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Early maladaptive schemas and negative eating attitudes: The moderating role of acculturation in Latina college students

Stacey Cardoz Lopez

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EARLY MALADAPTIVE SCHEMAS AND NEGATIVE EATING ATTITUDES: THE MODERATING ROLE OF ACCULTURATION IN LATINA COLLEGE STUDENTS

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology:
General-Experimental

by
Stacey Cardoz Lopez

June 2011
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Approved by:

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Dr. Michael R. Lewin, Chair, Psychology

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Dr. Matt Riggs

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(6-10-11)
ABSTRACT

Prior research on eating disorders has focused on Caucasian females despite the rapidly growing disordered symptoms among Latinas. The current study focused on the prevalence of negative eating attitudes in one hundred and forty five Latina college students and delineated the cognitive and cultural factors that may be responsible for the increase in negative eating attitudes (NEAT) in Latinas. As hypothesized specific Early Maladaptive Schemas (EMS) were predictive of NEAT. Acculturation was also predictive of NEAT. However, acculturation did not moderate the relationship between specific EMS and NEAT. Clinical implications and suggestions for future research will be discussed.
ACKNOWLEDGEMENTS

This thesis would not have been possible without the help of Dr. Michael R. Lewin, my advisor and mentor. I am very grateful because his encouragement, guidance, and support from undergrad years to the final level allowed me to develop into a better psychology student and person. I also offer my regards and blessings to Dr. Matt Riggs and Dr. David Chavez for agreeing to be on my thesis committee and for providing me with helpful suggestions. Lastly, but certainly not least, I am grateful to both my parents Angel and Marta Cardoz, as well as my brother Angel J. Cardoz for their encouragement and support.
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CHAPTER ONE

INTRODUCTION

Eating disorders and subclinical eating disturbances are a problem, especially for women in the United States and worldwide. The age onset of eating disorders is approximately 16 to 20 years of age, during the imperative transition from adolescence to early adulthood and into college life (Striegel-Moore, Dohm, Kraemer, Taylor, Daniels, Crawford, & Schreiber, 2003). Additionally, nearly 50% of females have dieted prior to adolescence (Gustafson-Larson & Terry, 1992). Overall, eating disorders and weight concerns are highest among college women than any other female demographic groups struggling with eating disorders (Klemchuk, Hutchinson, & Frank, 1990). It is so prevalent among this age group that some have regarded eating problems as a standard component of the female college experience (Rozing, Bauer, & Cataneses, 2003). Tylka and Subich, (2002) found that 59% of college females reported skipping meals, 37% reported eating less than the daily caloric requirement, 26% reported to have fasted for more than twenty four hours , and 7.2% used laxatives. Celio, Luce, Bryson, Winzelberg, Cunning, Rockwell, et al., (2006)
found that 32% of a large sample of college women (n = 484) reported using diet aids. They also found that weight and shape concerns were more common among those who reported use of these diet aids than those who did not use dietary aids for weight control. Within populations not seeking treatment for eating disorders, Berman (2006) found that low confidence in the ability to control eating behaviors while experiencing negative emotions, or having access to an abundance of food was related to negative eating attitudes in an undergraduate sample. Researchers have concluded that unhealthy weight regulation methods and body image concerns, which predispose people to clinical and subclinical eating disorders, are common among college students (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004).

Eating Disorders in Latinas

Due to the underrepresentation of ethnic minorities in eating disorders research, a general misperception is that eating disorders only occur within the Caucasian community (Cachelin, Veisel, Striegel-Moore, & Barzegarnazari, 2000). Croll, Neumark-Sztainer, Story, and Ireland (2002) revealed that almost 60% of minority adolescents surveyed reported
eating disorder symptoms. Seventy percent of those with disordered eating also exhibited body image concerns. Additionally, in a large sample of 453 multi-racial female athletes (277 Caucasian, 103 Latina, and 73 African American), Pernick, Nichols, Rauh, Kern, Ji, Lawson, and Wilfley (2006) found that Caucasian and Latinas were at a higher risk of developing eating disorders in comparison to African Americans. Even so, nearly all studies exploring the prevalence of eating disorders have primarily focused on Caucasian females; very little work has examined how eating disorders affect individuals of different ethnicities and further research must be conducted to ensure that our efforts to combat these illnesses are inclusive of all women. Of particular importance to the current research, is the finding that disordered symptoms among Latinas are growing rapidly and that Latinas may now be at a higher risk of developing an eating disorder compared to Caucasian females (Arriaza & Mann, 2001; Gluck & Geliebter, 2002; Robinson, Killen, Litt, Hammer, Wilson, et al., 1996).

In an attempt to explain the development of eating disorders, researchers have examined the role that cognitive factors may play (e.g., beliefs and assumptions
about eating and weight, schemas about self and relationships to others). For example, research has demonstrated a relationship between Early Maladaptive Schemas (EMS) and eating disorders (Waller, Ohanian, Meyer, & Osman, 2000). Although this research has led to some important implications for the development and treatment of eating disorders, little attention has been paid to cultural diversity. Additionally, the role of acculturation, the process of attitudinal and behavioral change that occurs as a result of contact with a new culture (Marin, 1992), has also been found to have an effect on eating disorders in Latinas. The current study is an attempt to examine the prevalence of negative eating attitudes (NEAT) in Latina college students and to delineate the cognitive and cultural factors that may be responsible for the increase in eating disorders in Latinas. Specifically, we will examine the moderating role of acculturation on the relationship between EMS and NEAT in Latina college students.
CHAPTER TWO
LITERATURE REVIEW

Acculturation and Eating Disorders

An important aspect to consider in the prevalence of eating disorders in Latinas is the role of culture. Culture, is the learned aspect of human society including the customs, manners, values, and other social behaviors that are shared among members of the particular society or group (Marshall, 1998). Acculturation, however, can be defined as the attitudinal and behavioral change of an individual as a result of continuous contact between two distinct cultures. It is the process by which the individual adapts to novel characteristics of the host culture in concurrence with their primary culture (Berry & Sam, 1996).

This is noteworthy since research has found that higher levels of acculturation are associated with higher levels of eating and body disturbances (Harris & Kuba, 1997) such as body dissatisfaction, restricted eating and drive for thinness (Abrams, Allen, & Gray, 1993), and consequently eating disorders (Cachelin, et al, 2000; Chamorro & Flores-Ortiz, 2000; Robinson et al., 1996).
For example, Pepper and Ruiz (2007) examined the relationship between acculturation and anti-fat attitudes (negative perception of overweight individuals) in a sample of 264 Latina and European American females. They found European American females reported greater anti-fat attitudes than Latinas. However, European Americans and highly acculturated Latinas did not differ in their anti-fat attitudes, compared to bicultural and low acculturated Latinas. According to the authors, the findings further confirm that adoption of the Western culture ideals are correlated with the adoption of negative eating attitudes.

In a sample of 920 adolescent females (45.7% European American, 14.3% Hispanic, 24% Asian), Gowen, Hayward, Killen, Robinson, and Taylor (1999) found that acculturation was positively associated with eating disorder symptoms for the Hispanic girls. Specifically, they found a 13.6% prevalence rate in highly acculturated Latinas versus 0% of low acculturated Hispanic. However, this was not found in the Asian and European females examined in the study.

