Relations of Sexual Objectification and Racist Discrimination with Latina Women’s Body Image and Mental Health

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Abstract
In the current study, we tested direct and mediated associations of objectification theory constructs and racist discrimination with eating disorder and depressive symptomatology in a sample of 180 Latina women (age range = 18-66). Results of a path analysis indicated that internalization of sociocultural standards of attractiveness was related to greater eating disorder and depressive symptomatology in part through the mediating roles of body shame and body surveillance, and body surveillance was related to greater eating disorder and depressive symptomatology through the mediating role of body shame. Sexual objectification did not yield hypothesized direct and indirect unique relations with criterion variables. However, racist discrimination was directly associated with greater depressive symptomatology and indirectly associated, through the mediating role of body shame, with greater eating disorder and depressive symptomatology. These results extend tenets of objectification theory to Latina women and point to the role of racist discrimination within this framework.

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Epidemiological studies conducted in the United States indicate that women are disproportionately affected by body image problems and associated eating disorder and depressive symptomatology (e.g., Hudson, Hiripi, Pope, & Kessler, 2007; Kessler, Chiu, Demler, & Walters, 2005). Although early body image research focused narrowly on European American women due to the stereotype that body image problems are uniquely salient for this population, recent scholarship challenges this thinking (Brown, Cachelin, & Dohm, 2009; Dohm, Brown, Cachelin, & Striegel-Moore, 2010), particularly for Latina women (i.e., women from Spanish-speaking cultures or nations of origin who reside in the United States; U.S. Census Bureau, 2011).

Indeed, despite the belief that Latina/o cultures and communities are more accepting of curvier body types among women (e.g., Franko et al., 2012; Viladrich, Yeh, Bruning, & Weiss, 2009), many Latina women nonetheless seek to be thinner than they currently are (e.g., Cachelin, Rebeck, Chung, & Pelayo, 2002; Viladrich et al., 2009). Furthermore, findings across studies, including a meta-analysis, suggest comparable levels of body dissatisfaction and eating disorder symptomatology among Latina and European American women (Frederick, Forbes, Grigorian, & Jarcho, 2007; Grabe & Hyde, 2006; Shaw, Ramirez, Trost, Randall, & Stice, 2004). With regard to depressive symptomatology, another meta-analysis found that Latina women actually reported higher levels of such symptoms than did European American women (Mendelson, Rehkopf, & Kubzansky, 2008). Similarly, comparisons of 12-month prevalence of eating or mood disorders between Latina/o and European American people, across Latina/o ancestries (e.g., Mexican, Puerto Rican, Cuban), and across groups of Latina/o people of different immigration statuses, have yielded nonsignificant results (Alegría et al., 2007; Marques et al., 2011; Mendelson et al., 2008). This evidence challenges the myth that body image and eating problems are uniquely salient for European American women and instead underscores the need for theoretically grounded research that identifies factors linked with body image problems and associated mental health concerns among Latina women.

Specifically, because of their dual stigmatized identities as women and racial/ethnic minorities, Latina women may experience multiple forms of oppression. The present study integrates objectification theory (Fredrickson & Roberts, 1997; Moradi & Huang, 2008), which documents the links of sexual objectification with body image and psychological symptomatology among women, with similar scholarship linking racist discrimination with...
body image and mental health among racial and ethnic minority people generally (e.g., Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006; Striegel-Moore & Smolak, 2000) and Latina/o people more specifically (Gordon, Castro, Sitnikov, & Holm-Denoma, 2010; Lee & Ahn, 2012; Menon & Harter, 2012). Based on these two bodies of research, we tested the unique associations of sexual objectification and racist discrimination with the body image concerns, eating disorder symptomatology, and depressive symptomatology of Latina women.

**Overview of Objectification Theory**

The conceptual foundation of the present study was largely derived from objectification theory (Fredrickson & Roberts, 1997). Objectification theory posits that girls and women routinely experience sexual objectification, such as sexual comments, leering, groping, or unwanted sexual advances (e.g., Kozee, Tylka, Augustus-Horvath, & Denchik, 2007). Such experiences reduce girls and women to their bodies, body parts, or body functions in sexualized ways. Omnipresent sexual objectification is theorized to increase girls’ and women’s internalization of sociocultural standards of attractiveness (hereafter called “internalization”), which is the extent to which individuals adopt dominant societal beliefs about appearance (e.g., “I must be skinny to be attractive and valued”). Greater internalization may lead women to self-objectify by focusing on how their body appears to others rather than on how it feels or what it can do. Self-objectification manifests behaviorally as body surveillance, or habitual monitoring of one’s appearance. Body surveillance is theorized to promote body shame when individuals fall short of the narrow (and arguably impossible to attain) sociocultural standards of attractiveness. Finally, body shame is posited to promote eating disorder and depressive symptomatology.

Evidence for this set of objectification theory relations is robust in research with samples composed primarily of college-age European American women (Moradi & Huang, 2008; Tiggemann, 2011). Specifically, in such studies, internalization partially mediated the positive link of sexual objectification with body surveillance, and fully mediated the positive link of sexual objectification with eating disorder symptomatology. Moreover, internalization and body surveillance simultaneously mediated the positive link of sexual objectification with body shame. Finally, body surveillance partially mediated the positive link of internalization with body shame, and body shame partially mediated the links of internalization and body surveillance with eating disorder symptomatology (e.g., Augustus-Horvath & Tylka, 2009; Kozee & Tylka, 2006; Moradi, Dirks, & Matteson, 2005). With depressive symptomatology as
the criterion, a pathway through body surveillance and body shame fully mediated the link of sexual objectification with depressive symptomatology. Furthermore, body shame fully mediated the positive link between body surveillance and depressive symptomatology. Finally, body shame has been linked positively and directly with depressive symptomatology (e.g., Carr & Szymanski, 2011; Grabe, Hyde, & Lindberg, 2007; Mitchell & Mazzeo, 2009). Notably, the unique direct link of internalization with depressive symptomatology has not been examined, although there is some evidence that body shame may fully mediate the positive link of an internalization-body surveillance composite variable with depressive symptomatology (e.g., Mitchell & Mazzeo, 2009). Taken together, these studies support the set of direct and mediated relations summarized in Figure 1.

