that previous studies of Hispanic-American family life often claimed a highly patriarchal structure based on Mexican and Puerto Rican traditions. But these reviews argue that previous work offered little evidence supporting that claim, countering instead that male dominance is not substantially greater among Hispanic Americans than among Caucasians (Gonzales, 1982; Montoya, 1996). Thus, these scholars suggest either similarity or greater egalitarianism in gender relations within the family for Hispanic Americans and African Americans, relative to whites.

Despite some evidence to the contrary, many scholars continue to expect people of color to hold more traditional gender-related attitudes than do whites. A variety of factors are associated with this expectation. These include the assumed tradition of male dominance among Mexican Americans (Kranau, Green, & Valencia-Weber, 1982) and a tendency toward male dominance as compensation for racial disadvantage among African-American men (Ransford & Miller, 1983). According to Kane (2000), the evidence available on Hispanic Americans’ gender-role attitudes is very limited, but consistent in what it suggests. Some argue that variation among the main groups that comprise the category of Hispanic-Americans is too great to justify use of the category (Garcia-Preto 1996; Montoya, 1996; Strong, McQuillen, & Hughey, 1994), while others
find too little variation to merit disaggregating Cubans, Mexican-Americans, and Puerto Ricans (Harris & Firestone, 1998). The available probability sample evidence that contrasts Hispanic-Americans as a single group with other racial/ethnic groups indicates less egalitarian gender-role attitudes among Hispanic-Americans than among Caucasians or African Americans (Harris & Firestone, 1998; Wilkie, 1993). College student samples suggest the same pattern (Gonzales 1982; Strong et al., 1994). As a single group, then, what little evidence is available points toward more traditional gender-role attitudes among Hispanic Americans than among African Americans or Caucasians. Turning to the contrast between Caucasians and African Americans, a greater array of evidence is available, but no consistent pattern arises regarding differences in gender role attitudes. A number of probability sample studies comparing the two groups note no significant racial differences in role-related attitudes, whether among men only (Wilkie, 1993), women only (Ransford & Miller, 1983; Wilcox & Kraft, 1989), or both men and women (Kane, 1998; Kluegel & Smith, 1986). A similar lack of racial difference is evident in some convenience sample studies as well, most of which focus on college students (Bailey, Silver, & Oliver, 1990; Lottes & Kuriloff, 1992; Rao & Rao, 1985).

The intersections of race and gender noted previously suggest not only the importance of attending to racial and ethnic variations in gender-related attitudes, but also the importance of asking whether race and gender interact in predicting such attitudes. To address this question, it is helpful to briefly review the literature that touches on gender-related attitudes and levels of adherence to gender roles in the three major American minority cultures, at least from a socio-cultural perspective. Increased attention is given to Hispanic-Americans as they will constitute the target population for this study.
African-American Gender-Role Profile

African Americans represent approximately 12.9% of the U.S. population (U.S. Bureau of the Census, 2005). Increasingly larger percentages of African American families are headed by single parents. In 1994, 47% of all African American families involved married couples, compared to 68% in 1970 and 56% in 1980 (U.S. Bureau of the Census, 1995). The African American family has been generally described as matriarchal and its apparent disintegration is blamed for many of the problems faced by African Americans today. Among lower-class African families, over 70% are headed by women. Unmarried Black females account for nearly 60% of births, and, of these mothers, the majority are teenagers. However, these statistics lack an acknowledgment of the strengths in the African American family structure. For many, there exists an extended family network that provides emotional and economic support. Among families headed by women, the rearing of children is often undertaken by a large number of relatives, older children, and close friends. Within the Black family is an adaptability of family roles, strong kinship bonds, strong work and achievement ethic, and strong religious orientation (McCollum, 1997). Within intact families, males are generally accepting of women’s work roles and are more willing to share in the responsibilities traditionally assigned to women, such as taking care of children. (Wilkie, 1993).

Asian-American Gender-Role Profile

The Asian American population in the United States is growing rapidly and consists of at least 30 various ethnic groups. According to the 2005 Census, approximately 4.3% of the U.S. Population consists of Asian Americans, and it is expected to double its size by 2020 and triple it by 2040 (U.S. Bureau of the Census,
Although customs and religions vary among these 30 groups, there are several similarities between the various Asian-American cultures. Authority is rooted in a patriarchal system wherein males are highly valued. In return for ensuring the family’s economic well-being and social status, the father has unchallenged authority and the loyalty and respect of all family members. Emotional well-being is the responsibility of the mother. Mothers are expected to meet the emotional needs of their children and often serve as the intermediary between the father and the children. Firstborn sons are the most valued child and receive preferential treatment as well as more familial responsibilities. They are expected to provide emotional support to the mother, assume responsibility for the educational and character development of younger siblings, and bring honor and financial support to the family (Huang & Ying, 1989). The father maintains an authoritative and distant role and is generally not emotionally affectionate or involved with his children. His role is to provide for the economic and physical needs of the family.

*Hispanic-American Gender-Role Profile.*

Hispanic Americans represent approximately 14.4% of the U.S. population (U.S. Bureau of the Census, 2005). Hispanic-Americans, who may be of any race, accounted for about one-half of the national population growth of 2.9 million between July 1, 2003, and July 1, 2004. The Hispanic-Americans growth rate of 3.6% over the 12-month period was more than three times that of the total population (U.S. Census Bureau News, 2005).

The family is the primary unit within Hispanic-American culture and a strong cultural value (Garcia-Preto, 1996). Relationships between the sexes vary tremendously
with age, education, and time in the United States, among other factors. The younger, more educated individuals who have spent most or all of their lives in the United States may have more in common with Anglo Americans that with traditional Hispanic-Americans. The two key features of the men’s role are machismo and patriarchal authority. Most Hispanic-American men agree that the job of a man is to work hard and to provide financially for the family, to protect the family, and to be the decision maker (Garcia-Preto, 1996).

Machismo is a term commonly associated with Hispanic-American men. It can have both positive and negative associations. On the positive side, it dictates that men are expected to behave valiantly to protect the honor and welfare of their families. A man with machismo is one with a strong work ethic, who is a good provider, and who lives up to his responsibilities. On the negative side, a man with machismo can also refer to someone who is a heavy drinker and can hold his alcohol, traits that are both socially acceptable and proof of manhood (Gushue, 2006). Machismo may also entail men’s active subjugation of women and performance of high-risk activities to “prove” their masculinity (CHISPA, 2002). Also related to machismo is the notion that the man is the boss and the head of the family. Women may make the day-to-day decisions, but fathers make or must be consulted for important decisions.

