Acculturation and eating disorders in a Mexican American community sample

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ACCULTURATION AND EATING DISORDERS IN A MEXICAN AMERICAN COMMUNITY SAMPLE

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Our purpose was to investigate acculturation and eating disorders by examining the role of ethnic identity and by utilizing a bidimensional perspective toward two cultures. We predicted that orientation toward European American culture and lower ethnic identity would be positively associated with eating disorders. Participants were 188 Mexican American women recruited from the community (79 with eating disorders and 109 control women). The Structured Clinical Interview for DSM-IV-TR and Eating Disorder Examination were used to establish diagnoses. The Acculturation Rating Scale for Mexican Americans–II and the Multigroup Ethnic Identity Measure assessed Anglo orientation, Mexican orientation, and ethnic identity. Orientation toward Anglo American culture was significantly associated with eating disorders, whereas orientation toward Mexican culture and strength of ethnic identity were not associated with eating disorder status. Findings point to the role of Anglo cultural orientation in the development of eating disorders and underscore the need for future research to utilize bidimensional models.

The mental health of growing populations of ethnic minorities in the United States has received increased attention in recent years (U.S. Surgeon General, 2001). Evidence-based medicine requires scientific data about the prevalence, clinical presentation and course, and treatment outcome of mental disorders across all population groups. Despite the recognition of the importance of research of mental health problems among ethnic minority groups, the field of eating disorders has been slow to produce such information. A growing literature suggests that eating disorders, traditionally described as disorders of European or European American women, are also experienced by ethnic minority girls and women (Shaw, Ramirez, Trost, Randall, & Stice, 2004; Smolak & Striegel-Moore, 2001; Striegel-Moore & Franko, 2003; Striegel-Moore et al., 2003, 2005). Sociocultural theorists (e.g., Stice, 2001; Striegel-Moore, Silberstein, & Rodin, 1986) have emphasized the role of culture in the risk for the development of an eating disorder as arising in part from the thin beauty ideal that is part of Western culture. Recent work by Stice and colleagues supports the role of the thin ideal and internalization of this ideal as contributing variables in the etiology of eating disorders in European American women (Presnell, Bearman, & Stice, 2004).

Increased exposure to U.S. majority cultural values (through television and other sources) may be producing heightened sociocultural pressures toward thinness among women of ethnic minority groups in the United States because these media are saturated with images of extremely thin women and with exhortations about the importance of thinness as a marker of interpersonal and financial success, as well as advice about how to achieve this unrealistically thin body size (Smolak & Striegel-Moore, 2001; Willfley & Rodin, 1995). It has been proposed, therefore, that acculturation to European American culture increases risk for the development of disordered eating in women from ethnic minority groups.

Eating disorders do occur in Hispanic women (Bruce & Agras, 1992; Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000; Fitzgibbon et al., 1998). Moreover, the frequency of occurrence in Hispanic women is similar to that reported for White populations (see review by Crago, Shisslak, & Estes, 1996). Symptomatology appears to be generally the same across ethnicities (Cachelin et al., 2000; Cachelin, Striegel-Moore, & Elder, 1998), but some evidence suggests that binge eating may be more severe and frequent among Hispanic women than White women (Fitzgibbon et al., 1998; Smith & Krejci, 1991). Studies that have focused on
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Mexican American women indicate that eating disorders are a health concern in this population (Cachelin, Schug, Juarez, & Monreal, 2005; Cachelin & Striegel-Moore, 2006), and it has been suggested that acculturation to European American culture may play a role in their development (Chamorro & Flores-Ortiz, 2000; Joiner & Kashubeck, 1996; Kuba & Harris, 2001; Lester & Petrie, 1995).