Furthermore, Cachelin et al., (2000), found that individuals who were more acculturated with the Anglo American culture, regardless of their ethnicity, were more
likely to suffer from eating problems (n = 136, Hispanic, Asian, African American, and White women). Ayala, Mickens, Galindo and Elder (2007), found that greater acculturation with the Anglo American culture was associated with a higher prevalence of disordered eating behaviors (n = 167, Mexican-born or children of Mexican parents).

On the other hand, Joiner & Kashubeck (1996) evaluated the relationship between acculturation, body image, self esteem and eating disorder symptomatology in a sample of 120 adolescent Mexican American women and did not find a relationship between acculturation and eating-disorder symptomatology. The authors speculate that the results suggest that the impact of acculturation may have been overemphasized in previous studies. However, their findings may have been a result of the use of different instruments to measure their construct of interest.

Alternatively, when Cachelin, Phinney, Schug and Striegel-Moore (2006) specifically examined the effects of acculturation upon eating disorders with different instruments, they found opposite results to that of the Joiner & Kashubeck (1996) study. With the use of a Mexican American sample (79 women diagnosed with an eating disorder and 109 without an eating disorder), they found that higher
acculturation with the Anglo American culture was a significant predictor of eating disorders. Specifically, for every 1-point increase in their scores on the (5-point) Anglo orientation subscale, Mexican American women’s risk for an eating disorder doubled. It was also found that a strengthened Mexican identity was not associated with eating disorders.

Dulce, Hunter, and Bettina, (1999) also found that less acculturated Latina women reported less eating disorder symptoms, than highly acculturated Latinas. Chamorro and Ortiz (1998) examined the relationship between acculturation and eating disorders, among five different generations of Mexican American women, in a sample of 139 Mexican American women. The results indicated that among the five generations, second generation Mexican American women, women who were born in the USA to parents born in a foreign country, revealed the highest degree of acculturation and eating disorders.

In addition to acculturation, other variables have been studied in the etiology of eating disorders. Research has examined the role of past experience and cognitive schemas on the development of eating disorders.
Early Maladaptive Schemas

According to the Cognitive theory, Schemas are cognitive structures that individuals use to evaluate and cipher environmental stimuli (Beck, 1976). In other words, schemas are the cognitive structures that help individuals organize their life experiences in memory and affect how an individual’s past, present and future events are interpreted based on past experiences (Beck, 1967). Adaptive schemas are the result of positive environmental events during development; accordingly it is imperative for healthy functioning as they allow for individuals to construe situations in a pragmatic manner rather than in an unrealistic one.

On the other hand, the development of maladaptive schemas is the result of early negative environmental experiences such as neglect, abuse, or abandonment (Beck, et al., 1990). Maladaptive schemas formulate a distorted atmosphere where the individual has distorted attitudes, unrealistic goals and expectations that inevitably set them up for failure (Young, Klosko, & Weishaar, 2003).

More specifically, Early maladaptive schemas (EMS) are self defeating emotional filters that develop as a result of not having their needs met in childhood and are
strengthened in the course of life to construe and mediate past, present and future perceptions (Young et al., 2004).

EMS are reinforced through alterations of reality that support the particular maladaptive schema and reinforced through self defeating lifestyles which limit disconfirmatory experiences (Young et al., 2003). As a result, the selective processing of information that solely confirms EMS fortifies EMS and the maladaptive way of interpreting experiences.

As a result, interest has shifted to schemas and their relationship with eating disorders. Schema therapy introduced by Young, Kolsko, and Weishaar (2003) is an advance from common cognitive therapies such as CBT as it includes perspectives from different models such as Gestalt models, attachment models, and most importantly, EMS (Young et al., 2003). According to Leung, Waller, and Thomas, (2000) high scored on many EMS can be predictive of low progress from psychotherapeutic methods. Thus, Young (1994) speculates that individuals with entrenched beliefs (such as those in eating disorders and personality disorders) respond best to treatments that attend to both schemas and secondary cognitions that traditional CBT usually address.
Early Maladaptive Schema Domains

EMS develop as a product of unmet core developmental needs such as nurturing, guidance, safety and protection (Young, et al., 2003). More specifically, EMS are believed to develop as a result of enduring ailing interactions with primary caregivers and peers, and also as a consequence of the physiological disposition of the child.

In summary, overindulgence of core childhood needs as well as maltreatment and trauma can lead to the development of EMS and maladaptive coping efforts that reinforce EMS (Young, et al., 2003).

According to Young’s schema model (2003), there are 18 EMS grouped into five broad developmental categories called schema domains. Each of the five domains is believed to represent EMS that develop due to the primary caregivers’ failure to meet important components of a child’s core developmental needs.

Disconnection/Rejection Domain

According to Young et al. (2003), individuals with EMS “... in this domain are unable to form secure and satisfying attachments toward others” (p. 13) and “believe their needs for stability, safety, nurturance, love, and belonging will not be met” (p. 13).
The EMS under this domain are Abandonment/Instability, the perceived notion that others are unavailable and unreliable for support and connection; Mistrust/Abuse the expectation that others will deliberately hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage; Emotional Deprivation the belief that one's desire for emotional support will not be met; Defectiveness/Shame the conviction that one is defective or inferior; and Social Isolation/Alienation the belief that one is isolated from society (Young et al., 2003).

**Impaired Autonomy and Performance Domain**

Individuals with schemas in this domain feel that they will fail in attempts to succeed, or function independently.

There are four EMS listed under this domain: Dependence/Incompetence, the belief that one is unable to handle day to day responsibilities independently; Vulnerability To Harm Or Illness, an exaggerated fear that unavoidable disasters will take place; Enmeshment/Undeveloped Self, the lack of individual identity as well as the lack of normal social development; and Failure, the believe that one is bound to fail (Young et al., 2003).
Impaired Limits Domain

People with EMS in this domain exhibit a lack of ambition, internal limits and inability to respect the rights of others. There are only two EMS listed under this domain: Entitlement/Grandiosity, the belief that one is superior to other people; and Insufficient Self-Control/Self-Discipline, and the refusal to apply self-control, and frustration tolerance to achieve one's personal goals or to restrain impulses (Young et al., 2003).

Other-Directedness Domain

Individuals with EMS in this domain show an excessive focus on other's needs at the expense of their own needs. There are three EMS under this domain: Subjugation, restraining personal needs by conceding personal control to others; Self-Sacrifice, extreme focus on attending the needs of others; and Approval-Seeking/Recognition-Seeking, excessive weight on gaining approval from others in order to gain a sense of self (Young et al., 2003).

Overvigilance and Inhibition Domain

People with EMS in this domain place excessive emphasis on suppressing spontaneity and focus on meeting rigid internal rules about the individual's performance and
ethical behavior. There are four EMS under this domain: Negativity/Pessimism, extreme focus on the negative aspects of life while disregarding the positive aspects; Emotional Inhibition, suppression of spontaneous action, feeling, or communication in order to avoid the disapproval of others; Unrelenting Standards/Hypercriticalness, the belief that one must meet very high standards of behavior and performance in order to avoid criticism; and Punitiveness, the belief that people should be penalize for making mistakes (Young et al., 2003).