On the other hand, the role of the traditional Hispanic woman is to take care of the family. Her job is to cook, clean, and care for the children. A good wife should be nurturing, self-sacrificing (marianismo), submissive, and should take orders from her husband. She should not question him but rather should stand behind whatever he decides, even if she disagrees. She must also be tolerant of his behavior. These
prescriptions have great consequence for issues of sexuality and violence among Hispanic-Americans. Traditionally, the most important jobs of Hispanic women are wife and mother. The *Quinceañera*, a traditional celebration of girls’ 15th birthdays, mirrors many of the features of a wedding, including bridesmaids and groomsmen. Although few Hispanic-American parents in the United States expect their daughters to marry at 15, the large amounts of money still spent on the ritual reflects the importance of the role of marriage in girls’ lives. According to the KPNDC (2001), fertility rates among Hispanic-Americans are among the highest in the United States. American born Hispanic Americans begin childbearing at an earlier age than do non-Hispanic-American Whites and continue for a longer time. Children are highly valued, and women’s status is related to her ability to bear children. Given the responsibility for the day-to-day raising of children, many Hispanic-American women may prefer smaller families; however, their husbands often oppose limiting family size because having a lot of children is seen as proof of their machismo.

According to the Centers for Disease Control and Prevention (2002), Hispanic-American women are one of the fastest growing AIDS populations in the country. Explanations for the high rates include constraints imposed by gender roles. The influence of Catholicism along with the values of motherhood, female modesty, and male dominance make it less likely for women to suggest men use condoms (KPNDC, 2001). Furthermore, if women ask their husbands to use condoms, their husbands may see that as an indication their wives think they are being unfaithful, an unwelcome inference. Rather than risk losing their husbands by asking that they use condoms, the women will keep quiet and thus increase their own risk of contracting HIV/AIDS. Additionally,
domestic violence is not uncommon among Hispanic-Americans. Women are expected to help maintain their families’ social respectability and thus may be reluctant to report domestic violence (Gushue, 2006), especially because they may not want to speak to outsiders about personal problems. Overall, those with higher levels of ethnic identity are more likely to subscribe to traditional male and female roles (Abreu, Goodyear, Campos, & Newcomb, 2000).

For the most part, recent studies have focused on these three groups (African, Asian, and Hispanic American) as a whole in terms of their societal progress and the many difficulties experienced by each group. The question now becomes, to what extent do African, Asian, and Hispanic American women experience gender role conflict while attempting to advance in American society while remaining members of their own subculture.

Between Two Cultural Constructions of Gender

Little research has examined how women in ethno-racial minority groups mediate cross-pressures in the production of femininity as they move between mainstream and ethnic cultures in different arenas such as family, work, and school. Distinct and even contradictory gender strategies may be enacted across these arenas. Many individuals move in social worlds that do not require dramatic inversions of their gender performances, thereby enabling them to maintain stable and seemingly unified gender strategies. However, members of communities that are racially and ethnically subordinate to mainstream culture and who regularly cross interactional arenas with conflicting gender expectations might engage in different gender roles depending on the context in which they are interacting (Pyke & Johnson, 2003).
Challenges for African American Women

African American women appear to be greatly disadvantaged in the job market, making it difficult even for those with higher education to contribute to society due to inadequate recognition from the dominant society (Crawford & Smith, 2005). Womanism is a feminist perspective that has recently been appropriated for social work practice with African American women. It emphasizes the centrality of gender role in African American women's psychosocial adaptation, and asserts that the archetypal gender role for this group incorporates both nurturing and economic providing functions. This gender role flexibility has been characterized both as a source of strength and strain (Billingsley & Cross, 1992).

Littlefield (2003) investigated the relationship between gender role identity and stress in African American women. The Bem Sex Role Inventory was used to classify participants into groups based on the degree to which they identified themselves with stereotypically masculine and feminine traits. Results showed that women who endorsed high levels of both masculine and feminine traits experienced lower levels of stress than did other women. The findings indicate that gender role identity is a factor in African American women's psychological well-being, and that mainstream gender role norms may not be adequate for analyzing the experiences of this group. Additionally, Littlefield (2003) studied racial identity attitudes and womanist identity attitudes in 200 African American college women from a large southeastern university. The results of this study provide support for Albert's hypotheses that racial identity and womanist identity are significantly correlated. Women in this study who were affiliated with organizations that
empower African American women displayed less conservative attitudes regarding gender roles. 

One would think that women who embrace feminism are more like to challenge gender roles and support the rights of minorities, however Harnois (2005) compared Caucasian and African American women and found some interesting differences regarding the extent to which education, marital status and religiosity predicted feminist attitudes. These three factors predicted the extent to which Caucasian women embraced feminism but none of them predicted African American women’s adherence to feminism. Multiracial feminist theories offer some explanations as to why this might be the case. While Caucasian women may experience involvement in the paid labor force and postponement or refusal of marriage as an act of independence, African American women, who have historically participated in the paid labor force out of necessity, may view these experiences as less significant, or significant but non-liberating events. Religiosity, which is usually negatively correlated with adherence to feminist values in Caucasian women (Oppenheim Mason & Kuhlthau, 1989), has no such relationship in African American women. Collins and Gunnar, (1990) maintain that African American churches have served as a space for women to exercise leadership and authority, to explore issues of oppression, and to build strong relationships among women, all of which help foster women’s relationship to feminism, broadly defined. As Hooks (1984) suggests, it could be that because oppression is a more salient aspect of African American girls’ and women’s lives, their concern for women’s or feminist issues is not generally associated with particular life events. While having been married and religiosity are negatively associated with Caucasian women’s closeness to feminism, it appears that
African American women's experiences in the religious institutions and marriage are comparatively less likely to discourage their embracing feminism.

**Challenges for Asian American Women**

Pyke and Johnson (2003), examined how second-generation Asian American women experience and think about the shifting dynamics involved in the “doing” of femininity in Asian ethnic and mainstream cultural worlds. Results suggested dynamics of internalized oppression and the social construction of inequality related to femininity ideology. Asian- American women’s descriptions of gender performances in ethnic settings were marked by self-disgust and referred to as a mere act not reflective of their true gendered nature. In mainstream settings, on the other hand, respondents often felt a pressure to comply with notions of Asian femininity or, conversely, to distance one’s self from derogatory images of Asian femininity in order to be taken seriously. In general, participants depicted women of Asian descent as uniformly engaged in subordinated femininity marked by submissiveness and depicted Caucasian women as universally assertive and gender egalitarian. Some Asian women claimed that because they were assertive or career oriented, they were not really Asian. That is, because they did not conform to racialized stereotypes of Asian women but identified with a Caucasian standard, they felt different from other women of Asian origin.