Culture change refers to the process of moving from one's indigenous cultural context to spend increasing time in an Anglo-American one; acculturation refers to the extent to which ethnic minorities retain their indigenous culture versus adopting the dominant Anglo culture. Acculturation research has been guided by two measurement approaches known as the uni-dimensional and the bidimensional models. In the unidimensional approach, acculturation is conceptualized as a continuum that ranges from traditional (immersed in one's indigenous culture) to acculturated (immersed in Anglo culture), with biculturalism a diluted midpoint between these endpoints. In this zero-sum model, relinquishing aspects of one's indigenous culture is presumed to entail simultaneously adopting aspects of the dominant Anglo culture wherein the latter replace the former. Alternatively, in the bidimensional model, the extent to which people are immersed in their indigenous culture is conceptualized as independent of their immersion in the dominant culture: People can be immersed solely in their indigenous culture (i.e., Separated, Traditional), solely in Anglo culture (Assimilated, Acculturated), in both (Bicultural), or in neither (Marginalization). The bidimensional model is the prevailing one because it consistently has been shown to be superior to the unidimensional approach (e.g., Ryder, Alden, & Paulhaus, 2000). Hence, a bidimensional measure of acculturation (detailed in the Method section) was used here. Many studies of acculturation and eating disorders have used unidimensional measures and, not surprisingly, their findings differ from studies using bidimensional measures.

Perhaps due to limitations in the conceptualization of acculturation, as well as measurement variability among studies, existing research on acculturation and disordered eating for Hispanics has produced an inconsistent pattern of findings. Such research has been conducted primarily with adolescent girls and college students and has not included community samples of adults. Some of these studies have demonstrated a positive correlation between acculturation toward European American/Anglo culture and abnormal eating attitudes, in which generational status, English language use, and acculturative stress have been found to be related to body dissatisfaction and eating disorder symptoms (Cachelin et al., 2000; Chamorro & Flores-Ortiz, 2000; Perez, Voelz, Pettit, & Joiner, 2002). However, some studies have not found a relationship between acculturation and eating disorder symptoms in Hispanic women (Joiner & Kashubeck, 1996; Kuba & Harris, 2001; Lester & Petrie, 1995).

Ethnic identity is an aspect of the process of acculturation that refers to one's sense of belonging to an ethnic group together with attitudes and feelings about one's ethnicity (Phinney, 2003). Ethnic identity varies across individuals; however, it tends to be more stable over time within individuals than do behavioral aspects of acculturation (Phinney, 2003). Ethnic identity may be particularly relevant to the understanding of eating disorders because it is integral to one's sense of self, particularly for minorities (Phinney, 1990). Ethnic identity has been shown to be associated positively with psychological well-being and negatively with depression and loneliness (Roberts et al., 1999) and may therefore contribute to resilience against poor mental health, including the development of eating disorders. However, the hypothesis that ethnic identity is inversely related to adverse mental health outcomes (such as alcohol use) has not been supported consistently for Hispanic populations (see review by Greig, 2003). We are not aware of any studies to date that have examined the relationship between ethnic identity and disordered eating in Mexican American or other Hispanic women.

The purpose of this study was to build upon prior research on acculturation and eating disorders by examining the role of ethnic identity and by utilizing a bidimensional perspective toward two cultures, which allows for a more accurate assessment of an individual's process of acculturation. Specifically, we predicted that orientation toward European American/Anglo culture and lower ethnic identity would be positively associated with eating disorders. We also examined whether ethnic identity and acculturation to European American culture were related to specific symptoms of eating disorder pathology. We utilized structured clinical interviews to establish clinical eating disorders in our sample, whereas prior studies have relied primarily on self-report questionnaires (e.g., Chamorro & Flores-Ortiz, 2000; Joiner & Kashubeck, 1996; Perez et al., 2002) and have examined only symptoms of disordered eating (Cachelin et al., 2000; Chamorro & Flores-Ortiz, 2000; Gowen, Hayward, Killen, Robinson, & Taylor, 1999; Joiner & Kashubeck, 1996; Kuba & Harris, 2001; Perez et al., 2002). We recruited directly from the community rather than utilizing convenience samples of high school and college students. Finally, we focused on a homogeneous cultural group, Mexican Americans, because the acculturation process is likely different for individuals from different cultural groups (Padilla & Perez, 2003).