Early Maladaptive Schemas and Eating Disorders

Women with eating disorders report more EMS than females without eating disorders (Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997; Leung, Waller, & Thomas, 1999; Waller, Ohanian, Meyer, & Osman, 2000). Several studies have found that Schemas are highly correlated with the development of eating disorders, the maintenance of negative eating attitudes (Dingemans et al., 2006; Waller et al., 2000). For example, Waller et al. (2000) found in a sample of 50 bulimic women and 50 control women with a mean age of 24.4 that the EMS of Emotional Inhibition beliefs as
measured by the Young Schema Questionnaire (YSQ) was predictive of bingeing severity. They also found that the EMS of Defectiveness/Shame predicted the severity of vomiting.

Leung and Price (2007), in a sample of 35 women with eating disorders (n= 16, anorexia nervosa, n= 19, bulimia nervosa) and a comparison symptomatic dieters group (n=16), found that women with eating disorders had higher scores than symptomatic dieters controlling for depression and low self-esteem on 8 of 15 EMS measured by the YSQ short form (YSQ-SF; i.e., Emotional Deprivation, Mistrust/Abuse, Social Isolation, Defectiveness/Shame, Failure to Achieve, Functional Dependence, Vulnerability to Harm and Subjugation). This indicates that the observed differences in eating symptomatology were not influenced by depression or self-esteem scores.

Furthermore, Jones, Harris, and Leung (2005) investigated EMS and eating disorder recovery. The sample was comprised of 66 women with eating disorders (mean age = 32.52, range = 16 - 59), 29 women recovered from eating disorders (mean age = 34.38, range = 18 - 61), and 50 undergraduate students (mean age = 30.78, range = 18 - 62). Results revealed that women with eating disorders scored
significantly higher than the recovered group and control group on all EMS except Emotional Deprivation, Abandonment, and Self Sacrifice beliefs (these levels did not differ between eating disordered women and recovered women). It was also found that Mistrust/Abuse, Social Isolation, Defectiveness/Shame, Failure to Achieve and Vulnerability to Harm, were lower in women who have recovered from an eating disorder than those who were current sufferers. Interestingly, it was found that women with a current eating disorder who engaged in bingeing reported higher scores on EMS of Abandonment and Vulnerability to Harm (Jones, Harris, & Leung, 2005).

Dingemans, Spinhoven, and Van Furth (2006) found that the EMS of the Disconnection/Rejection, Impaired Autonomy/Performance, Impaired Limits, and Overvigilance and Inhibition Domains were positively associated with compensatory behaviors (e.g., vomiting, laxative misuse and fasting) in a sample of 106 eating disordered patients (women =100, men = 6) and 27 healthy female controls.

According to the Cognitive Behavioral model set forth by Cooper, Wells, and Todd (2004), ‘triggers’ (e.g. an inquiry “Have you gained weight?”) activate a negative self-belief (e.g. ‘I’m unworthy) that then leads to the
activation of a specific EMS. The cycle then produces an emotion that allows for thoughts about food (both positive and negative); these thoughts then promote dysfunctional coping attempts, such as bingeing and purging (the eating disorder) in order to relieve the negative feelings. As a result, bulimic behaviors temporarily block the negative self beliefs that rise from the activation of the schema and allow for the maintenance of behaviors related to eating disorders (Cooper et al, 2004).

In a recent study about eating disorders and EMS, it was found that women with eating disorders demonstrated higher levels of negative beliefs about self and the world (i.e., EMS) in comparison to women without eating disorders (Jones, Leung, & Harris, 2007). Specifically, results indicated that the EMS of Emotional Deprivation, Social Isolation, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline were predictive of bulimic attitudes and behaviors (i.e., bingeing). Additionally, the EMS of Emotional Deprivation, Social Isolation, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline were predictive of caloric restriction (Jones et al., 2007).
Meyer and Gillings (2003) examined the mediating role of the mistrust/abuse schema on the relationship between parental bonding and bulimic psychopathology in a sample of 102 nonclinical women (mean age = 19.4). The results indicated that mistrust/abuse beliefs were predictive of bulimic attitudes and a partial mediator of the relationship between paternal overprotection and bulimic attitudes.

In a similar line of research, Murray, Waller, and Legg (1999) found that internalized shame (a concept similar to the EMS of defectiveness/shame) acted as a predictor of negative eating attitudes and was a complete mediator of the relationship between parental bonding and negative eating attitudes in a sample of 139 nonclinical undergraduate females (mean age = 21, range = 18 - 34).

Turner, Rose, and Cooper (2005a) found both Dependence/Incompetence and Defectiveness/Shame to be predictors of negative eating attitudes and mediators of the parental bonding and negative eating attitudes relationship in a sample of 367 nonclinical adolescent females. These findings suggest that low paternal caring and maternal overprotection may lead an individual to perceive oneself as being inferior or incompetent and these
beliefs then trigger eating disordered symptoms. Over time, this process may lead to negative views about body image and unhealthy eating attitudes. Turner, Rose, and Cooper (2005b) examined if a difference in EMS existed between overweight females and a control group in a sample of 367 adolescent girls. They found that overweight female adolescents reported higher levels of the EMS Emotional Deprivation, Abandonment/Instability, Subjugation, and Insufficient Self-Control/Self-Discipline than their average weight counterparts.

Leung, Waller, and Thomas (2000), examined the relationship between EMS and treatment outcomes after a 12 week long CBT intervention in a sample of 20 women. Results revealed that women with the EMS of severe Defectiveness/Shame, Social Isolation, and Social Undesirability did not improve in their frequency of vomiting at the end of treatment. It was also found that participants with high levels of the EMS of Dependence/Incompetence did not improve in their bulimic attitudes.

Furthermore, with the use of the full-length Schema Questionnaire, Waller, Meyer, and Ohanian (2001), found that bulimic individuals can be differentiated by a
specific set of EMS such as Defectiveness/Shame, Insufficient Self Control/Self-Discipline, and failure to achieve. They also found that bingeing was associated with the EMS of Abandonment, Defectiveness/Shame, Emotional Deprivation, Emotional Inhibition, and Failure to Achieve, Insufficient Self-Control/Self-Discipline, and Social Isolation. The authors also found that Vomiting was associated with the EMS of Abandonment, Functional Dependence, Defectiveness/Shame, Emotional Inhibition, Social Isolation, and Vulnerability to Harm. Results of multiple regression analyses where all 15 EMS were entered simultaneously, revealed that only the EMS of Emotional Inhibition was a significant predictor of bingeing and the EMS of Defectiveness and Subjugation were the only predictors of vomiting (Waller et al, 2001).

Unoka, Tolgyes, Czobor, and Simon (2010) examined the relationship between eating disorder behaviors (EDB) EMS in a sample of 114 women receiving treatment in an inpatient psychotherapy unit specialized for treating eating disorders. An association was found between EDB and EMS. More specifically, EDB such as high levels of binge-purging and low levels of physical exercise was associated with the
EMS of Emotional Deprivation, Abandonment, Enmeshments, Subjugation, and Emotional Inhibition.

Although several studies have examined the relationship between EMS and NEAT and the relationship between EMS and specific eating disorders, results revealed that specific EMS predictors have varied across studies. Based upon the literature reviewed, it appears that the EMS of Emotional Deprivation (Jones et al., 2007; Turner, Rose, & Cooper, 2005b), Defectiveness/Shame (Leung, Waller, & Thomas, 2000; Turner, Rose, & Cooper, 2005a; Waller, Ohanian, Meyer, & Osman, 2000; Waller, Meyer, and Ohanian, 2001), Dependence/Incompetence (Jones et al., 2007; Leung, Waller, & Thomas, 2000; Turner, Rose, & Cooper, 2005a), and Insufficient Self-Control/Self-Discipline (Jones et al., 2007; Turner, Rose, & Cooper, 2005b, Waller, Meyer, and Ohanian, 2001) are the most consistent EMS associated with NEAT and eating disorders.