**Challenges for Hispanic-American Women**

Hispanic-American professional women report feeling marginalized from their professional group as well as their social ethnic groups, which leads to feelings of stress and loneliness (Canabal & Quiles, 1995; Franks & Faux, 1990; Kranau, Green, Valencia-Weber, 1982; Romero, Castro, & Cervantes, 1988). Hispanic-American women still earn
less than their male counterparts and White female counterparts (Sanchez & Brock, 1996). In addition, the effects of the role of culture and gender on Hispanic-American women are important and not easily separated (Santiago-Rivera, Arredondo, & Gallardo, 2002) and have been found to have a profound effect on women of color, especially (Canabal & Quiles, 1995). There appears to be a strong pull to keep the roles of women and men separate (Kranau, et. al., 1982) in many Hispanic cultures and women feel they are scrutinized more rigorously and that stricter criteria are used to judge their ability and worth. Further, depression and conflict have been reported by Mexican American women as they attempted to play professional roles while meeting the needs of the culture and family (Arbona, Flores, & Novy, 1995; Hogg & Tery, 2000; Valentine & Mosley, 2000).

In a research study conducted by Constantine and Flores (2006), professional Hispanic-American women continued expressing the challenge of career and family balance, as they felt they were defying cultural and gender role expectations that demand that women remain in submissive and passive roles. For instance, the fact that professional women contribute to the household budget may impact gender relations at home. Contributions to the family wage lead to greater decision making, bargaining power, and control over the household budget. As a result, women are said to gain greater personal autonomy and independence while men lose ground (Espiritu, 1997), which creates a gender role conflict for Hispanic-American women. Some researchers cite that women’s work outside of the home may increase family tensions and cultural conflicts, leading in turn to hostility and even divorce rather than greater male-female cooperation (Gushue, 2006).
It is clear that many African, Asian, and Hispanic-American women experience gender role conflicts and act against femininity ideologies, both mainstream and culture-specific, in an effort to succeed and maintain a sense of self-respect. However, we know little about how that struggle plays out as one femininity ideology meets another and women are differentially affected by these competing ideologies. It is the hope of this study to modestly begin illuminating that question by focusing on the potentially differentiated impact of two components of mainstream femininity ideology on the well-being of two groups of college women: European Americans and Hispanic-Americans.

Aims of the Study and Hypotheses

Two major components of North American femininity ideology are 1) submission to the desires of others or self-abnegation, and 2) body ideals. Research suggests that over-adherence to these perceived aspects of femininity may result in reduced well-being, the extremes of which can be depression, anxiety and eating disordered behavior. Our first aim would thus be to examine the extent to which adherence to femininity ideology, as defined by these two components, is related to lower levels of well-being and academic performance in college women. However, in recognition of the variation in femininity ideologies across cultures, we would also like to test the extent to which these components of femininity ideology play out differently in two cultural groups; European-Americans and Hispanic-Americans. Given the greater emphasis on female self-abnegation in Hispanic culture (marianismo) and the greater emphasis on the thinness ideal of beauty in European-American culture, we would thus expect to find cultural differences in adherence to these aspects of femininity ideology. More importantly,
however, we would expect that young women with strong adherence to a component of femininity that is not a central aspect of their indigenous femininity ideology would suffer more severe well-being deficits. Our hypotheses are thus as follows:

*Hypothesis #1*

In the combined sample, Objectified Relationship with the Body (ORB) will be:

1.a. positively associated with eating disorder risk, depression, anxiety, and negatively associated with self-esteem (well-being variables)
1.b. negatively associated with self-reported GPA (achievement variable).

*Hypothesis #2*

In the combined sample, Inauthentic Self in Relationships (ISR) will be:

2.a. positively associated with eating disorder risk, depression, anxiety, and negatively associated with self-esteem (well-being variables)
2.b. negatively associated with self-reported GPA (achievement variable).

*Hypothesis #3*

European Americans will score higher on Objectified Relationship with the Body (ORB) than Hispanic Americans.

*Hypothesis #4*

Hispanic Americans will score higher on Inauthentic Self in Relationships (ISR) than European Americans.

*Hypothesis #5*

Hispanic Americans will evidence a stronger association than European Americans between Objectified Relationship with the Body (ORB) and
5.a. eating disorder risk, depression, and anxiety, (positive) and self-esteem (negative)

5.b. self-reported high school GPA (negative)

Hypothesis #6

European Americans will evidence a stronger association than Hispanic Americans between Inauthentic Self in Relationships (ISR) and

6.a. eating disorder risk, depression, and anxiety, (positive) and self-esteem (negative)

6.b. self-reported high school GPA (negative)
CHAPTER 3

METHODOLOGY

Participants

A total of 208 female participants completed the protocol, and no student refused to participate after carefully reviewing and signing the informed consent, which disclosed information about the nature of the study. Analyses, however, were limited to participants who were between the age of 18 and 22 and who had missing data on no more than 5% of items on any one of the measures used in this study. Also excluded from analyses were participants who identified with an ethnicity other than European American, Hispanic, Chicana or Latina. The final sample thus consisted of 162 participants; 82 European American women and 80 Hispanic American women. The majority of the participants were between 18-20 years of age ($M=19.78$ $SD=1.29$). In terms of school grade, 50% of the participants were freshmen, 27.8% sophomores, 16.7% juniors, and 4.9% were seniors.

Materials

Socio-demographic questionnaire. A brief socio-demographic questionnaire inquiring about age, ethnicity, and high school GPA was administered (See Appendix 1).

The Adolescent Femininity Ideology Scale (AFIS; Tolman & Porche, 2000). The AFIS measures young women’s internalization of two negative aspects of femininity ideology: 1) inauthentic self in their relationships (the ISR scale), and 2) objectified
relationship with their own bodies (the ORB scale). Each of these two subscales is composed of ten-self-report items. An example of an ISR item is “I express my opinions only if I can think of a nice way of doing it.” An example of an ORB item is “I am more concerned about how my body looks than how my body feels.” Each item is responded to on a 6-point scale in which 1 denotes strong disagreement and 6 denotes strong agreement. Scores for each of the subscales are computed separately by summing up the responses to each item (using reversed scoring when indicated) and then dividing by the number of items in each subscale. Scores thus range from 1-6 and higher scores on both scales of this measure denote higher levels of objectified relationship with one’s body and higher levels of inauthenticity of self in relationships. Internal consistency for the two scales have been reported to range from .64 to .77 for the ISR, and .62 to .81 for the ORB (Impett, Schooler, & Tolman, 2006; Tolman & Porche, 2000). In our sample the internal consistency coefficients were .61 for ISR and .84 for ORB. With regard to construct validity, there is a moderate negative correlation between mutuality in relationships and the ISR subscale (Tolman & Porche, 2000). For the ORB subscale, a strong correlation with a tendency to evaluate one’s appearance was found according to Tolman and Porche (2000), (See Appendix 2).