METHOD

Participants

Participants were 188 Mexican American women recruited from the community as part of a larger study who met the following inclusion criteria: age 18 to 48 years old, not pregnant within the past 4 months, and either met diagnostic criteria for a current eating disorder or did not meet criteria
Table 1
Descriptive Comparison of Eating Disorder and Control Groups on Age, SES, Generation, Anglo and Mexican Orientation, Acculturation Level, and Ethnic Identity

<table>
<thead>
<tr>
<th>Variable</th>
<th>Eating disorder (n = 79)</th>
<th>Control (n = 109)</th>
<th>Total sample (N = 188)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>28.00 (7.78)</td>
<td>24.60 (5.76)</td>
<td>26.03 (6.87)</td>
</tr>
<tr>
<td>SES</td>
<td>3.27 (1.08)</td>
<td>3.46 (1.04)</td>
<td>3.38 (1.06)</td>
</tr>
<tr>
<td>Generation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>26.6% (21)</td>
<td>24.1% (26)</td>
<td>25.1% (47)</td>
</tr>
<tr>
<td>2nd</td>
<td>48.1% (38)</td>
<td>63.0% (68)</td>
<td>56.7% (106)</td>
</tr>
<tr>
<td>3rd</td>
<td>10.1% (8)</td>
<td>4.6% (5)</td>
<td>7.0% (13)</td>
</tr>
<tr>
<td>4th</td>
<td>8.9% (7)</td>
<td>4.6% (5)</td>
<td>6.4% (12)</td>
</tr>
<tr>
<td>5th</td>
<td>6.3% (5)</td>
<td>3.7% (4)</td>
<td>4.8% (9)</td>
</tr>
<tr>
<td>Anglo orientation</td>
<td>3.84 (.56)</td>
<td>3.64 (.63)</td>
<td>3.72 (.61)</td>
</tr>
<tr>
<td>Mexican orientation</td>
<td>3.52 (.79)</td>
<td>3.64 (.69)</td>
<td>3.59 (.74)</td>
</tr>
<tr>
<td>Acculturation score</td>
<td>.32 (1.14)</td>
<td>−.001 (1.10)</td>
<td>.13 (1.13)</td>
</tr>
<tr>
<td>Ethnic identity</td>
<td>3.06 (.53)</td>
<td>3.10 (.48)</td>
<td>3.08 (.50)</td>
</tr>
</tbody>
</table>

Note. Mean scores, standard deviations, and frequencies (for generation status) are presented. SES = Socioeconomic Status ranging from 1 (highest level of SES) to 5 (lowest level of SES) (Hollingshead & Redlich, 1958). Standard deviations are italicized.

aSlightly Anglo oriented bicultural.
bMexican oriented to approximately balanced bicultural (Cuellar et al., 1995).

for an eating disorder or other major mental disorder, as set forth in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). The sample included 109 control women and 79 women who met diagnostic criteria for an eating disorder: 3 with anorexia nervosa, 26 with bulimia nervosa, 29 with binge-eating disorder, and 21 with eating disorder not otherwise specified. (See Table 1 for sample characteristics.)

Participants were recruited by way of English and Spanish ads in local papers and flyers posted in stores and organizations throughout Mexican American communities in the urban Los Angeles area. To recruit control women and women with eating disorders, half of the recruitment materials asked for Mexican American women to participate in a women's health study and the other half specified a focus on eating problems. This recruitment procedure resulted in a sample that was English and/or Spanish speaking and comprised individuals who volunteered to be in a study, who may have had an interest in women's health issues, and who may have self-identified as having eating problems. This recruitment procedure resulted in a sample that was English and/or Spanish speaking and comprised individuals who volunteered to be in a study, who may have had an interest in women's health issues, and who may have self-identified as having eating problems. Interviewers were unaware of the expected status (eating disorder or control) of the participant (i.e., they did not know to which type of flyer the participant had responded). Thirty-three participants were Spanish dominant and completed the materials in Spanish with bilingual staff. Compared to English-dominant participants, Spanish-dominant participants were somewhat older in age, lower in socioeconomic status (SES), and were more likely to be first-generation Americans.