As a result it is hypothesized that the EMS of Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline will be predictive of NEAT. Likewise, it is hypothesized that acculturation, more specifically, identification with Latino culture and
identification with American culture will be a significant predictor of NEAT. Additionally, it is hypothesized that acculturation (identification with Latino culture and identification with American culture) will moderate the relationship between each of the EMS of Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, Insufficient Self-Control/Self-Discipline and NEAT.
CHAPTER THREE
METHODOLOGY

Participants

Participant data from a larger study investigating EMS, psychological symptoms, and coping styles were used to run analyses. Specifically, college students enrolled in undergraduate psychology courses at California State University, San Bernardino were recruited to voluntarily participate in the study for extra course credit. Participants included 162 Latina females. All participants were treated in accordance with the Ethical Principles of the American Psychological Association (2002).

Measures

Demographics Questionnaire

Participants were asked to indicate their age, gender, ethnicity, primary language spoken in home, income, monthly income, number of people living on the income, and highest education attained by parents.

Young Schema Questionnaire-Short Form

Young Schema Questionnaire-Short Form (YSQ-SF; Young, 1998) is a 75-item self-report questionnaire designed to
measure presence and severity of Early Maladaptive Schemas. Each item is rated on a 6-point Likert-type scale indicating the degree to which participant agrees with the statement (1 = completely untrue of me; 2 = mostly untrue of me; 3 = slightly more true than untrue; 4 = moderately true of me; 5 = mostly true of me; 6 = described me perfectly). Higher scores indicate greater presence and or severity of EMS. The YSQ-SF yields five domains and 15 schemas (see introduction for further elaboration regarding schemas and domains). Three of the 18 schemas that failed to emerge in factor analysis (See Schmidt, Joiner, Young, & Telch, 1995) have been omitted. These include Approval/Recognition Seeking, Negativism/Pessimism, and Punitiveness. Adequate internal consistency of the schema subscales has been reported with Cronbach’s alpha coefficients ranging from .76 to .93 (Welburn et al., 2002) and .71 to .93 (Glaser, Campbell, Calhoun, Bates & Petrocelli, 2002). Construct validity of this measure is supported where 70 of the 75 items loaded as designed and where all 15 of the EMS subscales compared well to other symptoms measures and accounted for statistically significant variance in several measures of symptomology (see Glaser et al., 2002).
Eating Attitudes Test-26

Eating Attitudes Test-26 (EAT-26; Garner, Olmsted & Bohr, 1982) is a self-report instrument measures attitudes and behaviors that are associated with eating disorders. The 26-item inventory contains three subscales: dieting ("Am terrified of being overweight", bulimia and food preoccupation ("Feel that food controls me life"), and oral control ("Feel that others pressure me to eat"). The scores are scaled on a six-point Likert-type scale ranging from 1 = "always" to "never". Higher scores indicate a greater amount of eating disorder attitudes and behaviors.

Doninger, Enders & Burnett (2005) examined the psychometric properties of the EAT-26 and reported adequate internal consistency of the total scale and the three subscales, with Cronbach alpha coefficients that ranged from .70 to .88.

Asian American Multidimensional Acculturation Scale

Asian American Multidimensional Acculturation Scale (AAMAS; Chung, Kim, & Abreu, 2004) is a scale that was used because it consists of 45 items that generally measure cultural behavior, identity, and knowledge, not solely Asian American acculturation. The items are rated on a six-point Likert type scale ranging from (1 = not very much to 6
= very much). The AAMAS has three subscales that the authors report evidence of convergent and discriminant validity, however, for the current study only the Culture of Origin (AAMAS-CO), and AAMS-CO were utilized, not the Asian American (AAMAS-AA) subscale. The alpha coefficients for each of the three AAMAS scales are as follows: .87 to .91 for AAMAS-CO, .78 to .83 for AAMAS-AA, and .76 to .81 for AAMAS-EA. Respondents rate each item according to these reference groups: a) their culture of origin, b) other Asian Americans, and c) European Americans within each cultural dimension (Gim Chung, Kim, & Abreu, 2004).

Procedure

Questionnaires were distributed to various social science classes. Participants were asked to take the questionnaire packet home and return them completed one week later. Each packet was completed anonymously and contained a statement of informed consent as well as a debriefing statement. Upon return of the questionnaires, extra credit was given.

A non-experimental correlational design was employed to test all study hypotheses. The predictor variables in this design were the EMS of Emotional Deprivation,
Defectiveness/Shame, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline; and Acculturation (identification with Latino culture and identification with American culture). The criterion variable was NEAT. Multiple regression and hierarchical regression analyses were utilized to test all study hypotheses.
CHAPTER FOUR
RESULTS

One hundred and sixty two Latina students participated in this study. Data from 17 participants were excluded from analyses due to missing data. Table 1 displays the descriptive statistics of all study variables.

Table 1.

Descriptive Statistics

<table>
<thead>
<tr>
<th>Model/Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Alpha Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Eating</td>
<td>59.84</td>
<td>17.71</td>
<td>.88</td>
</tr>
<tr>
<td>American Acculturation (AA)</td>
<td>76.54</td>
<td>8.90</td>
<td>.82</td>
</tr>
<tr>
<td>Ethnic Acculturation (EA)</td>
<td>69.41</td>
<td>14.65</td>
<td>.92</td>
</tr>
<tr>
<td>SQ-Emotional Deprivation</td>
<td>9.10</td>
<td>5.38</td>
<td>.88</td>
</tr>
<tr>
<td>SQ-Defectiveness and Shame</td>
<td>7.68</td>
<td>4.31</td>
<td>.87</td>
</tr>
<tr>
<td>SQ-Dependence/Incompetence</td>
<td>8.9</td>
<td>4.42</td>
<td>.77</td>
</tr>
<tr>
<td>SQ-Insufficient Self-Control</td>
<td>12.24</td>
<td>5.31</td>
<td>.80</td>
</tr>
</tbody>
</table>

Note. SD=Standard Deviation
Additionally, Table 2 displays correlations among all the variables.

Table 2.

Correlations Among Predictor and Outcome Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>NEAT (DV)</th>
<th>AA</th>
<th>EA</th>
<th>E/D</th>
<th>D/S</th>
<th>D/I</th>
<th>I/S</th>
</tr>
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<tbody>
<tr>
<td>AA</td>
<td>-.011</td>
<td></td>
<td></td>
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<tr>
<td>EA</td>
<td>-.216*</td>
<td>.099</td>
<td></td>
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<tr>
<td>E/D</td>
<td>.270*</td>
<td>-.295*</td>
<td>-.135</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/S</td>
<td>.267*</td>
<td>-.230*</td>
<td>-.207*</td>
<td>.453*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/I</td>
<td>.275*</td>
<td>-.143</td>
<td>-.221*</td>
<td>.258*</td>
<td>.662*</td>
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<td></td>
</tr>
<tr>
<td>I/S</td>
<td>.187*</td>
<td>-.259*</td>
<td>-.113</td>
<td>.337*</td>
<td>.439*</td>
<td>.443*</td>
<td></td>
</tr>
</tbody>
</table>

Means 59.84 76.54 69.41 9.10 7.68 8.9 12.24
SD 17.71 8.90 14.65 5.38 4.31 4.42 5.31

Note. NEAT = Negative Eating Attitudes; AA = American Acculturation; EA = Ethnic Acculturation; E/D = Emotional Deprivation; D/S = Defectiveness Shame; D/I = Dependence Incompetence; I/S = Insufficient Self-Control/Self-Discipline; SD = Standard Deviation; * p < .05.