**Objectification Theory and Latina Women**

Tenets of objectification theory have also been supported in research with women of diverse backgrounds, including African American women (e.g., Watson, Ancis, White, & Nazari, 2013), Muslim American women (Tolaymat & Moradi, 2011), Deaf women (Moradi & Rottenstein, 2007), and middle-age women (Augustus-Horvath & Tylka, 2009). Although objectification theory research with Latina women is limited, findings from associated bodies of research support the salience of sexual objectification in this population. For example, in an examination of Spanish-language soap operas (telenovelas) that air in the United States, Rivadeneyra (2011) found that female characters were sexualized more often than male characters. In turn, exposure to sexually objectifying media has been associated with poorer body image among Latina adolescents (e.g., Schooler & Daniels, 2014). Similarly, studies composed of
substantial proportions of Latina women have indicated that experiences of sexist discrimination or sexual harassment—which are related to sexual objectification—are associated with poorer psychosocial functioning (e.g., Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Shupe, Cortina, Ramos, Fitzgerald, & Salisbury, 2002). However, to our knowledge, no study has focused specifically on Latina women’s experiences of interpersonal sexual objectification.

Particularly relevant to the present investigation, two prior studies with Latina women supported the positive interrelations of internalization, body surveillance, body shame, and eating disorder symptomatology (Boie, Lopez, & Sass, 2013; Montes de Oca, 2006). Importantly, Boie et al. (2013) found that levels of internalization, body surveillance, body shame, and eating disorder symptomatology, as well as the relations among these variables, did not differ significantly between Latina/o and European American participants. In addition, the instruments used in this study demonstrated measurement and structural invariance across ethnic groups, supporting the validity of these constructs among Latina/o individuals (Boie et al., 2013). In a sample of Latina women, Montes de Oca (2006) found that body surveillance partially mediated the link of internalization with body shame, and body shame partially mediated the links of internalization and body surveillance with eating disorder. Thus, the limited available research on objectification theory constructs with Latina/o samples suggests that levels and interrelations of these constructs are similar to those observed in samples of European American women. However, previous studies have not examined interpersonal sexual objectification experiences or depressive symptomatology, and therefore, the roles of these variables in the objectification theory framework remain untested with Latina women.

Racist Discrimination and Latina Women’s Body Image and Mental Health

There are a number of calls to consider racist discrimination in extensions of objectification theory to racial and ethnic minority women (e.g., Moradi, 2010, 2011). Numerous studies have indicated that experiences of racist discrimination—for example, a person being called racial slurs or being suspected of wrongdoing based on race—are associated with adverse mental health outcomes (Landrine et al., 2006; Moradi & Subich, 2003; Szymanski & Stewart, 2010). Indeed, a meta-analysis of studies with Latina/o individuals indicated that racist discrimination yielded small to medium correlations with psychological distress, anxiety, and depression (Lee & Ahn, 2012). Moreover, Striegel-Moore and Smolak (2000) argued that racist discrimination may be
linked to eating disorder symptomatology through intervening variables such as media internalization and body dissatisfaction.

Empirical research provides support for these links among racial and ethnic minority women generally and Latina women specifically. In a study of Asian and Asian American women, self-esteem and internalization mediated the positive association of racist discrimination with body dissatisfaction and partially mediated the positive relation of racist discrimination with eating disorder symptomatology (Cheng, 2014). Among Latina women, research indicates that acculturative stress—or the stress associated with the acculturation process, which often includes discrimination (Benet-Martínez & Haritatos, 2005)—is associated with body image concerns and eating disorder symptomatology (Gordon et al., 2010; Menon & Harter, 2012; Perez, Voelz, Pettit, & Joiner, 2002). In a test of objectification theory with Latina women, an acculturative stress indicator that included racist discrimination yielded an indirect positive relation with eating disorder symptomatology through the partial mediating role of body shame (Montes de Oca, 2006). Importantly, research aiming to clarify the distinctive roles of racist discrimination from those of the broader acculturative stress construct indicated that racist discrimination was the more robust and consistent correlate of Latina/o people’s psychological symptoms (e.g., Lee & Ahn, 2012; Stein, Gonzalez, & Huq, 2012). Thus, racist discrimination may be a salient correlate of body image and mental health concerns for Latina women, with body shame as a potential mediator of the link between racist discrimination and outcomes.

**Overview of the Present Study**

The present study integrates research on objectification theory and racist discrimination to examine theoretically grounded correlates of body image concerns, eating disorder symptomatology, and depressive symptomatology for Latina women. The goal of the study was to better understand the unique roles of contextual factors (sexual objectification, racist discrimination) and intrapersonal factors (internalization, body surveillance, body shame) that may be important targets of psychotherapeutic and educational interventions with Latina women. On the basis of theoretical and empirical integration, we tested a number of hypotheses (see Figure 1).

Based on the objectification theory literature, positive correlations were predicted among experiences of sexual objectification, internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology (Hypothesis 1). Objectification theory research also suggests multiple patterns of indirect or mediated relations involving these variables. Experiences of sexual objectification were posited to yield positive indirect links with body surveillance via the partial mediating role of internalization.
(Hypothesis 2a); with body shame via the simultaneous mediating roles of internalization and body surveillance (2b); with eating disorder symptomatology via the mediating role of internalization (2c); and with depressive symptomatology via a pathway through body surveillance and body shame (2d). Internalization was predicted to yield positive indirect links with body shame via the partial mediating role of body surveillance (Hypothesis 3a) and with eating disorder symptomatology via the partial mediating role of body shame (3b). As noted previously, research on the link of internalization with depressive symptomatology is limited. However, consistent with objectification theory, internalization was posited to yield a positive indirect link with depressive symptomatology via the serial mediating roles of body surveillance and body shame (Hypothesis 3c). Similarly, body surveillance was predicted to yield positive indirect links with eating disorder symptomatology via the partial mediating role of body shame (Hypothesis 4a) and with depressive symptomatology via the full mediating role of body shame (4b).

Beyond the aforementioned associations, and in light of prior research with Latina women (Gordon et al., 2010; Menon & Harter, 2012; Montes de Oca, 2006; Perez et al., 2002), racist discrimination was expected to be positively associated with body shame, eating disorder symptomatology, and depressive symptomatology (Hypothesis 5). Moreover, racist discrimination was expected to yield positive indirect links with eating disorder symptomatology via the partial mediating role of body shame (Hypotheses 6a and 6b).

Last, prior research has found that younger women may report higher levels of sexual objectification, body surveillance, body shame, and eating disorder symptoms (Augustus-Horvath & Tylka, 2009; McKinley, 2006; McKinley & Hyde, 1996). In addition, greater body mass index (BMI) has been linked with poorer body image and greater eating disorder symptoms (e.g., Stice, 2002). Thus, both age and BMI were explored as covariates to provide more stringent tests of the hypotheses. Notably, we did not use a maximum age limit as a participation inclusion criterion because prior scholarship suggests that body image concerns are salient across women’s life span (although issues such as functional impairment become more important for older women; Tiggemann, 2004), and because our individual differences approach to measuring the constructs of interest was expected to capture variability between and within age groups.