Procedure and Instruments

Interviews were conducted by phone by extensively trained research assistants. Graduate research assistants participated in an initial intensive training workshop and continued training individually (6 to 9 months) until the master trainer (the first author, trained by authors of the interview measures) was in 100% agreement with the research assistant regarding ratings on three consecutive interviews. Throughout data collection, interview tapes were reviewed in weekly supervision meetings. For data collected in Spanish, published Spanish language versions of all measures were used.

Conducting interviews by phone increases the rate of participation because it relieves potential participants from having to commute or arrange transportation to a site. Using telephone administration has been found not only to be an economical alternative but also to result in higher participation rates than face-to-face interviews (Allgood-Merten, Lewinsohn, & Hops, 1990; Wells, Burnam, Leake, & Robins, 1988). In addition, structured clinical telephone interviews and face-to-face interviews generate comparable Axis I and II diagnostic information (Rhode, Lewinsohn, & Seeley, 1997; Study Group on Anorexia Nervosa, 1995). Interviews included the following components:

Demographics. Each participant reported her ethnicity, age, occupation, and highest level of education. SES was calculated for each participant based on her education and occupation according to Hollingshead's two-factor index of social position (Hollingshead & Redlich, 1958). A lower score indicates higher social status. Scores correspond to five SES levels, with 1 indicating the highest and 5 indicating the lowest SES level.

Structured Clinical Interview for DSM-IV-TR (SCID-IV-TR). The SCID-IV-TR (First, Spitzer, Gibbon, & Williams, 2001) was used to determine the presence or
absence of Axis I disorders as defined in DSM-IV-TR (American Psychiatric Association, 2000). The SCID-IV-TR is a widely used interview for detecting current and lifetime psychiatric disorders and has strong reliability and validity in English (Spitzer, Williams, Gibbon, & First, 1992) and Spanish (First, Spitzer, Gibbon, & Williams, 1999), with Kappa values for the Axis I disorders ranging from .70 to 1.00 for the English version (Segal, Hersen, & Van Hasselt, 1994) and .54 to .97 for the Spanish version (Torrens, Serrano, Astals, Perez-Dominguez, & Martin-Santos, 2004).

Eating Disorder Examination (EDE). Participants who met SCID-IV-TR criteria for an eating disorder were interviewed further using the EDE (Fairburn & Cooper, 1993). The EDE is a well-established, standardized, investigator-based interview designed to make a differential eating disorder diagnosis based on DSM-IV criteria. It measures the severity of the characteristic psychopathology of eating disorders and establishes onset ages for symptoms. Information is gathered on frequency of binge eating during the past 6 months, frequency of purging behaviors (vomiting, laxative and diuretic abuse) during the past 6 months, degree of dietary restriction in the past 6 months (rated on a 3-point scale from no restriction to fasting), degree of distress regarding binge eating (rated on a 6-point scale from no distress to long-lasting distress), and importance of weight or shape (rated on a 6-point scale from no importance to supreme importance). The EDE has been shown to have high discriminant and concurrent validity and reliability (Guest, 2000; Rizvi, Peterson, Crow, & Agras, 2000) and is considered to be the most reliable and comprehensive interview for assessing eating disorders (Wilson, 1993). Internal consistency of the EDE has been shown to be good, with Cronbach’s alpha of the five subscales ranging from .67 to .90. Inter-rater reliability has been reported to be very good in several studies, both for individual items (r = .69 to 1.00) and for the subscales (r = .83 to .99; Williamson, Anderson, Jackman, & Jackson, 1995). All subscales are highly correlated (r = .78 to .82) with other measures of weight and shape control (Williamson et al., 1995). The Spanish version of the EDE has demonstrated validity and reliability, with Cronbach’s alpha of the subscales ranging from .80 to .85 (Escurcell, Giral, & Clarasó, 2000).