Early Maladaptive Schemas

A multiple regression analysis with simultaneous entry of the EMS of Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, and Insufficient Self-control/Self-Discipline as a block was conducted with NEAT as the criterion. Results revealed that Emotional Deprivation (β = .194, t(157) = 2.26, p = .025), Dependence/Incompetence (β = .185, t(157) = 1.79, p =
Defectiveness/Shame Dependence/Incompetence ($\beta = .049$, $t(157) = 0.45, p = .656$), and Insufficient Self-Control/Self-Discipline ($\beta = .019$, $t(157) = 0.22, p = .830$) accounted for 12% of the variance in NEAT ($F(4,157) = 5.34, p < .05, R^2 = .12$).

Acculturation

A multiple regression analysis with simultaneous entry of identification with Latino culture and identification with American culture entered as a block was conducted with NEAT as the criterion. Results revealed that identification with Latino culture ($\beta = -.241$, $t(127) = -2.79, p = .006$) and identification with American culture ($\beta = .039$, $t(127) = 0.45, p = .656$) accounted for 5.8% of the variance in NEAT ($F(2,127) = 3.9, p < .05, R^2 = .058$).

Moderation of Early Maladaptive Schemas—Negative Eating Attitudes Relationship

Lastly, to test if the relationship between the EMS of Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline and NEAT were each moderated by Acculturation, a series of eight hierarchical regression
analyses with the specific EMS and identification with Latino culture or identification with American culture were entered as a block in step one and their interaction entered in step two. Contrary to study hypotheses, results of the eight hierarchical regression analyses revealed that there was no moderation of the relationship between EMS and NEAT (See Table 3).

Table 3.

Hierarchical Regression Models in Predicting Negative Eating Attitudes from Early Maladaptive Schemas and Acculturation

<table>
<thead>
<tr>
<th>Model/Variable</th>
<th>R²</th>
<th>ΔR²</th>
<th>B</th>
<th>β</th>
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<tr>
<td>1. ED</td>
<td>.074*</td>
<td>.074*</td>
<td>5.555*</td>
<td>.285*</td>
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<tr>
<td>AA</td>
<td></td>
<td></td>
<td>1.766</td>
<td>.073</td>
</tr>
<tr>
<td>2. ED</td>
<td>.075</td>
<td>.000</td>
<td>5.458*</td>
<td>.280*</td>
</tr>
<tr>
<td>AA</td>
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<td></td>
<td>1.786</td>
<td>.074</td>
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<td>ED x AA</td>
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<td></td>
<td>-0.536</td>
<td>-0.022</td>
</tr>
<tr>
<td>1. ED</td>
<td>.100*</td>
<td>.100*</td>
<td>4.354*</td>
<td>.233*</td>
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<tr>
<td>EA</td>
<td></td>
<td></td>
<td>-3.841*</td>
<td>-0.185*</td>
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<td>2. ED</td>
<td>.101</td>
<td>.001</td>
<td>4.333*</td>
<td>.232*</td>
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<td>-0.183*</td>
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<tr>
<td>ED x EA</td>
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<td></td>
<td>.526</td>
<td>.027</td>
</tr>
<tr>
<td>1. DS</td>
<td>.074*</td>
<td>.074*</td>
<td>4.785*</td>
<td>.280*</td>
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<tr>
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<td></td>
<td>1.287</td>
<td>.054</td>
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<tr>
<td>2. DS</td>
<td>.078</td>
<td>.003</td>
<td>4.711*</td>
<td>.276*</td>
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<tr>
<td>AA</td>
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<td>1.634</td>
<td>.068</td>
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<td>DS x AA</td>
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<td>-1.212</td>
<td>-0.060</td>
</tr>
<tr>
<td>1. DS</td>
<td>.107*</td>
<td>.107*</td>
<td>4.249*</td>
<td>.251*</td>
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<tr>
<td>EA</td>
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<td>2. DS</td>
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<td>.000</td>
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<td>.251*</td>
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<td>EA</td>
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<td>-0.165*</td>
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<tr>
<td>DS x EA</td>
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<td>.049</td>
<td>.003</td>
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<tr>
<td>1. DI</td>
<td>.094*</td>
<td>.094*</td>
<td>4.949*</td>
<td>.310*</td>
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31
<table>
<thead>
<tr>
<th></th>
<th>AA</th>
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<tbody>
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<td>2.</td>
<td>DI</td>
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<td>.004</td>
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<td>AA</td>
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<td>DI x AA</td>
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<tr>
<td>1.</td>
<td>DI</td>
<td>.108*</td>
<td>.108*</td>
<td>4.148*</td>
<td>.254*</td>
<td></td>
<td></td>
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<td>-0.160</td>
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<tr>
<td>2.</td>
<td>DI</td>
<td>.114</td>
<td>.005</td>
<td>4.316*</td>
<td>.265*</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>EA</td>
<td>-3.040</td>
<td>-0.146</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DI x EA</td>
<td>-1.489</td>
<td>-0.074</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1. | IS    | .040 | .040 | 3.513* | .206* |    |    |    |
|    | AA    | 1.023 | .043 |    |    |    |    |    |
| 2. | IS    | .062 | .022 | 3.281* | .193* |    |    |    |
|    | AA    | -0.608 | -0.025 |    |    |    |    |    |
|    | IS x AA | 3.122 | 1.62 |    |    |    |    |    |

| 1. | IS    | .078* | .078* | 3.193* | .177* |    |    |    |
|    | EA    | -4.080* | -0.196* |    |    |    |    |    |
| 2. | IS    | .081 | .003 | 2.917 | .161 |    |    |    |
|    | EA    | -4.188* | -0.202* |    |    |    |    |    |
|    | IS x EA | 1.210 | .059 |    |    |    |    |    |

Note. AA = American Acculturation; EA = Ethnic Acculturation; E/D = Emotional Deprivation; D/S = Defectiveness Shame; D/I = Dependence Incompetence; I/S = Insufficient Self-Control/Self-Discipline; *p < .05.