**Method**

**Participants**

We analyzed data from 180 Latina women. Participants ranged in age from 18 to 66 ($M = 27.73$, $SD = 9.99$, $Mdn = 25$). For all subsequent descriptive
data, percentages may not sum 100% due to missing demographic data. With regard to family’s nation of origin, approximately 35% indicated Mexico, 14% Puerto Rico, 9% Colombia, 8% Cuba, 6% the Dominican Republic, 4% Panama, 4% Peru, 3% Spain, 2% Argentina, and 2% Ecuador. Approximately 65% of participants were born in the United States whereas 32% were born outside of the United States. For individuals born outside of the United States, the average number of years spent living in the United States was 20.13 ($SD = 10.13, Mdn = 20$). Participants self-reported their English speaking and reading ability on 5-point scales (1 = very poor, 5 = very good); the sample evinced high levels of both English speaking ($M = 4.85, SD = 0.47$) and reading ability ($M = 4.87, SD = 0.42$).

In terms of sexual orientation, approximately 73% of participants identified as exclusively heterosexual, 19% as mostly heterosexual, 2% as exclusively lesbian, and 1% each as bisexual and asexual. With regard to social class, approximately 14% identified as lower class, 36% as lower-middle class, 38% as middle class, less than 1% as upper-middle class, and 8% as upper class. In terms of highest level of education attained, 4% reported that they completed high school, 26% completed some college, 6% completed an associate’s degree, 21% completed a bachelor’s degree, 9% completed some graduate school, and 32% reported that they had completed an advanced degree (e.g., MA, PhD, MD); no participants indicated that they had less than a high school education. With regard to current employment, 38% were employed full-time, 32% were employed part-time, 23% were currently unemployed, and 2% each were self-employed full-time and part-time. Most participants resided in the Southern region (44%) of the United States, followed by the West (32%), Northeast (16%), and Midwest (4%).

Procedures

Participants were recruited via the Internet. We sent messages that included a description of the study and a link to the survey via message boards or online communities (yahoo and Facebook groups) that catered to Latina women specifically or racial and ethnic minority women more generally. Individuals who followed the link were taken to an online survey hosted by Qualtrics. The first page of the survey was an informed consent that described the study and asked participants to confirm that they (a) were 18 years of age or older, (b) resided in the United States, (c) identified as women, and (d) identified as Latina or Hispanic. After reading the study description and affirming that they met the inclusion criteria, individuals were prompted to confirm their consent and proceed to complete the survey. The survey was only available in English. Participants received no compensation or incentives for participation.
From a total of 284 submissions, 68 (24%) were from individuals who confirmed the informed consent page but did not respond to any items. Some of these individuals may have confirmed the informed consent to “check out” the survey and returned to complete the survey at a later time, but the anonymity of the data precluded confirmation of this possibility. One-hundred and three (36%) individuals were removed from the data set because they were missing more than 20% of the survey items, which falls outside of the tolerance range for missing data suggested in prior research (Dodeen, 2003; Parent, 2013). Notably, 89 (86%) of these 103 cases were missing more than 50% of the data. Four validity check items were distributed throughout the survey that requested participants to select a particular response (e.g., “Please select strongly agree”). One case was removed from the data set because the individual responded incorrectly to more than 2 of the 4 validity check items, which may indicate random or inattentive responding. Of the remaining 180 participants, 134 (74%) were missing no data and 38 (21%) were missing between 1 to 10 items. The primary analyses were performed using Mplus 6.1 (Muthén & Muthén, 1998-2010) with full information maximum likelihood (FIML) estimation, which handles missing data by generating a likelihood function for each case based on the variables that are present; thus, all available data were used.

**Instruments**

**Sexual objectification experiences.** Sexual objectification experiences were assessed using the 15-item Interpersonal Sexual Objectification Scale (ISOS; Kozee et al., 2007). Items were rated on a 5-point scale ranging from 1 = never to 5 = almost always. Item ratings were averaged to derive a scale score, with higher scores indicating more frequent sexual objectification experiences. A sample item is “How often have you felt that someone was staring at your body?” In three predominantly European American samples of college women, ISOS items yielded Cronbach’s alphas that ranged from .91 to .95, and the validity of ISOS scores was supported by a positive correlation with broader experiences of sexist discrimination (Kozee et al., 2007). To our knowledge, no study has used this instrument with a sample of Latina women. Cronbach’s alpha in the current sample was .94.

**Racist discrimination experiences.** Experiences of racist discrimination in the last year were assessed using the 18-item Recent scale of the General Ethnic Discrimination Scale (GEDS-Recent; Landrine et al., 2006). Items were rated on a 6-point scale ranging from 1 = never to 6 = almost all of the time. Item ratings were averaged to derive a scale score, with higher scores reflecting
more frequent experiences of racist discrimination. A sample item is “How often have you been treated unfairly by strangers because of your race/ethnic group?” In a large sample in which approximately 11% ($n = 174$) of participants were Latina/o individuals, GEDS-Recent items yielded a Cronbach’s alpha of .94, and the validity of GEDS-Recent scores was supported by significantly higher scores among racial and ethnic minority participants than among European American participants (Landrine et al., 2006). In the current sample, Cronbach’s alpha was .93.

**Internalization of sociocultural standards of attractiveness.** Internalization of sociocultural standards of attractiveness was assessed with the eight-item Internalization subscale of the Sociocultural Attitudes Toward Appearance Questionnaire (SATAQ-I; Heinberg, Thompson, & Stormer, 1995). Items were rated on a 5-point scale ranging from 1 = *completely disagree* to 5 = *completely agree*. Appropriate items were reverse-scored, and item ratings were averaged to derive subscale scores, with higher scores indicating greater internalization. A sample item is “I believe that clothes look better on thin models.” In a sample of primarily European American college women, the validity of SATAQ-I scores was supported by positive correlations with drive for thinness and body dissatisfaction (Low et al., 2003). In a study of Latina/o and European American women and men, SATAQ-I items demonstrated measurement invariance across gender and ethnicity, supporting construct validity across groups (Boie et al., 2013). Among Latina/o women and men in the same sample, SATAQ-I items yielded a Cronbach’s alpha of .87 (Boie et al., 2013). Cronbach’s alpha in the current sample was .87.