*The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965).* The RSE Scale is a 10-item measure of overall self-esteem. Items are rated from strongly disagree (1) to strongly agree (4). A sample item is “I feel that I have a number of good qualities.” Five items that are negatively worded are reverse scored so that higher scores reflect more positive self-esteem. Total scores can range from 10 to 40. Multiple studies have shown the RSE to be a reliable and valid measure of self-esteem with internal consistency.
coefficient reported to be in the .90's, and test-retest reliability ranging from .80 to .85. (Dobson, Goudy, & Keith, 1979; Rosenberg, 1965; Hagborg, 1993). In our sample, the internal consistency coefficient was .81 (See Appendix 3).

*The Eating Disorder Inventory-2 (EDI-2; Garner, 1991)*. The EDI-2 is a widely used self-report measure of Eating Disorder symptoms. The first version retained 64 items grouped into 8 standardized subscales representing dimensions that are clinically relevant to eating disorders. The first 3 subscales deal with attitudes and behavior concerning eating, weight, body shape, namely, Drive for Thinness (DT), Bulimia (B), and Body Dissatisfaction (BD). The remaining 5 dimensions tap more general psychological and relational constructs relevant to eating disorders, namely Ineffectiveness (I), Perfectionism (P), Interpersonal Distrust (ID), Interoceptive Awareness (IA), and Maturity Fears (MF). The second version of the EDI (EDI-2) has been expanded with 27 items on three subscales: Asceticism (A), Impulse Regulation (IR), and Social Insecurity (SI), creating a total of 91 items. Internal consistency reliability coefficients for the EDI-2 scales are between .44 and .93. The EDI-2 validity is supported by a significant body of literature indicating that the EDI-2 subscales measure clinically relevant dimensions of experience for eating-disorder patients (Nevonen, Clinton, & Norring, 2006; Doninger, Enders, & Burnett, 2005). Examples of the items included in the EDI are “I am terrified about being overweight,” and “I feel extremely guilty about eating.” Respondents must rate whether each item applies “always,” “usually,” “often,” “sometimes,” “rarely,” or “never.” Responses for each item are weighted from zero to three, with a score of 3 assigned to the responses farthest in the “symptomatic” direction (“always” or “never” depending on whether the items is keyed
in the positive or negative direction), a score of 2 for the immediately adjacent response, a score of 1 for the next adjacent response, and 0 score assigned to the three responses farthest in the “asymptomatic” direction. Thus, positively scored items are weighted as follows: Always=3, Usually=2, Often=1, Sometimes=0, Rarely=0, Never=0. Reversed-scored items are weighted in the opposite manner (i.e., Never=3, Rarely=2, Sometimes=1, Often=0, Usually=0, Always=0). For the purpose of this study only the following eating disorder risk scales were analyzed: Drive for Thinness (DT), Bulimia (B), and Body Dissatisfaction (BD). As per the EDI manual, all items in each scale were added to arrive at a scale score for each participant. Total scale scores were then transformed into T scores and then the 3 subscale T-scores were added and then transformed into yet another T score entitled the Eating Disorder Risk Composite (EDCR). The EDCR provides a global measure of eating and weight concerns with equal weighting for each of the contributing scales. Total scores pertaining to the EDCR can range from 18-70. An EDCR score in the Elevated Clinical range is within the 67th to 99th percentile (T score ≥ 57) and indicates that the respondent has extreme eating and weight concerns that consist of fear of weight gain, desire to be thinner, binger eating tendencies, and body dissatisfaction. (See Appendix 4).

The Rand Mental Health Inventory-18 (MHI-18; Berwick, Murphy, Goldman, Ware, Barsky, & Weinstein, 1991). The MHI-18 measures psychological well-being and was designed for use with general populations (Ware, 1984). Four factors reflect the multidimensional nature of psychological well-being: anxiety, depression, loss of behavioral/emotional control, and general positive affect. The MHI contains 18 items accompanied by 6-point adjectival response scales ranging from 1 (all the time) to 6
Internal consistency coefficients have ranged from 0.83 to 0.92 for the four scales and 0.96 for the overall score. In our sample the internal consistency coefficient for the overall score was .93. One-year test-retest reliability ranged from .56-.64. In terms of validity, the depression and anxiety scales performed very favorably against a criterion diagnosis using the Diagnostic Interview Schedule (Weinstein, Berwick, Goldman et al; 1989). For the purpose of this study, only two subscales (depression and anxiety) on this measure were analyzed. In our sample, internal consistency coefficients were .87 for the anxiety scale, and .88 for the depression scale. Total scores for the depression subscale can range from 1 to 24, and 1 to 30 for the anxiety subscale, so that higher scores denote better well-being. Although higher scores on this scales denote higher levels of well-being, we have reversed the direction of relationships in correlational analyses with these scales to avoid confusion (See Appendix 5).

**General Ethnicity Questionnaire (GEQ).** The General Ethnicity Questionnaire (GEQ; Tsai, Ying, & Lee, 2001) permits assessment of different kinds of cultural orientation. For this particular study, we used the GEQ-Latino/Hispanic version to assess Hispanic American women’s level of acculturation to American culture. This measure seeks to obtain cultural orientations pertaining to the individual’s culture of origin as well as to American culture. Participants use scale ratings from 1 = strongly agree to 5 = strongly disagree to rate how much they agree with statements about their cultural orientation (e.g., “When I was growing up I was exposed to the culture with which I most closely identify”). For items that pertain to the participant’s language proficiency, the scale ratings range from 1 = very much to 5 = not at all (e.g., “How fluently do you write...
English?”). The GEQ is comprised of 38 items. Internal reliability (Cronbach’s alpha) for the Asian versions has been reported to be .92 with a one-month test-retest reliability of .62 (SD=.22). In our sample, the internal consistency coefficient for Hispanic participants was .94. Standard indices of acculturation (age of arrival, generational status, and length of residency in the United States) as identified by Marin (1992) were positively correlated with higher scores on the GEQ and thus support the notion that the GEQ is a valid measure. The total scores for this measure can range from 38 to 190, so that higher scores denote greater acculturation to American culture. (See Appendix 6)

**Academic Performance.** Although we attempted to measure academic performance by self-reported high school GPA on the demographics questionnaire, (See Appendix 1), we realized that this resulted in an unreliable assessment as different high schools use different GPA ceilings. Consequently academic achievement results will not be reported.