Because interviews were not conducted in person, the following paper-and-pencil self-report questionnaires were sent to participants and returned via mail. The return rate was 100% for these measures:

Acculturation Rating Scale for Mexican Americans-II (ARSMA-II). The ARSMA-II (Cuellar, Arnold, & Maldonado, 1995) is a well-established instrument for measuring acculturation in Mexican Americans that includes different cultural domains inherent in the acculturation experience (Cabassa, 2003), including language use and preference, ethnic identity and classification, cultural heritage, and ethnic behaviors, and ethnic interaction. The ARSMA-II uses a bidimensional approach to measure cultural orientation toward the Mexican culture (Mexican Orientation Subscale [MOS], 17 items) and the Anglo culture (Anglo Orientation Subscale [AOS], 13 items) independently. Sample MOS items are: “I enjoy speaking Spanish” and “My family cooks Mexican foods.” Sample AOS items are: “I associate with Anglos” and “I enjoy listening to English language music.” Participants rate each item on a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely often or almost always). Higher scores indicate stronger orientation toward Mexican or Anglo culture, respectively. Acculturation scores can be calculated as AOS minus MOS, corresponding to five levels of acculturation: level 1 = very Mexican oriented, level 2 = Mexican oriented to approximately balanced bicultural, level 3 = slightly Anglo oriented bicultural, level 4 = strongly Anglo oriented, and level 5 = very assimilated and Anglicized (Cuellar et al., 1995). Information about generational status is collected as part of the measure. The ARSMA-II has been shown to have high reliability and strong construct validity in English and Spanish, with Cronbach’s alpha = .88 and .86 for the MOS and AOS, respectively, and concurrent validity with the original ARSMA of r = .89 (Cuellar et al., 1995). Cronbach’s alpha in our sample was .89 for the MOS and .88 for the AOS.

Multigroup Ethnic Identity Measure (MEIM). The MEIM (Phinney, 1992) is a scale of ethnic identity that is widely used to assess the strength and security of one’s sense of self as an ethnic group member. It consists of 14 items rated on a 5-point Likert scale. Sample items are: “I feel a strong attachment toward my own ethnic group” and “I have a clear sense of my ethnic background and what it means for me.” A mean score across all items is calculated for each individual, ranging from 1 to 5, with higher scores indicating stronger ethnic identity. The scale has high reliability in English and Spanish, with alphas above .90 across a wide range of ethnic groups and ages (Phinney, 1992). Cronbach’s alpha for this scale was .86 in our sample.

Each participant provided informed consent and was ensured confidentiality of responses. Monetary compensation of $45 for the SCID-IV-TR interview or $60 for the SCID-IV-TR and EDE interviews was paid to each participant.

RESULTS

Preliminary descriptive analyses revealed that, for the total sample, AOS and MOS mean scores were similar to the scores of the validation sample of the ARSMA-II (Cuellar et al., 1995: AOS M = 3.82, SD = .57; MOS M = 3.28, SD = .54). See Table 1 for group mean scores.

Logistic regression analysis was used to examine whether the variables of interest (Anglo orientation, Mexican orientation, ethnic identity) predicted eating disorder outcome (eating disorder vs. control). Demographic variables (age, SES, generation status) were entered in block one of the
regression and AOS, MOS, and ethnic identity scores were entered in block two. The results revealed that the model successfully distinguished between the eating disorder and control groups, $\chi^2(6) = 18.50, p = .005$. The model demonstrated good ability to correctly predict participants' outcome category, yielding an overall prediction success rate of 66.3%. Tests of the individual predictors revealed that Anglo orientation in particular significantly differentiated between the eating disorder and control groups. Specifically, being more Anglo oriented increased the probability of having an eating disorder, above and beyond the risk associated with the other variables, by a multiplicative factor of 2.02; that is, for every 1-point increase in their scores on Anglo orientation, a Mexican American woman’s risk for (or probability of) an eating disorder doubled. Age was a significant demographic predictor of eating disorder outcome with an odds ratio of 1.10, indicating that Mexican American women’s risk for eating disorders increases slightly but significantly every year between the ages of 18 and 48 years. The remaining individual predictors (SES, generation status, Mexican orientation, and ethnic identity) were not significantly related to eating disorder outcome (see Table 2).