**Body surveillance.** Body surveillance was assessed with the eight-item Body Surveillance subscale of the Objectified Body Consciousness Scale (OBCS-Surv; McKinley & Hyde, 1996). Items were rated on a 7-point scale ranging from 1 = *strongly disagree* to 7 = *strongly agree*, with a “not applicable” option for items that do not apply. Appropriate items were reverse-scored, and ratings of applicable items were averaged to derive subscale scores. Higher scores indicate higher body surveillance. A sample item is “During the day, I think about how I look many times.” In a sample of primarily European American college women, the validity of OBCS-Surv scores was supported by a positive correlation with public self-consciousness and a negative correlation with body esteem (McKinley & Hyde, 1996). In a sample of Latina/o and European American women and men, the OBCS-Surv items demonstrated measurement invariance across gender and ethnicity, supporting the validity of the construct across groups (Boie et al., 2013). OBCS-Surv items yielded a Cronbach’s alpha of .76 in a sample of Latina/o college
women and men (Boie et al., 2013). In the current sample, Cronbach’s alpha was .82.

**Body shame.** Body shame was assessed with the eight-item Body Shame subscale of the Objectified Body Consciousness Scale (OBCS-Shame; McKinley & Hyde, 1996). Items were rated on a 7-point scale ranging from 1 = *strongly disagree* to 7 = *strongly agree*, with a “not applicable” option for items that do not apply. Appropriate items were reverse-scored, and ratings of applicable items were averaged to derive subscale scores. Higher scores indicate greater body shame. A sample item is “I feel ashamed of myself when I haven’t made the effort to look my best.” In a predominantly European American sample of college women, the validity of OBCS-Shame scores was supported by a negative correlation with body esteem (McKinley & Hyde, 1996). In a sample of Latina/o and European American women and men, the OBCS-Shame items demonstrated measurement invariance across gender and ethnicity, supporting the validity of the construct across groups (Boie et al., 2013). OBCS-Shame items yielded a Cronbach’s alpha of .76 in a sample of Latina/o college women and men (Boie et al., 2013). In the current sample, Cronbach’s alpha was .87.

**Eating disorder symptomatology.** Eating disorder symptomatology was assessed with the 26-item Eating Attitudes Test (EAT-26; Garner, Olmstead, Bohr, & Garfinkel, 1982). Items were rated on a 6-point scale ranging from 1 = *never* to 6 = *always*. Across samples of women, EAT-26 items have yielded Cronbach’s alphas that range from .79 to .94 (see Kashubeck-West, Mintz, & Saunders, 2001), and validity was supported by a large correlation of continuous EAT-26 scores with diagnostic group (eating disorder vs. nonclinical control group) in a sample of predominantly European American women (Mintz & O’Halloran, 2000). In a sample of Latina women, EAT-26 items yielded a Cronbach’s alpha of .87 (Montes de Oca, 2006). In the current sample, EAT-26 items yielded a Cronbach’s alpha of .87.

**Depressive symptomatology.** Symptoms of depression were assessed using the 20-item Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). Participants rated the frequency of various symptoms of depression in the past week using a 4-point scale ranging from 1 = *rarely or none of the time (less than 1 day)* to 4 = *most or all of the time (5-7 days)*. A sample item is “I thought my life had been a failure.” Appropriate items were reverse-scored, and item ratings were averaged to derive scale scores. Higher scores indicate greater depressive symptomatology. In a sample of Latina women, CES-D items yielded a Cronbach’s alpha of .91 (González-Guarda, Peragallo, Vasquez,
Urrutia, & Mitrani, 2009). The validity of CES-D scores was supported by positive correlations with other self-report measures of depression and with clinical ratings of depression (Radloff, 1977). In the current sample, Cronbach’s alpha was .91.

BMI was computed from participants’ self-reported height and weight using the Center for Disease Control and Prevention’s formula (weight in pounds / [height in inches]$^2 \times 703$). Self-reported height and weight are highly correlated with measured values and are considered practical indicators of BMI (Goodman & Strauss, 2003). In addition, health-risk estimates based on variations in self-reported BMI and measured BMI are very similar (Stommel & Schoenborn, 2009).

**Results**

Bivariate correlations among the variables of interest, age, and BMI are presented in Table 1. The magnitude of correlations is described using small ($r = .10$), medium ($r = .30$), and large ($r = .50$) benchmarks (Cohen, 1992). Bivariate correlations were largely consistent with Hypothesis 1. Specifically, with the exception of a nonsignificant link between sexual objectification experiences and internalization, the correlations among sexual objectification, internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology were significant and medium to large in magnitude. Consistent with Hypothesis 5, racist discrimination yielded significant small to near-medium correlations with body shame, eating disorder symptomatology, and depressive symptomatology.

With regard to the potential demographic covariates, age yielded significant small to medium negative correlations with sexual objectification, internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology, but its correlation with racist discrimination was nonsignificant. Also, BMI yielded significant small to medium positive correlations with body shame, eating disorder symptomatology, and depressive symptomatology, but it yielded nonsignificant correlations with the other variables of interest. In light of these significant correlations, partial correlations controlling for age and BMI were examined and are presented in Table 1. Partial correlations were largely consistent in direction, magnitude, and significance with bivariate correlations. However, controlling for the demographic covariates rendered the correlation of sexual objectification with depressive symptomatology nonsignificant. Despite this minimal attenuation, age and BMI were controlled as covariates in subsequent analyses to more stringently test the hypotheses.
**Table 1.** Bivariate Correlations, Partial Correlations Controlling for Age and BMI, Descriptive Statistics, and Cronbach’s Alphas for Variables of Interest.