**Procedure**

This study was approved by the Institutional Review Board of the University of Nevada, Las Vegas. Participants were recruited on a volunteer basis from the Department of Psychology subject pool and from various campus organizations. Campus organizations’ recruitment was only necessary for Hispanic American women. Each participant was administered a questionnaire packet that includes the general socio-demographic questionnaire, The Adolescent Femininity Ideology Scale (AFIS), The Rosenberg Self-Esteem Scale (RSE), The Eating Disorder Inventory-2 (EDI-2), and The Rand Mental Health Inventory (MHI). Additionally, for Hispanic American women, the General Ethnicity Questionnaire (GEQ-Latino/Hispanic Version) was included in their
packages and was administered accordingly. The questionnaire order was randomized to avoid questionnaire order effects.
CHAPTER 4

RESULTS

Overview of Analyses

First we present our treatment of missing data, followed by the investigation of the degree to which the dependent measure data met the assumptions of Analysis of Variance (ANOVA). We then present analyses that test whether the only sociodemographic variable other than ethnicity that we inquired about (age) was related to our independent variable (ethnicity). The results of tests designed to test our 6 study hypotheses follow. Finally, we present analyses investigating the extent to which acculturation in our Hispanic American participants was related to the dependent measures.

Missing data

We excluded from analyses the data of any participant who had failed to answer more than 5% of any one measure. There were five such participants. Ten other participants had some missing data but the missing data constituted less than 5% of any one measure. In these cases, we used mean substitution in place of missing data which is considered an acceptable strategy when there is very little missing data as was the case in this study (Tabachnik & Fidell, 2001). For each missing data point we used the ethnic group mean for the measure in question.
Characteristics of the Distribution of Variables

To examine the extent to which the data met the normality assumptions of Analysis of Variance (ANOVA), the skewness and kurtosis of the distribution of the dependent measures were analyzed in each ethnic group separately. Any measure distribution with a skewness between +1.0 and -1.0 was considered to be sufficiently normal (Morgan, Leech, Gloeckner, & Barrett, 2004). All of our measures, [Inauthentic Self in Relationships (ISR), Objectified Relationship with Body (ORB), Eating Disorder Risk Composite Score (EDRC), Rosenberg Self-Esteem Score (RSE), Mental Health Inventory-Depression Scale (MHI-D), and Mental Health Inventory-Anxiety Scale (MHI-A)], fell between the acceptable range for skewness. In terms of outliers, defined here as falling two standard deviations from the mean, we had only one European American and one Hispanic outlier on the Rosenberg Self-Esteem Scale. Considering that all variables were sufficiently normally distributed, that analyses without the two outliers did not change the significance of results, and that ANOVA is a robust test, we decided to present analyses conducted on the complete original data set.

Covariation

The only sociodemographic variable other than ethnicity that was inquired about was age. There was not a significant age difference between European Americans \((M = 19.60, SD = 1.15)\) and Hispanic Americans \((M = 19.98, SD = 1.40)\), \(t(160) = -1.87, p > .05\). We thus did not use age as a covariate in subsequent analyses.
Hypotheses Testing

Hypothesis 1: In the combined sample there will be a positive association between Objectified Relationship with the Body (ORB) and eating disorder risk, depression, anxiety, and a negative association with self-esteem.

Table 1 presents the means, standard deviations, and intercorrelations of the all of the variables entered into the correlation matrix for hypothesis 1 and 2. ORB appeared to have a positive association with Eating Disorder Risk \((r = .68, p < .001)\), Depression \((r = .39, p < .001)\) and Anxiety \((r = .37, p < .001)\), and a negative association with Self-Esteem \((r = -.55, p < .001)\), in the combined sample (see Table 1).

To test for the combined and unique effect of these variables on the prediction of ORB, we also ran a multiple regression analysis with the combined sample. In predicting ORB, the regression equation was significant \([F (5, 156) = 49.31, p < .001]\) and accounted for 61% of the variance (see Table 2). However, only eating disorder risk, self-esteem and anxiety were unique predictors.

Hypothesis 2: In the combined sample, there will be a positive association between Inauthentic Self in Relationships (ISR) and eating disorder risk, depression, and anxiety, and a negative association with self-esteem.

Results showed a positive association between ISR and Depression \((r = .43, p < .001)\) and Anxiety \((r = .17, p < .05)\), and a negative association with Self-Esteem \((r = -.35, p < .001)\). No significant associations were found between ISR and Eating Disorder Risk (see Table 1).
To test for the combined and unique effect of these variables on the prediction of ISR we also ran a multiple regression analysis with the combined sample. In predicting ISR, the regression equation was significant \[ F(5, 156) = 7.57, p < .001 \] and accounted for 20% of the variance (see Table 3). However, only Depression was a unique predictor.

Hypothesis 3: European Americans will score higher on Objectified Relationship with the Body (ORB) than Hispanic Americans.

Table 4 presents a One-Way Analysis of Variance (ANOVA) comparing European and Hispanic Americans on ORB scores. Contrary to the hypothesis, Hispanic Americans \((M = 3.30, SD = 1.05)\) scored significantly higher on ORB than European Americans \((M = 2.95, SD = .81)\), \(F(1, 160) = 5.86, p < .05\).

Hypothesis 4: Hispanic Americans will score higher on Inauthentic Self in Relationships (ISR) than European Americans.

Table 5 presents a One-Way Analysis of Variance (ANOVA) comparing European and Hispanic Americans on ISR scores. Consistent with the hypothesis, Hispanic Americans \((M = 3.06, SD = .62)\), scored higher on ISR than European Americans \((M = 2.74, SD = .60)\), \(F(1,160) = 10.63, p < .001\).

Hypothesis 5: Hispanic Americans will evidence a stronger positive association than European Americans between Objectified Relationship with the Body (ORB) and eating disorder risk, depression, and anxiety, and a stronger negative association with self-esteem.

Table 6 presents the intercorrelations between ORB and the dependent variables as a function of ethnicity. To determine whether or not our two ethnic groups differed significantly in terms of the strength of the correlations between ORB and the well-being...
variables, Fisher's z transformations were conducted (see Table 7). Results did not show a significant ethnic group difference in the magnitude of the correlations of well-being variables with ORB. There did, however, appear to be a trend toward the support of our hypothesis with correlations between ORB and Depression and Anxiety appearing substantially larger in Hispanics than in European Americans.

**Hypothesis 6:** European Americans will evidence a stronger positive association than Hispanic Americans between Inauthentic Self in Relationships (ISR) and eating disorder risk, depression, and anxiety, and a stronger negative association with self-esteem.

Table 6 presents correlations between ISR and the dependent variables as function of ethnicity. To determine whether or not our two ethnic groups differed significantly in terms of the strength of the correlations between ISR and the well-being variables, Fisher's z transformations were conducted (see Table 8). Results did not show a significant ethnic group difference in the magnitude of the correlations of well-being variables with ISR. There did not appear to be any trend supporting our hypothesis. In fact, the one the association that approached significance was that between Depression and ISR which was stronger in Hispanics, contrary to our hypothesis.