Post Hoc Analyses

To test whether identification with Latino culture added explanatory variance above that accounted for by the EMS of Emotional Deprivation, a post hoc hierarchical regression analysis was conducted with Emotional Deprivation entered in step one and identification with Latino culture in step two. Results revealed that identification with Latino culture added 3.4% explanatory variance ($F(1,143) = 5.34, p < .05; \beta = - .185, t(143) = - 2.3, p < .05$). Results indicate that greater levels of
identification with Latino culture were predictive of lower levels of NEAT above and beyond that accounted for by EMS of Emotional Deprivation. Additionally, to examine which specific cultural identification factors were predictive of NEAT, a multiple regression analysis with simultaneous entry of Latino culture identification, Latino language, Latino knowledge, and Latino food that compose the identification with Latino culture variable was conducted with NEAT as the criterion. Results revealed that Latino food ($\beta = - .268$, $t(141) = -2.893$, $p = .004$), Latino language ($\beta = -.177$, $t(141) = -1.629$, $p = .106$), Latino knowledge ($\beta = .058$, $t(141) = .447$, $p = .655$), and Latino culture identification ($\beta = .036$, $t(141) = .292$, $p = .771$), accounted for 9.8% of the variance in NEAT ($F(4,141) = 3.8$, $p < .05$). Results indicated that a greater level of preference/frequency of consumption of Latino food negatively related to NEAT. Additionally, a multiple regression analysis with simultaneous entry of American culture identification, American language, American knowledge, and American food that compose the identification with American culture variable was conducted with NEAT as the criterion. Results revealed that American language ($\beta = -.181$, $t(140) = -1.873$, $p = .063$), American
culture identification ($\beta = .108, t(140) = 1.099, p = .274$), American food ($\beta = .023, t(140) = .241, p = .810$), and American knowledge ($\beta = .000, t(140) = .003, p = .998$), did not have a significant result ($F(4, 140) = 1.12, p = .35$).

Finally, a multiple regression analysis with simultaneous entry of all 15 EMS was conducted with NEAT as the criterion. Results revealed that all 15 EMS accounted for 19% of the variance in NEAT ($F(15,146) = 2.33, p < .05$), however no single EMS was a significant unique predictor of NEAT. The EMS of abandonment ($p = .065$) and unrelenting standards ($p = .079$) approached significance.
Early Maladaptive Schemas Hypotheses

The hypothesis that EMS of Emotional Deprivation, defectiveness/shame, Dependence/incompetence, and Insufficient self-control/self-discipline would be predictive of NEAT was partially supported primarily as the EMS of Emotional Deprivation was the only unique significant predictor of NEAT. Past research has found that Emotional Deprivation along with other EMS to be present in women with eating and body disturbances (Jones, Harris, & Leung, 2005; Leung and Price, 2007; Turner, Rose, & Cooper, 2005b; Unoka, Tolgyes, Czobor, and Simon, 2010). The impact of EMS on eating disorders have been emphasized in prior studies, and have specifically focused on the individual EMS rather than the overall domains (Jones et al., 2005). Prior research has shown that the EMS of Emotional Deprivation to be high among women with current eating disorders (Jones, Harris, & Leung, 2005; Leung and Price, 2007), to be predictive of bulimic attitudes and behaviors as well as predictive of caloric restriction (Jones et al., 2007). The EMS of Emotional Deprivation has also been found
to be predictive of low physical exercise, bingeing and purging behaviors (Unoka, Tolgyes, Czobor, and Simon, 2010). The current study's results are consistent with these findings.

This is interesting in that Emotional Deprivation is the conviction that one's longing for emotional support will not be met (Young et al., 2003). More specifically, it is the lack of faith in receiving key emotional needs such as nurturance, compassion, love, and security from significant others. Although not directly tested here, the results therefore suggest that a Latina with an emotional Deprivation schema might feel deprived of love and nurturing and may attempt to compensate for these feelings with food. For example, according to the Cognitive Behavioral Model by Cooper, Wells, and Todd (2004), a person with an Emotional Deprivation schema, will subconsciously choose a partner who is incapable of providing emotional support. This choice in partner may cause the person with Emotional Deprivation to be demanding of emotional support which may push the partner away and will activate a negative self-belief that will then lead to the activation of the Emotional Deprivation schema. Once activated, it can lead to painful emotions that promote
dysfunctional coping attempts such as bingeing and purging in order to relieve the negative feelings.

**Acculturation Hypotheses**

It was also hypothesized that acculturation, or more specifically, identification with Latino culture and identification with American culture would be significant predictors of NEAT. It was expected that identification with the American culture would result in a positive relationship with NEAT, Conversely, it was anticipated that identification with Latino culture would result in a negative relationship with NEAT.

The hypothesis was partially supported in that Latino culture was the primary significant predictor of NEAT. These results are consistent with past studies (Dulce, Hunter, and Bettina, 1999), in that identification with Latino culture resulted in a negative correlation with NEAT. This suggests that identification with the Latino culture may be protective against western cultural ideals about beauty and body shape and the development of negative eating attitudes. The findings are consistent with past studies such as Cachelin, Phinney, Schug and Striegel-Moore
that found that strengthened Mexican identity was negatively associated with eating disorders.

Post Hoc

Through post hoc analyses, it was also revealed that identification with Latino culture explained 3.4% variance above and beyond that accounted for by the EMS of Emotional Deprivation. Additionally, in post hoc analyses, it was found that collectively, the Latino identification factors accounted for 9.8% of NEAT. Interestingly, culture identification, knowledge of the Latino culture, and ability, or preference to speak the Latino language did not significantly predict NEAT. The primary predictor was high frequency and preference to consume Latino food and was negatively related to NEAT.

Based on the study's findings, if Latino culture identity serves as a protective factor against NEAT, or more specifically the preference and regularity of consuming ethnic food, then future research should further explore what specific factors of the preference to consume Latino food protects Latinas against NEAT. Traditionally, Latinos who primarily identify with the Latino culture preserve core factors of the customary Latino diet, such as
grains, beans, and fruits (Guendelman, & Abrams, 1995). Family life has traditionally been imperative in the Latino culture, which in turn sways eating behaviors through not only the preparation of the meals, but also through the traditional practice of families eating together (Guendelman, & Abrams, 1995). It is possible that the relationship between preference for cultural foods and NEAT may be affected by this third variable of eating together as a family. This may be the actual protective factor.

Although not directly tested here, it is also possible that as a result of the consumption of ethnic food, Latinas continue to experience social ethnic gatherings with less acculturated individuals who continue to support a level of health ideals that endorses heavier weight which protects against NEAT. These social cultural factors may offset the beliefs and feelings associated with the EMS of Emotional Deprivation, which was found to predict NEAT.

Additionally, since Latino ethnic food is generally higher in fat and calories, cognitive dissonance theory (Festinger, & Carlsmith, 1959) would suggest that attitudes about eating and food would need to be altered to fit the behavioral patterns of food consumption. Lastly, it has been suggested that traditional Latino cultural views of
beauty embraces “curves” (Ruiz, & Vicki, 1993); Latinas who identify with the traditional Latino culture may have different views about eating, dieting and food given the more “permissive” and realistic cultural beauty ideals (i.e., less worry about gaining extra “curves”).

Moderation Hypothesis

Lastly it was hypothesized that identification with Latino culture and identification with American culture would each moderate the relationship between each of the EMS of Emotional Deprivation, Defectiveness/Shame, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline and NEAT. The results indicated that acculturation did not affect the direction and strength of the relation between an EMS and NEAT.

Limitations

To our knowledge, no other study has examined the moderating role of acculturation on the relation of EMS and NEAT. Although acculturation did not result as a significant moderator of this relation, the findings can be as a consequence of the specific sample used in the study. According to Ayala, Mickens, Galindo and Elder (2007),
identification with Latino culture decreases in a linear trend in the course of three generations. In the current study, 74% of the sample was composed of individuals born in the United States to immigrant parents ("2nd generation"), and individuals born in the U.S. to 2nd generation parents (3rd generation), which suggest a restricted range of more experience in the United States than other studies.