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Possible range</th>
<th>M</th>
<th>SD</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sexual objectification</td>
<td>—</td>
<td>.54***</td>
<td>.05</td>
<td>.17*</td>
<td>.26**</td>
<td>.21***</td>
<td>.14</td>
<td>1-5</td>
<td>2.47</td>
<td>0.71</td>
<td>.94</td>
</tr>
<tr>
<td>2. Racist discrimination</td>
<td>.49***</td>
<td>—</td>
<td>.05</td>
<td>.15</td>
<td>.26**</td>
<td>.20*</td>
<td>.29***</td>
<td>1-6</td>
<td>1.91</td>
<td>0.70</td>
<td>.93</td>
</tr>
<tr>
<td>3. Internalization</td>
<td>.15</td>
<td>.03</td>
<td>—</td>
<td>.54***</td>
<td>.52***</td>
<td>.46***</td>
<td>.20**</td>
<td>1-5</td>
<td>2.77</td>
<td>0.90</td>
<td>.87</td>
</tr>
<tr>
<td>4. Body surveillance</td>
<td>.23***</td>
<td>.14</td>
<td>.56***</td>
<td>—</td>
<td>.49***</td>
<td>.40***</td>
<td>.06</td>
<td>1-7</td>
<td>4.47</td>
<td>1.19</td>
<td>.82</td>
</tr>
<tr>
<td>5. Body shame</td>
<td>.28***</td>
<td>.23***</td>
<td>.51***</td>
<td>.49***</td>
<td>—</td>
<td>.50***</td>
<td>.30***</td>
<td>1-7</td>
<td>3.30</td>
<td>1.43</td>
<td>.87</td>
</tr>
<tr>
<td>6. Eating disorder symptoms</td>
<td>.23***</td>
<td>.19*</td>
<td>.47***</td>
<td>.43***</td>
<td>.55***</td>
<td>—</td>
<td>.18*</td>
<td>1-6</td>
<td>2.28</td>
<td>0.61</td>
<td>.87</td>
</tr>
<tr>
<td>7. Depressive symptoms</td>
<td>.20**</td>
<td>.28***</td>
<td>.24**</td>
<td>.12</td>
<td>.39***</td>
<td>.25**</td>
<td>—</td>
<td>1-4</td>
<td>1.69</td>
<td>0.51</td>
<td>.91</td>
</tr>
<tr>
<td>8. Age</td>
<td>-.30***</td>
<td>.03</td>
<td>-.31***</td>
<td>-.27***</td>
<td>-.25**</td>
<td>-.25**</td>
<td>-.20*</td>
<td>18-66*</td>
<td>27.73</td>
<td>9.99</td>
<td>—</td>
</tr>
<tr>
<td>9. BMI</td>
<td>-.07</td>
<td>.11</td>
<td>-.02</td>
<td>-.01</td>
<td>.34***</td>
<td>.18*</td>
<td>.17*</td>
<td>16.74-46.94*</td>
<td>25.48</td>
<td>5.65</td>
<td>—</td>
</tr>
</tbody>
</table>

*Note. Values below the diagonal represent bivariate correlations whereas values above the diagonal represent partial correlations, controlling for age and BMI. BMI = body mass index.

*Values reflect observed ranges.

* p < .05. ** p < .01. *** p < .001.
Mplus 6.1 (Muthén & Muthén, 1998-2010) was used to conduct path analyses with FIML estimation to test the hypothesized indirect relations. Data for each variable of interest met criteria for univariate normality (i.e., skewness < 3, kurtosis < 10; Weston & Gore, 2006). Moreover, none of the cases had a significant ($p < .001$) Mahalanobis distance, which suggests that multivariate non-normality was not a concern (Tabachnick & Fidell, 2007). A priori power analyses were performed using effect sizes found in prior studies that included the greatest overlap in variables of interest with the present study (Moradi et al., 2005; Tolaymat & Moradi, 2011; Wiseman & Moradi, 2010). The results indicated that the present sample size ($N = 180$) yielded sufficient power (i.e., greater than .80) to detect the most conservative effect sizes found in prior research. Model fit was evaluated using the comparative fit index (CFI), root mean square error of approximation (RMSEA), and standardized root mean residual (SRMR). Guidelines for acceptable fit using these indices have ranged from more liberal benchmarks (CFI $\geq .90$ and RMSEA and SRMR $\leq .10$) to more conservative benchmarks (CFI $\geq .95$, RMSEA $\leq .06$, and SRMR $\leq .08$; for example, Hu & Bentler, 1999; Quintana & Maxwell, 1999).

Results for the estimated model are depicted in Figure 2. In light of the significant bivariate correlations, we estimated the paths from age to internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology, and from BMI to body shame, eating disorder symptomatology, and depressive symptomatology. Thus, path coefficients in the model reflect interrelations among the variables of interest after taking into account significant relations of age and BMI. In addition, correlations among the exogenous variables (i.e., age, BMI, sexual objectification experiences, racist discrimination) and between the disturbance terms for eating disorder and depressive symptomatology were estimated. The model provided an excellent fit to the data, $\chi^2(8, N = 180) = 8.91, p = .35$, CFI = 1.00, RMSEA = .03 (90% confidence intervals [CI] = [.00, .09]), SRMR = .02. The model accounted for 9% of the variance in internalization, 33% of the variance in body surveillance, 48% of the variance in body shame, 37% of the variance in eating disorder symptomatology, and 21% of the variance in depressive symptomatology. Standardized path coefficients for the model are presented in Figure 2.

To test the significance of the hypothesized indirect relations, a bootstrap procedure with 1,000 bootstrap samples drawn from the original data was conducted to generate bias-corrected 95% CI for indirect relations. If the CI does not contain 0, the indirect relation is significant at $p < .05$ (e.g., Mallinckrodt, Abraham, Wei, & Russell, 2006). Results of these bootstrap tests of unique indirect relations are presented in Table 2.
Contrary to our expectation, sexual objectification did not yield significant indirect links with body surveillance, body shame, eating disorder symptomatology, or depressive symptomatology through the posited mediators (Hypotheses 2a-2d). Consistent with the hypotheses, however, internalization yielded significant positive indirect links with body shame through the partial mediating role of body surveillance (Hypothesis 3a) and with eating disorder symptomatology through the partial mediating role of body shame (3b). Moreover, an auxiliary inspection of additional pathways indicated that internalization yielded another significant positive indirect link with eating disorder symptomatology via a pathway through body surveillance and body shame. In support of Hypothesis 3c, internalization yielded a significant positive indirect link with depressive symptomatology via a pathway through body surveillance and body shame. Furthermore, inspection of additional pathways indicated that internalization yielded an additional significant positive indirect link with depressive symptomatology via body shame. In addition to these significant indirect relations, internalization yielded a significant positive direct link with eating disorder symptomatology.

Figure 2. Path model of hypothesized direct and indirect relations between variables of interest.

Note. Values reflect standardized coefficients. Dashed lines indicate nonsignificant paths. The following parameters were also estimated but have been omitted from the figure for the sake of parsimony: paths from age to internalization (−.28***), body surveillance (−.06), body shame (−.17***), eating disorder symptomatology (−.14*); paths from BMI to body shame (.37***), eating disorder symptomatology (.09), and depressive symptomatology (.09); the correlations of age with sexual objectification (.30**), racist discrimination (.05), and BMI (−.11); the correlations of BMI with sexual objectification (−.07) and racist discrimination (.11); and the correlations of the disturbance terms for eating disorder and depressive symptomatology (.24***). BMI = body mass index.