**Acculturation**

Finally, in order to investigate the extent to which levels of acculturation in our Hispanic participants were related to the study measures, we ran bivariate correlations between the latter and scores on the GEQ-Latino/Hispanic version. The only measure that evidenced a significant association with acculturation was depression \( r = -.25, p < \)
.05). In other words, the more acculturated women in our sample tended to be slightly less depressed.
Results confirmed our hypotheses that, regardless of ethnicity, the more that women adhered to certain femininity ideologies, as in Objectified Relationship with their Body (ORB) and Inauthentic Self in Relationships (ISR), the less well-being they would report. Based on our appraisal of differences in cultural values, we had also predicted that European American women would adhere to body objectification to a greater extent than Hispanic American women and that Hispanic American women would adhere to inauthentic self in relationships to a greater extent than European American women. However, Hispanic American women in our sample adhered more than European American women to both of those afore-mentioned aspects of femininity ideology. Finally, we hypothesized that adherence to an aspect of femininity ideology that was not as strongly supported by the culture of origin would be associated with more psychological distress. In other words, we expected the negative association between inauthenticity of self in relationships and well-being to be stronger for European Americans than for Hispanic Americans. By the same token, we also expected the negative association between of objectification of body and well-being to be stronger in Hispanic Americans than in European Americans. No support was found for the hypothesized ethnic group differences with regard to the magnitude of the correlations of well-being and adherence to femininity ideology. Finally, the level of acculturation of the
Hispanic American women in our sample did not appear to be strongly related to our dependent measures, with the exception of depression with which it was negatively associated.

*Hyperfemininity and Well-being*

Most studies have found that women who adhere to extremely stereotypic feminine gender roles (hyperfemininity) present with more well-being deficits (Grimmell and Stern, 1992; Grimmell, 1998; Silverstein, Caceres, Perdue, & Cimarolli, 1995; Silverstein, & Blumenthal, 1997; Broderick and Korteland, 2002; Garner, Garfinkel & Bermis, 1982), indicating that hyperfemininity may be detrimental to women’s welfare. Our findings are consistent with the existing literature. Accumulating support for this association between hyperfemininity and distress may be explained by Grimmell and Grimmell and Stern’s Social Conflict Model (1992). In this model, gender roles may affect well-being by any or all of three mechanisms: suppressing otherwise healthy coping behavior that is considered gender-inappropriate, causing an intrinsically harmful hypertrophy of other behaviors, and most generally, by setting up negative self-evaluations based upon the difference between one’s own perceived behavior and one’s idea of the ideal person of one’s gender. In support of the third aspect of this model, Grimmell (1998) reported finding that gender-role self-discrepancy — the degree of perceived difference between one’s self and the ideal person on gender-typed attributes — was a stronger predictor of psychological well-being than was personal gender role alone. Although attitudes toward gender roles are now much more flexible, different cultures retain varying degrees of expectations regarding male and female behavior. An individual may personally disregard gender expectations, but society may disapprove of
his or her behavior and impose external social consequences. On the other hand, an individual may feel internal shame if he or she experiences emotions or desires that go against his or her gender norms. Gender role conflict (O’Neil, Helms, Gable, David, & Wrightman, 1986; Pleck, 1981) thus arises out of expected gender differences imposed on individuals by cultural pressures to conform to traditional gender role stereotypes. According to O’Neil et al., (1986) gender roles are seen as operationally defined, internally inconsistent, constantly changing, and inevitably producing a degree of psychological distress in all individuals. If these inconsistencies are unresolved, gender role conflict contributes to poor mental health (Lengua & Stormshak, 2000). From this theoretical perspective, many negative behaviors can be characterized as a consequence of the psychological damage women experience as they struggle to conform to a psychologically dysfunctional or distressing gender role (O’Neil, et al., 1986). Therefore, one can conclude that over-adhering to traditional gender roles is dysfunctional and distressing to women, and the outcome of such phenomena can result in negative consequences to their well-being, regardless of ethnicity.

Studies suggest that women are more prone to experience internalizing disorders partly as a result of stress caused by gender role conflicts (Efthimi, Maureen, & James, 2001). Primary symptoms of internalizing disorders involve negative inner emotions as opposed to outward negative behavior. In our sample, the specific psychological problems that were associated with hyperfemininity included depression, anxiety, self-esteem deficits, and eating disorder risk. Clearly, our results support the extensive literature, which has indicated that depression (both mild and severe) (Weissman, Bland, & Canino, 1996; Broderick & Korteland, 2002) and anxiety (generalized or “free-
floating” anxiety, phobias, and panic attacks) are internalizing disorders common to women as a result of gender role stress (Silverstein & Blumenthal, 1997). Studies suggest that starting in early adolescence, girls become depressed and experience more anxiety, which may result from women being subjected to gender role related limitations (Cairney & Wade, 2002; Stordal & Kruger, 2001). Symptoms may include sadness; a sense of loss, helplessness, or hopelessness; doubt about one’s ability to handle problems; high levels of worry or nervousness; poor self-esteem; guilt, self-reproach, and self-blame; decreased energy, motivation, interest in life, or concentration; and problems with sleep or appetite (Lengua, & Stromshak, 2000).

Gender role conflict has also been linked to body image disturbances and preference for thinness in young women. Body image is formed, to some extent, as a function of the culturally defined images of desirable bodily appearances (Silverstein, Perlick, Clauson, & McKoy, 1993; Cantelon, Leichner, & Harper, 1986; Cantrell and Ellis, 1991; Mintz & Betz, 1988). From this perspective, a girl’s self-esteem may be influenced by the degree to which she believes she meets cultural standards of beauty (Antill & Cunningham, 1979; Ossana, Helms & Leonard, 1992). This can be particularly problematic for adolescent girls continually exposed to media images depicting the ideal woman as unrealistically thin, passive, and overly sexualized, while portraying them as both career and family oriented (Wolf, 1992). These conflicting and largely unattainable cultural standards may result in confusion and a sense of inadequacy (Petersen, 1988), causing the development of eating disorders.
Furthermore, research suggests that feelings of competence and self-esteem have been related to nontraditional gender roles among women (Ossana, Helms & Leonard, 1992).