Correlational analyses were conducted among the eating disorder group to examine relationships between severity of specific eating disorder symptoms (i.e., binge-eating frequency, purging frequency, dietary restriction, distress regarding binge eating, importance of weight or shape) and Anglo orientation, Mexican orientation, and ethnic identity. MEIM scores were negatively associated with vomiting frequency ($r = -.31, p < .01$) and positively associated with degree of distress regarding binge eating ($r = .36, p < .01$). MOS scores were positively associated with degree of distress regarding binge eating ($r = .36, p < .01$). There were no other significant correlations.

**DISCUSSION**

In this study we found that degree of orientation toward Anglo American culture significantly predicted eating disorders in Mexican American women; for every 1-point increase in Anglo orientation, a Mexican American woman’s probability of having an eating disorder doubled. Degree of orientation toward Mexican culture and strength of ethnic identity, however, did not predict eating disorder outcome. Our findings support the hypothesis that Anglo orientation is a correlate, and possibly a risk factor (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Striegel-Moore & Cachelin, 2001), for eating disorders in Mexican American women. Mexican American women who are Anglo oriented may experience heightened sociocultural pressures toward thinness because of their increased exposure to and adoption of European American beauty ideals. Our findings suggest that eating disorder status in Mexican American women is not associated with the degree to which the individual is attached (or not attached) to her own culture (i.e., Mexican orientation and ethnic identity), but rather is associated with how much the individual is attached to the new host culture (i.e., orientation toward Anglo culture). Mexican culture does not have the same emphasis on body image as American culture. Therefore, Mexican orientation may not be related to eating disorders. These results are similar to those of Phinney and Flores (2002), who found that markers of an American orientation (English language and American friends) were associated with more liberal sex role attitudes whereas a Hispanic orientation (Spanish language and Hispanic friends) was unrelated to these attitudes. The attitudinal and behavioral changes in acculturation may be influenced more by what one adopts in a new culture rather than by what one holds onto from the original culture. These findings provide support for the importance of using a bidimensional approach in studying acculturation, so that influences of the original culture and the new culture can be examined separately.

We did predict ethnic identity to be related to eating disorders. The lack of a strong relationship may reflect the fact that one’s ethnic identity is focused on oneself as a member of a cultural group, rather than on one’s personal identity as an individual with a particular appearance or body type. Although ethnic identity has generally been shown to be associated with psychological well-being, the relationship is modest, explaining 5 to 10% of variance (Roberts et al., 1999); hence, it is not surprising that it does not predict a specific psychological disorder.

**Table 2**

Hierarchical Logistic Regression Predicting Presence of Eating Disorders From Women's Age, SES, Generation, Anglo and Mexican Orientation, and Ethnic Identity

<table>
<thead>
<tr>
<th>Variables entered at step</th>
<th>$\chi^2$</th>
<th>Wald</th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.09</td>
<td>11.95</td>
<td>1.10</td>
<td>1.040, 1.153</td>
<td>.001</td>
</tr>
<tr>
<td>SES</td>
<td>.01</td>
<td>.56</td>
<td>1.01</td>
<td>0.988, 1.028</td>
<td>.455</td>
</tr>
<tr>
<td>Generation status</td>
<td>.13</td>
<td>.51</td>
<td>1.14</td>
<td>7.92, 1.648</td>
<td>.475</td>
</tr>
<tr>
<td>Anglo orientation</td>
<td>.70</td>
<td>4.93</td>
<td>2.02</td>
<td>1.086, 3.742</td>
<td>.026</td>
</tr>
<tr>
<td>Mexican orientation</td>
<td>.11</td>
<td>.15</td>
<td>1.12</td>
<td>.637, 1.961</td>
<td>.698</td>
</tr>
<tr>
<td>Ethnic identity</td>
<td>.15</td>
<td>.17</td>
<td>1.16</td>
<td>.570, 2.359</td>
<td>.682</td>
</tr>
</tbody>
</table>