*p < .05. **p < .01. ***p < .001.
Table 2. Magnitude and Significance of Unique Indirect Relations.

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Predictor</th>
<th>Mediator(s)</th>
<th>Criterion</th>
<th>( \beta )</th>
<th>SE</th>
<th>B</th>
<th>SE</th>
<th>95% CI of unstandardized relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a</td>
<td>Sexual objectification</td>
<td>Internalization</td>
<td>Surveillance</td>
<td>.03</td>
<td>.04</td>
<td>.06</td>
<td>.06</td>
<td>(-.080, .175)</td>
</tr>
<tr>
<td>2b</td>
<td>Sexual objectification</td>
<td>Internalization</td>
<td>Shame</td>
<td>.02</td>
<td>.03</td>
<td>.04</td>
<td>.05</td>
<td>(-.061, .139)</td>
</tr>
<tr>
<td>2b</td>
<td>Sexual objectification</td>
<td>Surveillance</td>
<td>Shame</td>
<td>.03</td>
<td>.02</td>
<td>.07</td>
<td>.04</td>
<td>(-.001, .168)</td>
</tr>
<tr>
<td>2c</td>
<td>Sexual objectification</td>
<td>Internalization</td>
<td>Eating disorder</td>
<td>.01</td>
<td>.02</td>
<td>.01</td>
<td>.02</td>
<td>(-.018, .046)</td>
</tr>
<tr>
<td>2d</td>
<td>Sexual objectification</td>
<td>Surveillance → Shame</td>
<td>Depression</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.00</td>
<td>(.000, .016)</td>
</tr>
<tr>
<td>3a</td>
<td>Internalization</td>
<td>Surveillance</td>
<td>Shame</td>
<td>.13</td>
<td>.04</td>
<td>.21</td>
<td>.06</td>
<td>(.092, .336^*)</td>
</tr>
<tr>
<td>3b</td>
<td>Internalization</td>
<td>Shame</td>
<td>Eating disorder</td>
<td>.10</td>
<td>.03</td>
<td>.07</td>
<td>.02</td>
<td>(.025, .116^*)</td>
</tr>
<tr>
<td>3c</td>
<td>Internalization</td>
<td>Surveillance → Shame</td>
<td>Depression</td>
<td>.03</td>
<td>.02</td>
<td>.02</td>
<td>.01</td>
<td>(.002, .035^*)</td>
</tr>
<tr>
<td>4a</td>
<td>Surveillance</td>
<td>Shame</td>
<td>Eating disorder</td>
<td>.07</td>
<td>.03</td>
<td>.04</td>
<td>.02</td>
<td>(.010, .081^*)</td>
</tr>
<tr>
<td>4b</td>
<td>Surveillance</td>
<td>Shame</td>
<td>Depression</td>
<td>.06</td>
<td>.03</td>
<td>.03</td>
<td>.01</td>
<td>(.003, .051^*)</td>
</tr>
<tr>
<td>6a</td>
<td>Racist discrimination</td>
<td>Shame</td>
<td>Eating disorder</td>
<td>.05</td>
<td>.02</td>
<td>.04</td>
<td>.02</td>
<td>(.005, .088^*)</td>
</tr>
<tr>
<td>6b</td>
<td>Racist discrimination</td>
<td>Shame</td>
<td>Depression</td>
<td>.04</td>
<td>.02</td>
<td>.03</td>
<td>.02</td>
<td>(.001, .062^*)</td>
</tr>
<tr>
<td>Auxiliary</td>
<td>Internalization</td>
<td>Surveillance → Shame</td>
<td>Eating disorder</td>
<td>.04</td>
<td>.02</td>
<td>.03</td>
<td>.01</td>
<td>(.007, .055^*)</td>
</tr>
<tr>
<td>Auxiliary</td>
<td>Internalization</td>
<td>Shame</td>
<td>Depression</td>
<td>.08</td>
<td>.04</td>
<td>.04</td>
<td>.02</td>
<td>(.005, .084^*)</td>
</tr>
</tbody>
</table>

Note. CI = confidence interval.

*p < .05.
body surveillance yielded significant positive indirect links with eating disorder symptomatology and depressive symptomatology through the mediating role of body shame (Hypotheses 4a and 4b). The nonsignificant direct links from body surveillance to eating disorder and depressive symptomatology indicate that the corresponding indirect links reflect full mediation.

Finally, racist discrimination yielded significant positive indirect links with both eating disorder symptomatology and depressive symptomatology through the mediating role of body shame (Hypothesis 6a and 6b). Because the direct link of racist discrimination with eating disorder symptomatology is nonsignificant, the corresponding indirect link reflects full mediation. In contrast, because the direct link of racist discrimination with depression is non-zero and significant, the corresponding indirect link reflects partial mediation.

**Nested Model Comparisons**

Inspection of modification indices indicated that including unestimated paths (i.e., sexual objectification to body shame, eating disorder symptomatology, and depressive symptomatology; racist discrimination to internalization and body surveillance; body surveillance to depressive symptomatology) would not significantly improve model fit. To determine whether a more parsimonious model fit the data, a nested model comparison was performed. Specifically, the model depicted in Figure 2 was compared with a trimmed, full mediation model in which significant direct predictor–criterion relations were constrained to zero (i.e., eliminated) when the corresponding indirect relation was also significant (i.e., internalization to body shame and eating disorder symptomatology, racist discrimination to depressive symptomatology). This full mediation model provided poor fit to the data according to two of the three fit indices (CFI and RMSEA): $\chi^2(11, N = 180) = 49.73, p < .001$, $\text{CFI} = .88$, $\text{RMSEA} = .14$ (90% CI = [.10, .18]), $\text{SRMR} = .06$. Moreover, a chi-square difference test indicated that the fit of the full mediation model was significantly worse than the fit of the original model, $\Delta \chi^2(4) = 44.75, p < .001$.

To determine whether the inclusion of racist discrimination contributed substantively to the model, a nested model comparison was performed in which the paths from racist discrimination to internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology were constrained to 0. This model provided poor fit to the data, $\chi^2(14, N = 180) = 89.78, p < .001$, $\text{CFI} = .76$, $\text{RMSEA} = .17$ (90% CI [.14, .21]), $\text{SRMR} = .10$. Moreover, a chi-square difference test indicated that this nested model provided significantly poorer fit to the data than the original model, $\Delta \chi^2(6) = 80.87, p < .001$. 