Ethnic Differences and Hyperfemininity

Researchers have examined the extent to which adherence to certain femininity ideologies vary by ethnicity (Harris & Firestone, 1998; Wilkie, 1993; Gonzales, 1982; Strong et al., 1994). Most studies have found that European American women tend to be more concerned with their body image than ethnic minority women (Feingold, 1990; Marlowe, Schneider, & Nelson, 1996; Pingitore, Dugoni, Tindale, & Spring, 1994; Popkin & Udry, 1998; Stunkard, 1996). The submission of their desires of those of others (marianismo) is a cultural value strongly associated with Hispanic notions of femininity (Nieto-Gomez, 1976). We did not find this type of ethnic differentiation. Our sample of Hispanic American women did indeed score higher on inauthenticity of self in relationships but, contrary to our hypothesis, they also scored higher on objectification of the body. Perhaps this finding is reflective of recent literature that reports an increase in eating disorders (full syndromes or partial syndromes) and disordered patterns of eating among people of color (men and women) and among prepubertal girls in all social classes and within all regions of the United States and countries around the world (Golden, 1997; Morande', Celada, & Casas, 1999; Mukai & McCloskey, 1996; Rosenvinge & Gresko, 1997; Striegel-Moore, 1995; Comerci & Greydanus, 1997; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000; Warheit, Langer, Zimmerman & Biafora, 1993). Ethnic minority women appear to be becoming more concerned with their body image, which in turn promotes eating disorders. Additionally, this finding may suggest that Hispanic
culture may not be protecting Hispanic American women the way it traditionally has with its traditional ideals of beauty as somewhat more corpulent than American ones. Slowly, studies are being published that point to this sea-change in Hispanic American culture. As an example, Fitzgibbon, Spring, Avellone, and Blackman (1998) compared the severity and correlates of binge eating in Caucasian, African American, and Hispanic American women and found that binge-eating symptoms were more severe in Hispanic Americans than in African Americans or Caucasian women. Participants, who binged more frequently, were heavier; more depressed, and preferred a slimmer body than those who did not binge as much in all groups.

Adherence to Culturally Emphasized or Culturally De-emphasized Aspects of Femininity Ideology

We expected that women who adhered to an aspect of femininity that was not central aspect of their cultural ideology would be worse off than women who adhered to culturally consonant notions of femininity. Our thinking was as follows: If the femininity ideologies of cultures other than the young woman's own are manifesting an added influence then the young woman may be even more of a victim of restricting gender roles and subsequently feel even more distressed. Our results did not support this contention. There was a trend supporting our hypothesis, with substantially larger (though not significant) magnitudes of association between objectified relationship to body and depression and anxiety in Hispanic American women. On the other hand, contrary to our hypothesis, a trend was found wherein an association between inauthenticity of self in relationships and depression approached significance in Hispanic American women, despite this being a supposedly more culturally consonant notion of femininity.
Hispanic American women may be caught between their indigenous cultural values and those of the host culture in regards to notions of femininity. Part of their femininity ideology may be to adhere to all femininity ideologies thrown at them in order to both “fit in” and remain loyal to their origins. Research suggests that Hispanics believe in living in harmony, emphasizing the present, and identifying individual goals as subordinate to group goals (Fouad, 1995). Hispanic American women may perceive themselves to have two groups: their culture of origin and mainstream American culture. In an attempt to avoid conflict on all fronts, they may be attempting to adhere to multiple constraints. Root (1990) examined the interaction across boundaries of nationality, ethnicity, and culture, and found that regardless of racial or ethnic group status, most individuals are subject to the standards of the dominant culture, particularly when their culture or racial/ethnic group of origin is devalued by the dominant culture. Under these conditions, cultural and ethnic identity, social, familial, and individual factors contribute to the development of well-being deficits. Perhaps, Hispanic American women are finding themselves struggling between maintaining their indigenous femininity ideologies, and adhering to those suggested by the mainstream culture, in an attempt to “fit in” in two different metaphorical spaces. Our results may reflect what occurs when a person tries to meet the compelling expectations and obligations of two roles simultaneously (Kitchener, 1988).

**Acculturation**

We did not have any hypotheses in regard to acculturation; however, we thought it might be germane to investigate the extent to which levels of acculturation in our Hispanic American women were related to the femininity ideology and well-being. For
the most part, our investigation showed a lack of acculturation associations. The only measure that evidenced a significant association with acculturation was depression. The more acculturated women in our sample tended to be slightly less depressed. This finding supports the body of research that has presented similar results stating that acculturation may enhance psychological well-being because of the acquisition of the language, behavioral norms, and values of the mainstream society that allow minorities to adapt to and become accepted by members of the dominant culture (Rogler, Cortes, & Malgady, 1991; Warheit, Vega, Auth, & Meinhardt, 1985; Atkinson, 1989; Griffith & Villavencio, 1985). Tran, Hoang, Docuyanan, and Jung (1992) found that within each ethnic minority (Asian American and Hispanic American) higher acculturation was associated with better scores on most measures of well-being, suggesting that as acculturation occurs, well-being may increase. Thus, our finding demonstrating a negative association between acculturation and depression adds to the body of literature that supports the association of acculturation and increased well-being.

Limitations

The interpretation of our findings requires the consideration of a number of limitations. Power was a limitation in regards to the investigation of ethnic differences in the magnitude of associations between aspects of femininity ideology and well-being. A larger sample would have clarified those differences. On the other hand, we had ample power for the other study hypotheses for which we obtained small effect sizes. These small effect sizes put into perspective how much we can make of our results.

Another limitation was the characteristic of the sample itself. We utilized a convenience sample that consisted mostly of college freshmen and sophomore women.
Clearly, we had a highly acculturated sample as they were all attending university, which at the very least implies language proficiency. Perhaps, a less acculturated sample would yield different results.

Furthermore, since the sampling strategy differed slightly for each ethnic group, this may have introduced some unknown confound. Hispanic American women were recruited from the Department of Psychology subject pool, and from various campus organizations, whereas, European American women were recruited only from the subject pool. It is unclear, whether this may have affected our results.

Finally, although we were investigating femininity ideology, we do not know if men who adhere to inauthenticity of self in relationships and who worry about their bodily appearance are not suffering from the same, if not worse, well-being deficits. Perhaps these two supposed components of femininity ideology are in fact markers of psychological distress in both genders.

Future Research

According to the literature, traditional sex roles are found to be more prevalent in first and second generation of Hispanic women (Ortiz & Cooney, 1982). Perhaps future studies could more carefully delineate the relationship of femininity ideology to different generations of Hispanic American women. Other culturally salient factors, such as religiosity, could also be investigated in relation to Hispanic women as religion is central to Hispanic American culture. This relationship may be worth investigating considering that one of the roles of Hispanic women is to maintain the religion (Diaz-Stevens, 1994). The very ideology of “marianismo” (the veneration of the Virgin Mary and the valuing of submissiveness) developed out of Catholic notions of femininity as saintly and
passive, (Nieto-Gomez, 1976). This study focused on Hispanic American women, but questions of femininity ideology and its relationship to well-being seem germane to other minority groups, such as African Americans and Asian Americans. Perhaps, in depth one-on-one interviews or focus groups could be conducted to validate the experiences and struggles of different ethnic groups regarding their struggle to adhere to multiple femininity ideologies.