Additionally, it has been found that second generation Mexican American women were the most acculturated among five different generations (Chamorro and Ortiz, 1998). Interestingly, this study included 54.9% of second generation Latina. It could be that, this study had less variability on the identification with American culture variable, since half of the sample identified with the American culture.

Another limitation in the study is the exclusive use of self-report surveys. This method relies upon the accurate recall of distal information and could lead to inaccurate information. Additionally, this method is subject to social desirability biases with participants depicting themselves positively; as a result self report surveys may yield to inaccurate reports.
Another potential limitation of the study relates to the choice to measure acculturation with a general measure that is not ethnic group specific. This allows for cross ethnic group comparisons, however in the current study only Latinas, and mostly Mexican Latinas were studied. The use of a Mexican American acculturation measure may have yielded different results, such as Acculturation Rating Scale for Mexican Americans (ARSMA) which is suitable for Mexican Americans (Cuellar, Harris, & Jasso, 1980).

Although, the studies that investigated the specific EMS examined in this current study used clinical samples and not college Latinas (Jones, Harris, & Leung, 2005; Jones, Leung, & Harris, 2007; Leung, & Price, 2007; Leung, Waller, & Thomas, 2000; Unoka, Tolgyes, Czobor, & Simon, 2010; Waller, Meyer, & Ohanian, 2001), the inclusion of college women is important because the prevalence of eating disorders is high in this age group (Klemchuk, Hutchinson, & Frank, 1990). Nevertheless, if a clinical or community sample of similar ages were included along with college females, the results may be generalized to a broader range of women in this age group and may improve the acculturation range.
Implications

While it is important that the results of the study be generalizable to a clinical sample, these findings add additional support that eating and body disturbances do not exclusively have an effect on affluent Caucasian women. The current finding also supports the notion that identification with the Latino culture serves as a protective factor against developing NEAT. Perhaps these findings can encourage Mexican American women suffering from eating disorders that it is fine, if not preferred to embrace their cultural backgrounds, since it probably balances the beliefs and feelings associated with the EMS of Emotional Deprivation, which the current study found to predict NEAT.

Although preliminary, this finding provides support for the need of a model that better explains the factors affecting NEAT and consequently the development of eating disorders. Research developing a new model should consider including the effects that the attitudinal and behavioral change that occurs as a result of continuous contact between two distinct cultures has on eating disorder maintenance. The inclusion of this in a new model will result in an improved understanding of the factors that
lead to the maintenance of eating disorders which will also allow for the development of effective treatments. Since psychotherapy helps individuals suffering from eating disorders to comprehend the thoughts, feelings, emotions and behavior patterns that trigger maladaptive eating behaviors, informing Latina women suffering from eating disorders how acculturation and cognitive emotional imbalances may affect their physical health is crucial.

The improved model should include the effects that a strong identification with the Latino culture has on the prevention of eating disorders. The inclusion of cultural factors in research on eating disorder will also assist in the development of intervention efforts that would assess the familial mechanism surrounding intergenerational eating weight ideals and eating behaviors. Such interventions will help Latina women to develop healthier ways of coping with acculturation transitions and will also encourage the embrace of ethnic ideals.

Future research should investigate similar concepts of acculturation and EMS on the development of NEAT. Future research should consider incorporating interviews when evaluating Latina’s dietary behaviors specially if the interest is to assess the familial systems surrounding
intergenerational patterns of eating behaviors. Cognitive behavioral and interpersonal therapies should continue to identify early predictors of maladaptive behaviors and acculturation.

Although results from this study did not find Identification with the American culture to be predictive of NEAT, potential clinical researchers may be interested in conducting a similar study where they investigate how factors of Latino food protect against high levels of NEAT. Future research may also consider the use of a clinical sample of college Latinas as well as a control sample of college Latinas that significantly vary in their acculturation in order to identify how acculturation and EMS affects college-aged Latinas in general.

The results from these studies will open the door for further research that may lead to an improved understanding of the development and subsequently the treatment of eating disorders. Collectively, the results of the analyses addressing the research hypotheses indicated that maladaptive schemas and acculturation do have a role in the maintenance of NEAT. The study findings suggest that EMS was present prior to the development of NEAT which allowed for the maintenance of NEAT through EMS. The connections
between the EMS of Emotional Deprivation and NEAT suggest that Emotional Deprivation: the lack of faith in receiving key emotional needs from others is an important factor in the development of eating disorders and maladaptive coping behaviors. This particular finding illustrates the close links between emotional and physical health. Acculturation issues should be included as a target in therapy given that level of acculturation affects levels of NEAT.
APPENDIX A:

DEMOGRAPHICS
DEMOGRAPHICS

Please answer each question to the best of your knowledge.

1. Age: ______

2. Male ☐ Female ☐

3. Ethnicity:
   Asian or Asian American ☐
   African American (or black) ☐
   Caucasian (or white) ☐
   Latino (or Hispanic) ☐
   Native American (or American Indian) ☐
   Other (please specify) ☐

4. Yearly Household Income:
   $0 - $14,999 ☐
   $15,000-$29,999 ☐
   $30,000-$44,999 ☐
   $45,000-$59,999 ☐
   $60,000-$74,999 ☐
   $75,000-$89,999 ☐
   $90,000-$99,999 ☐
   Over $100,000 ☐
5a. Number of people living on the yearly income listed above: ____

5. Class Level
Freshman [ ]
Sophomore [ ]
Junior [ ]
Senior [ ]
Graduate Student [ ]

6. Body Weight
Current Weight: _______
Current Height (feet/inches): _______
Highest Weight Ever: _______
When was that (month/year)? _______
Lowest Weight at Current Height: _______
Desired Weight: _______
APPENDIX B:

SURVEY
INSTRUCTIONS:
Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there you are not sure, base your answer on what you emotionally feel, not on what you think to be true. Choose the highest rating from 1 to 6 that describes you and write the number in the space before the statement.

RATING SCALE:
1 = Completely untrue of me
2 = Mostly untrue of me
3 = Slightly more true than untrue
4 = Moderately true of me
5 = Mostly true of me
6 = Describes me perfectly

1. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.

2. _____ In general, people have not been there to give me warmth, holding, and affection.

3. _____ For much of my life, I haven't felt that I am special to someone.

4. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.

5. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

6. _____ I find myself clinging to people I'm close to, because I'm afraid they'll leave me.