Discussion

This study contributes to the understanding of Latina women’s body image and mental health by testing hypotheses grounded in an expanded objectification theory framework. Most of the present findings supported tenets of objectification theory with Latina women. In contrast, other findings are consistent with previous research with racial and ethnic minority women that suggests departures from objectification theory. Lastly, the findings regarding Latina women’s experiences of racist discrimination suggest group-specific expansion of objectification theory. Within the context of the study’s design and sample characteristics, our findings can guide future research and clinical work with Latina women.

With a few notable exceptions, the pattern of bivariate correlations was consistent with objectification theory. Specifically, sexual objectification and the body image variables yielded significant small to large correlations with eating disorder and depressive symptomatology. This pattern of relations was largely unchanged when BMI and age were controlled and is consistent with prior research with predominantly European American women (Moradi & Huang, 2008; Tiggemann, 2011). Moreover, findings of the path analysis revealed direct or indirect links of internalization, body surveillance, and body shame with eating disorder and depressive symptomatology and pointed to body surveillance and body shame as important mediators within the objectification theory framework. Specifically, internalization and body shame were uniquely and directly related to greater eating disorder symptomatology, whereas body shame was uniquely and directly related to greater depressive symptomatology. Beyond these direct links, internalization was indirectly related to greater eating disorder and depressive symptomatology via the mediating roles of body shame and body surveillance. Similarly, body surveillance was indirectly related to greater eating disorder and depressive symptomatology via body shame. These findings are consistent with patterns observed in prior objectification theory research (Moradi & Huang, 2008; Tiggemann, 2011) and further belie the assumption that the links between body image concerns and psychological symptomatology are restricted to European Americans (e.g., Brown et al., 2009; Dohm et al., 2010). Importantly, because our analyses controlled for participants’ age and BMI, the significant relations hold true after taking into account the links of age and BMI. Thus, for example, compared with younger Latina women, older Latina women reported lower levels of sexual objectification, internalization, body surveillance, body shame, eating disorder symptomatology, and depressive symptomatology, but the significant relations among these variables emerged beyond the variability due to age.
These findings also suggest points of intervention for clinical work with Latina women. Critiquing the thin ideal has been shown to decrease body dissatisfaction, negative affect, dieting, and bulimic symptoms (Stice, Presnell, Gau, & Shaw, 2007), and experiencing body acceptance from others has been indirectly related to greater intuitive eating through the mediating roles of body surveillance and body appreciation (Oh, Wiseman, Hendrickson, Phillips, & Hayden, 2012). Thus, clinical work with Latina women may focus on affirming body image, critiquing the thin ideal, and encouraging clients to attend to how their body feels rather than how it looks. Latina/o cultural values may also counteract internalization, body surveillance, and body shame. For example, prior research suggests that *familismo*—the individuals’ deep connection or attachment to their families of origin—weakened the link of acculturation to US culture with body image concerns and eating disorder symptomatology (Bettendorf & Fischer, 2009). Such culturally salient factors may buffer some of the relations observed in the present study.

In a departure from prior research with primarily European American samples (Kozee et al., 2007; Moradi et al., 2005; Wiseman & Moradi, 2010), sexual objectification was not correlated with internalization in the present sample. In addition, after controlling for BMI, age, and internalization, the link of sexual objectification with body surveillance became nonsignificant. These divergent findings have also been observed in prior studies with African American women (Mitchell & Mazzeo, 2009; Watson, Ancis, et al., 2013). In future studies, researchers could conduct invariance testing to directly compare objectification theory relations across groups. Moreover, future research could explore potential moderators that may shape differential relations. For example, in one study of African American women, high levels of multicultural racial identity attitudes—which affirm one’s racial or ethnic group as well as other sociocultural groups—rendered the direct link of sexual objectification with internalization nonsignificant (Watson, Ancis, et al., 2013). Similarly, exposure to sexualized images of women was associated with more negative body image among Latina girls low in ethnic identity, but this association was nonsignificant for girls high in ethnic identity (Schooler & Daniels, 2014). Notably, because participants in the present sample were recruited from Internet communities for Latina women, it is possible that their average level of ethnic identity was higher than in the general population of Latina women. This cannot be confirmed with the present data because ethnic identity was not measured. Future research is needed to determine whether ethnic identity moderates the link of sexual objectification experiences with internalization among Latina women as well as among women from other racial and ethnic minority groups. Beyond potential moderating roles, ethnic identity may also yield first-order associations with...
objectification theory constructs. For example, a study of Asian and Asian American women found that positive ethnic identity was directly or indirectly (through self-esteem) associated with lower internalization, body dissatisfaction, and eating disorder symptoms (Cheng, 2014). In addition to examining the role of ethnic identity in future objectification theory research with Latina women, it would be helpful to also assess the role of severe forms of sexual objectification, such as childhood sexual abuse or trauma, which has been linked with objectification theory constructs in diverse samples of women (Watson, Matheny, Gagné, Brack, & Ancis, 2013; Watson, Robinson, Dispenza, & Nazari, 2012).

A major contribution of the present study is that it acknowledges Latina women’s experiences of multiple forms of oppression by testing the links of both sexual objectification and racist discrimination with body shame and psychological symptomatology. Consistent with prior research with racial and ethnic minority individuals, racist discrimination was positively correlated with body shame, eating disorder symptomatology, and depressive symptomatology (Gordon et al., 2010; Menon & Harter, 2012; Montes de Oca, 2006; Perez et al., 2002). Furthermore, when included in the path model, racist discrimination yielded positive unique direct links with body shame and depressive symptomatology and positive indirect links to both eating disorder and depressive symptomatology via the mediating role of body shame. Thus, body shame may be one mechanism by which racist discrimination is “embodied” and linked with psychological symptomatology. These results are consistent with Striegel-Moore and Smolak’s (2000) hypotheses about the development of eating disorder symptomatology in racial and ethnic minority women. These authors posit that aspects of the oppressive sociocultural context, such as racist discrimination, lead to self-concept deficits and poorer body image, which are then related to eating disorder symptomatology.