Finally, it would also be interesting to investigate adherence to masculinity ideologies across ethnic groups and to investigate its impact on the well-being of young men. It seems that strict adherence to oppressive gender roles is a risk factor for mental health problems in both men and women. Attempts to free young men and women from this type of oppression seems like a good investment in their mental and emotional health.
REFERENCES


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373-385.


Gushue, G.V. (2006). The relationship of ethnic identity, career decision-making self-
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75


Women Quarterly, 12(3), 281-297.


Table 1

Means, Standard Deviations, and Intercorrelations for the Independent (ORB and ISR) and Well-Being Variables for the Combined Sample

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ORB (1-6)</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ISR (1-6)</td>
<td>.23**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ED Risk (18-70)</td>
<td>.68***</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Self-esteem (10-40)</td>
<td>-.55***</td>
<td>-.35***</td>
<td>-.28***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Depression (4-24)</td>
<td>.39***</td>
<td>.43***</td>
<td>.12</td>
<td>-.67***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Anxiety (5-30)</td>
<td>.37***</td>
<td>.17*</td>
<td>.28***</td>
<td>-.35***</td>
<td>.53***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05; ** p < .01; *** p < .001.
Table 2.

Regression Analyses Summary for Well-Being Variables Predicting Objectified Relationship to Body (ORB) in Combined Sample

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SEB</th>
<th>( \beta )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating disorder risk</td>
<td>.02</td>
<td>.00</td>
<td>.56***</td>
</tr>
<tr>
<td>Self esteem</td>
<td>- .09</td>
<td>.02</td>
<td>-.36***</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.02</td>
<td>.01</td>
<td>.13*</td>
</tr>
<tr>
<td>Depression</td>
<td>- .01</td>
<td>.02</td>
<td>-.04</td>
</tr>
</tbody>
</table>

*\( p<.05, \quad ***p<.001 \)

Note: \( R^2= .61 \ (N=161, \ p<.001) \)
Table 3.

**Regression Analyses Summary for Well-Being Variables Predicting Inauthentic Self in Relationships (ISR) in Combined Sample**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating disorder risk</td>
<td>.00</td>
<td>.00</td>
<td>.01</td>
</tr>
<tr>
<td>Self esteem</td>
<td>-.02</td>
<td>.02</td>
<td>-.12</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.01</td>
<td>.01</td>
<td>-.08</td>
</tr>
<tr>
<td>Depression</td>
<td>.05</td>
<td>.02</td>
<td>.39**</td>
</tr>
</tbody>
</table>

***p = .001

**Note:** $R^2=.20 \ (N=161, \ p<.001)$
Table 4

One-Way Analysis of Variance (ANOVA) comparing European and Hispanic Americans on Objectified Relationship with Body scores.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>Sig</th>
<th>$\omega^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>1</td>
<td>5.14</td>
<td>5.14</td>
<td>5.86</td>
<td>.017</td>
<td>.04</td>
</tr>
<tr>
<td>Within Groups</td>
<td>160</td>
<td>140.34</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>145.48</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5

One-Way Analysis of Variance (ANOVA) Comparing European and Hispanic Americans on Inauthentic Self in Relationships Scores.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>Sig</th>
<th>$\omega^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>1</td>
<td>4.01</td>
<td>4.01</td>
<td>10.63</td>
<td>.001</td>
<td>.06</td>
</tr>
<tr>
<td>Within Groups</td>
<td>160</td>
<td>60.40</td>
<td>.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>64.41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6
Means, Standard Deviations, and Intercorrelations Between Objectified Relationship with Body and Inauthentic Self in Relationships and Predictor Variables as a Function of Ethnicity

<table>
<thead>
<tr>
<th>Measure</th>
<th>European Americans</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Hispanic Americans</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>1. ORB</td>
<td>2.95</td>
<td>.81</td>
<td>--</td>
<td>.14</td>
<td>.63***</td>
<td>-.45***</td>
<td>.17</td>
<td>.26*</td>
</tr>
<tr>
<td>2. ISR</td>
<td>2.74</td>
<td>.60</td>
<td>.24*</td>
<td>--</td>
<td>.21</td>
<td>-.26*</td>
<td>.27*</td>
<td>.25*</td>
</tr>
<tr>
<td>3. EDI</td>
<td>33.62</td>
<td>10.35</td>
<td>.71***</td>
<td>- .08</td>
<td>--</td>
<td>-.31**</td>
<td>.10</td>
<td>.16</td>
</tr>
<tr>
<td>4. Self-Esteem</td>
<td>20.26*</td>
<td>3.50</td>
<td>-.58***</td>
<td>-.36**</td>
<td>-.25*</td>
<td>--</td>
<td>-.53***</td>
<td>-.31**</td>
</tr>
<tr>
<td>5. Depression</td>
<td>17.98*</td>
<td>4.15</td>
<td>.41***</td>
<td>.51***</td>
<td>.11</td>
<td>-.74***</td>
<td>--</td>
<td>.70***</td>
</tr>
<tr>
<td>6. Anxiety</td>
<td>18.80</td>
<td>4.20</td>
<td>.41***</td>
<td>.07</td>
<td>.33**</td>
<td>-.34**</td>
<td>.42***</td>
<td>--</td>
</tr>
</tbody>
</table>

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

Note: Intercorrelations for European Americans (n=82) are presented above the diagonal, and intercorrelations for Hispanic Americans (n=80) are presented below the diagonal. Means sharing superscript “a” are significantly different from each other at the .01 level and means sharing superscript “b” are significantly different at the .05 level.
Table 7

Results of Fisher z transformations to Test Group Differences in the Strength of Correlations between ORB and Well-being Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hispanic Americans (r)</th>
<th>European Americans (r)</th>
<th>z-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Disorder Risk</td>
<td>.71</td>
<td>.63</td>
<td>.94</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>-.58</td>
<td>-.45</td>
<td>1.12</td>
</tr>
<tr>
<td>Depression</td>
<td>.41</td>
<td>.17</td>
<td>1.56</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.41</td>
<td>.26</td>
<td>1.06</td>
</tr>
</tbody>
</table>
Table 8

Results of Fisher $z$ transformations to Test Group Differences in the Strength of Correlations between ISR and Well-being Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hispanic Americans</th>
<th>European Americans</th>
<th>z-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Disorder Risk</td>
<td>-.08</td>
<td>.21</td>
<td>-.75</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>-.36</td>
<td>-.26</td>
<td>.69</td>
</tr>
<tr>
<td>Depression</td>
<td>.51</td>
<td>.27</td>
<td>1.68</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.07</td>
<td>.25</td>
<td>1.19</td>
</tr>
</tbody>
</table>
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Committee Member, Dr. Jeffrey Kern, Ph.D.
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