*Note. SES = Socioeconomic Status.*
However, strength of ethnic identity may influence the particular symptoms an individual with a psychological disorder exhibits. In our sample of eating disorder cases, stronger Mexican ethnic identity seemed to protect against the more pathological symptom of purging. At the same time, stronger Mexican identity and greater Mexican orientation were associated with greater distress regarding binge eating. Purging as compensation for binge eating serves to reduce anxiety regarding weight gain (American Psychiatric Association, 2000). Therefore, those who do not compensate for binge eating by purging may remain distressed about the binge eating and consequent weight gain for longer periods of time. Strength of Mexican ethnic identity may influence the type of eating disorder an individual develops (i.e., binge eating disorder, characterized by binge eating in the absence of compensatory behaviors). The sample size of this study did not provide sufficient statistical power to examine differences in ethnic identity between types of eating disorder and, therefore, our results in this area should be viewed as preliminary. Further research is needed to examine how loss of ethnic identity may impact the development of the specific symptomatology of eating disorders.

We found no relationship between the presence of eating disorder and generational status. One-item proxy measures such as generation provide an incomplete picture of the acculturation process (Phinney & Flores, 2002). For example, generational status may mask differences in parental or grandparental orientation toward Anglo culture. Some parents of first-generation children may have arrived in the host country already speaking English fluently and thus providing a role model for speaking English. Some parents may be encouraging of their first-generation children’s exposure to Anglo culture (e.g., encourage learning and using English) while other parents may not support such exposure.

A limitation of this study was the cross-sectional design, which does not allow for establishing a causal relationship between a stronger orientation toward European American culture and the development of eating disorders. Further, the self-selected nature of the sample may reduce the generalizability of our findings. The average education level of our sample (completion of some college) was higher than that of the Los Angeles Latino population (high school education or less; The Regents of the University of California, 1999), and the average family income of our sample ($30,000 to $40,000 annually) was somewhat more than the median family income for Los Angeles Latinos ($28,155/year; The Regents of the University of California, 1999). Additionally, our participants had regular use of landline telephones whereas their lower income counterparts may lack landline phones (Cabral et al., 2003). Therefore, our findings regarding eating disorder morbidity and acculturation may not apply to the Los Angeles Latino population as a whole. These limitations are offset by several strengths, including recruitment of women meeting diagnostic criteria for eating disorders from the community, the inclusion of an ethnic minority population that has been largely neglected in eating disorder research, and the use of state-of-the-art diagnostic interviews administered by highly trained staff. Prior research has relied on convenience samples of college students with some symptoms of disordered eating (not actual eating disorders) or on patient samples in which women of ethnic minority groups are not represented (see Cachelin et al., 2000, 2001; Cabral & Striegel-Moore, 2006). Data collection was conducted in Spanish and English, so we were able to include Mexican American women from a range of backgrounds who typically are not included in research studies on eating disorders.

Our findings point to the role of Anglo cultural orientation in the development of eating disorders and underscore the need for future research in this area to utilize bidimensional models that capture orientation toward the host culture as a separate construct. In addition, future studies should systematically control for the effects of any demographic variables such as age or SES that may be confounded with acculturation level. More research is needed that examines the role of acculturation to European American culture in the development of eating disorders and other mental health problems in the Mexican American population. In particular, longitudinal studies that examine the contribution of the acculturation process to risk for and resilience against mental health problems are needed. For example, long-term studies of body image development in immigrant children and adolescents could shed light on the relationship between acculturation and eating disorders. In conclusion, our findings suggest that acculturation, measured as increased orientation toward the host European American culture, is related to the development of eating disorders in Mexican American women.

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