Notably, sexual objectification and racist discrimination shared 25% of their variance in the current study, which resembles overlap in experiences of sexist and racist discrimination in other samples of racial and ethnic minority women (e.g., Moradi & Subich, 2003; Szymanski & Stewart, 2010). Such overlap may reflect the reality that racial and ethnic minority women experience “racialized” sexism and “gendered” racism (e.g., Moradi & Subich, 2003). Indeed, qualitative findings suggest that sociocultural attitudes regarding race, gender, and sexual orientation all shape the sexual objectification experiences of African American women and racial and ethnic minority gay and bisexual men (Brennan et al., 2013; Watson et al., 2012). Thus, future studies may explore how racism, sexism, heterosexism, classism, and other forms of oppression combine to shape diverse Latina women’s experience of objectification.
The findings regarding racist discrimination underscore the importance of attending to the variety of sociocultural identities and experiences that clients bring into clinical settings. When working with Latina women, clinicians may assess the potential role of racist discrimination in clients’ feelings about their bodies, disordered eating, and depressive symptoms. In addition, given potential overlap in Latina women’s experiences of racist discrimination and sexual objectification, exploring the co-occurrence of both forms of discrimination and their links with both body image and mental health may be warranted. At the structural level, clinicians may engage in outreach or consultation to mitigate the occurrence of racist discrimination and sexual objectification across contexts.

Limitations and Future Directions

The findings of the present study must be interpreted in light of the study’s methodological limitations. Self-report data such as those analyzed in the present study are often the sole form of data available to clinicians and researchers. Nonetheless, such data may be susceptible to perceptual biases. For example, perceptions of discrimination may be influenced by affect, knowledge of discrimination, and characteristics of the perpetrator (e.g., Barrett & Swim, 1998). Thus, future research should attempt to reproduce the present study’s findings using other sources of data, such as external indicators of objectification (e.g., exposure to sexually objectifying media) or clinician assessments of body image attitudes and psychological symptomatology.

Similarly, although the conceptual framework of the present study assumes a causal chain of relations among the variables of interest, the cross-sectional nature of the data precludes causal interpretation. Experimental and longitudinal studies support many of the directional links within the objectification theory framework (e.g., Moradi & Huang, 2008) and between racist discrimination and mental health outcomes (e.g., Burrow & Ong, 2010), but more research is needed to test the specific causal or temporal links examined in the present study.

The demographic characteristics of the sample are also potential limitations. The sample reported high levels of educational attainment—approximately 62% had a bachelor’s degree or higher—which is markedly higher than the 16% reported by Latina women or the 32% reported by women in the U.S. overall (U.S. Census Bureau, 2015). Similarly, notwithstanding the limitations of single-item, self-report estimates of social class, a slight majority of participants identified as middle class. Moreover, although acculturation to U.S. culture was not directly assessed in the current study, the proportion of participants born in the United States, number of years spent living in the United States, and other sociocultural characteristics may influence the results. To generalize findings from the current study to Latina women in the general population, future research should consider the role of acculturation and other sociocultural factors.
United States, and the level of English proficiency in the present sample suggest high levels of acculturation. Assessment of acculturation is consistent with the importance of internalization of dominant societal values within the objectification theory framework. However, empirical findings regarding the links of acculturation with body dissatisfaction and eating disorder symptomatology in Latina/o samples have been mixed, with some research indicating significant positive relations (e.g., Bettendorf & Fischer, 2009; Poloskov & Tracey, 2013) and other findings indicating nonsignificant relations (e.g., Gordon et al., 2010; Montes de Oca, 2006; Warren & Rios, 2013). These discrepant findings may be due, in part, to variability in operationalization and assessment of acculturation across studies, ranging from multi-item scales to single-item proxies of acculturation (e.g., time residing in the United States). Nonetheless, more research is needed to identify potential moderators of the relations of acculturation with body image and psychological symptomatology.

Mean scores for sexual objectification, internalization, body surveillance, and body shame were close to the midrange of possible scores for each instrument and consistent with mean scores reported in prior research using the same instruments with diverse samples of women (e.g., Augustus-Horvath & Tylka, 2009; Kozee et al., 2007; Moradi et al., 2005; Moradi & Rottenstein, 2007; Tolaymat & Moradi, 2011; Watson, Ancis, et al., 2013). Mean scores for racist discrimination, eating disorder symptomatology, and depressive symptomatology were closer to the lower end of possible scores. Relatively lower mean levels of racist discrimination are typical in research with racial and ethnic minority individuals (e.g., Landrine et al., 2006; Moradi & Subich, 2003; Szymanski & Stewart, 2010). Similarly, the levels of eating disorder and depressive symptomatology evinced in the present study resemble levels reported in prior research (e.g., Carr & Szymanski, 2011; Moradi et al., 2005; Watson, Ancis, et al., 2013). Nonetheless, the low mean and variability of racist discrimination and psychological symptomatology in the present sample may have attenuated relations with other variables.

Although most of the instruments used in the present study were developed with samples composed primarily of European American women, tests of measurement and structural invariance across racial and ethnic groups support the validity of the constructs with Latina/o people (Boie et al., 2013). Nonetheless, a fruitful avenue for future research would be to incorporate intersectional conceptualizations (Cole, 2009) into definition and measurement of core objectification theory constructs. For example, qualitative findings suggest that African American women experience sexual objectification via exposure to racist, hypersexualized media portrayals that reduce African American women to seductive, sexually lascivious “Jezebels” (Watson et al.,
Similarly, sexual objectification experiences for Latina women may reflect racist stereotypes of Latina women—for example, that they are fiery, sexually aggressive, or devious (e.g., Mastro & Behm-Morawitz, 2005; Merskin, 2007). Prior intersectional objectification theory research has focused on aspects of body image beyond weight, such as African American women’s skin tone surveillance and dissatisfaction (Buchanan, Fischer, Tokar, & Yoder, 2008) and South Korean women’s facial size and shape surveillance (Kim, Seo, & Baek, 2014). Although the findings of the current study and prior research (e.g., Boie et al., 2013; Gordon et al., 2010; Viladrich et al., 2009) indicate that weight-based body image concerns are salient correlates of eating disorder and depressive symptomatology among Latina women, it is likely that other aspects of Latina women’s body image (e.g., skin tone, hair texture) are also shaped by exposure to societal oppression.

Despite these limitations, the present findings point to connections among contextual (e.g., racist discrimination) and intrapersonal (e.g., internalization, body surveillance, body shame) factors that may shape eating disorder and depressive symptomatology for Latina women. These findings also suggest the promise of objectification theory—with some modifications, such as inclusion of racist discrimination—for advancing the understanding of eating disorder and depressive symptomatology for Latina women in research and practice.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Bonnie Moradi is a professor of psychology and director of the Center for Women’s Studies and Gender Research at the University of Florida. Her research focuses on experiences of prejudice, discrimination, and objectification, as well as on collective identity. This research examines the nature of these experiences, their implications for health and well-being for women, racial and ethnic minority, sexual minority, and other minority populations, and the intersections of minority stressors and identities across populations.