7. _____ I need other people so much that I worry about losing them.
8. _____ I worry that people I feel close to will leave me or abandon me.
9. _____ When I feel someone I care for pulling away from me, I get desperate.
10. _____ Sometimes I am so worried about people leaving me that I drive them away.
11. _____ I feel that people will take advantage of me.
12. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.
13. _____ It is only a matter of time before someone betrays me.
14. _____ I am quite suspicious of other people's motives.
15. _____ I'm usually on the lookout for people's ulterior motives.
16. _____ I don't fit in.
17. _____ I'm fundamentally different from other people.
18. _____ I don't belong; I'm a loner.
19. _____ I feel alienated from other people.
20. _____ I always feel on the outside of groups.
21. _____ No man/woman I desire could love me one he/she saw my defects.
22. _____ No one I desire would want to stay close to me if he/she knew the real me.
23. _____ I'm unworthy of the love, attention, and respect of others.
24. _____ I feel that I'm not lovable.
25. _____ I am too unacceptable in very basic ways to reveal myself to other people.
RATING SCALE:
1 = Completely untrue of me        4 = Moderately true of me
2 = Mostly untrue of me             5 = Mostly true of me
3 = Slightly more true than untrue  6 = Describes me perfectly

26. _____ Almost nothing I do at work (or school) is as good as other people can do.
27. _____ I'm incompetent when it comes to achievement.
28. _____ Most other people are more capable than I am in areas of work and achievement.
29. _____ I'm not as talented as most people are at their work.
30. _____ I'm not as intelligent as most people when it comes to work (or school).
31. _____ I do not feel capable of getting by on my own in everyday life.
32. _____ I think of myself as a dependent person, when it comes to everyday functioning.
33. _____ I lack common sense.
34. _____ My judgment cannot be relied upon in everyday situations
35. _____ I don't feel confident about my ability to solve everyday problems that come up.
36. _____ I can't seem to escape the feeling that something bad is about to happen.
37. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.
38. _____ I worry about being attacked.
39. I worry that I'll lose all my money and become destitute.
40. I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.
41. I have not been able to separate myself from my parent(s), the way other people my age seem to.
42. My parent(s) and I tend to be overinvolved in each other's lives and problems.
43. It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.
44. I often feel as if my parent(s) are living through me— I don't have a life of my own.
45. I often feel that I do not have a separate identity from my parent(s) or partner.
46. I think that if I do what I want, I'm only asking for trouble.
47. I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.
48. In relationships, I let the other person have the upper hand.
49. I've always let others make choices for me, so I really don't know what I want for myself.
50. I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.
51. I'm the one who usually ends up taking care of the people I'm close to.
52. _____ I am a good person because I think of others more than of myself.
53. _____ I'm so busy doing for the people that I care about, that I have little time for myself.

**RATING SCALE:**
1 = Completely untrue of me  
2 = Mostly untrue of me  
3 = Slightly more true than untrue 
4 = Moderately true of me  
5 = Mostly true of me  
6 = Describes me perfectly

54. _____ I've always been the one who listens to everyone else's problems.
55. _____ Other people see me as doing too much for others and not enough for myself.
56. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).
57. _____ I find it embarrassing to express my feelings to others.
58. _____ I find it hard to be warm and spontaneous.
59. _____ I control myself so much that people think I am unemotional.
60. _____ People see me as uptight emotionally.
61. _____ I must be the best at most of what I do; I can't accept second best.
62. _____ I try to do my best; I can't settle for "good enough."
63. _____ I must meet all my responsibilities.
64. _____ I feel there is constant pressure for me to achieve and get things done.
65. ____ I can't let myself off the hook easily or make excuses for my mistakes.

66. ____ I have a lot of trouble accepting "no" for an answer when I want something from other people.

67. ____ I'm special and shouldn't have to accept many of the restrictions placed on other people.

68. ____ I hate to be constrained or kept from doing what I want.

69. ____ I feel that I shouldn't have to follow the normal rules and conventions other people do.

70. ____ I feel that what I have to offer is of greater value than the contributions of others.

71. ____ I can't seem to discipline myself to complete routine or boring tasks.

72. ____ If I can't reach a goal, I become easily frustrated and give up.

73. ____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

74. ____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.

75. ____ I have rarely been able to stick to my resolutions.
EATING AND ATTITUDES TEST-26

INSTRUCTIONS:
Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. Choose the highest rating from 1 to 6 that describes you and write the number in the space before the statement.

RATING SCALE:
1 = Always
2 = Usually
3 = Often
4 = Sometimes
5 = Rarely
6 = Never

1. _____ I am terrified about being overweight.
2. _____ I avoid eating when I am hungry.
3. _____ I find myself preoccupied with food.
   I have gone on eating binges where I feel that I may not be able to stop.
4. _____ I cut my food into small pieces.
5. _____ I am aware of the calorie content of foods that I eat.
   I particularly avoid food with a high carbohydrate content
   (i.e. bread, rice, potatoes, etc.)
6. _____ I feel that others would prefer if I ate more.
7. _____ I vomit after I have eaten.
8. _____ I feel extremely guilty after eating.
9. _____ I am preoccupied with a desire to be thinner.
10. _____ I think about burning up calories when I exercise.
11. _____ Other people think that I am too thin.
14. _____ I am preoccupied with the thought of having fat on my body.
15. _____ I take longer than others to eat my meals.
16. _____ I avoid foods with sugar in them.
17. _____ I eat diet foods.
18. _____ I feel that food controls my life.
19. _____ I display self-control around food.
20. _____ I feel that others pressure me to eat.
21. _____ I give too much time and thought to food.
22. _____ I feel uncomfortable after eating sweets.
23. _____ I engage in dieting behavior.
24. _____ I like my stomach to be empty.
25. _____ I have the impulse to vomit after meals.
26. _____ I enjoy trying new rich foods.
ASIAN AMERICAN MULTIDIMENSIONAL ACCULTURATION SCALE

Please respond to each question using the scale below. Write your chosen responses in the blanks provided. There are no right or wrong answers, so please respond honestly. If you consider your culture of origin to be “American culture”, please only respond to the “American culture” questions.

My culture of origin (my ethnic culture) is:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at All</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very Much</td>
</tr>
</tbody>
</table>

1. How much do you feel you have in common with people from...
   ________ Your culture of origin?
   ________ American culture?

2. How much do you interact and associate with people from...
   ________ Your culture of origin?
   ________ American culture?

3. How much do you identify with...
   ________ Your culture of origin?
   ________ American culture?

4. How much would you like to interact and associate with people from...
   ________ Your culture of origin?
   ________ American culture?

5. How proud are you to be a part of...
   ________ Your culture of origin?
   ________ American culture?
6. How negative do you feel about people from...
   _______________ Your culture of origin?
   _______________ American culture?

7. How well do you speak the language of...
   _______________ Your culture of origin?
   _______________ American culture?

8. How well do you understand the language of...
   _______________ Your culture of origin?
   _______________ American culture?

9. How well do you read and write in the language of...
   _______________ Your culture of origin?
   _______________ American culture?

10. How often do you listen to music or look at movies and magazines from...
    _______________ Your culture of origin?
    _______________ American culture?

11. How knowledgeable are you about the culture and traditions of...
    _______________ Your culture of origin?
    _______________ American culture?

12. How knowledgeable are you about the history of...
    _______________ Your culture of origin?
    _______________ American culture?

13. How much do you actually practice the traditions and keep the holidays of...
    _______________ Your culture of origin?
    _______________ American culture?
14. How often do you actually eat the food of...

__________ Your culture of origin?

__________ American culture?

15. How much do you like the food of...

__________ Your culture of origin?

__________ American culture?

Sometimes the experience of immigrants and the children of immigrants is described by using the term "generation". Below are descriptions of various generations. Please read these and mark the generation that best describes your experience. If you consider your culture of origin to be American culture, please disregard this question.

____ 1st generation: An individual who immigrated to the U.S. as an adult (18 years or older).

____ 1 ½ generation: An individual who immigrated to the U.S. as a child/teenager (4-17 years old).

____ 2nd generation: An individual born in the U.S. to immigrant parents.

____ 3rd generation: An individual born in the U.S. to 2nd generation parents.

____ Other, please specify______________________________

Some items adapted from:

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REFERENCES


Cognitive Therapy and Research, 26(4), 519-530.


http://www.schematherapy.com